Submission to:
Pharmacy Remuneration and Regulation Review

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The Society of Hospital Pharmacists of Australia (SHPA) is the national professional organisation for more than 4000 pharmacists, pharmacists in training, pharmacy technicians and associates working across Australia’s health system.

SHPA is the only professional pharmacy organisation with a core base of members leading pharmacy practice in public and private hospitals and other health service facilities.

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

In today’s dynamic health landscape the role played by pharmacists in supporting patient outcomes through management of medicines and the provision of professional pharmacy services is drawing increasing interest and attention from health policymakers.

Managing medicines remains a substantial challenge for contemporary society. Even as community expectations of health and medical treatments grow, the sub-optimal management of medicine contributes to life-shortening outcomes for vulnerable populations, evidenced by the 230,000 medication related hospital admissions each year (ACSQHC, 2013). With almost half of Australians experiencing a chronic health condition (AIHW, 2016) requiring regular medicine use, a consensus is growing around the benefit of greater access for patients to professional pharmacy services, an expansion of the role of pharmacists in a variety of healthcare settings to assist other health and medical professionals, and a recognition of the valuable role played by pharmacists as key members of the multi-disciplinary healthcare team.

In 2016 hospital pharmacists continue to lead innovation in the provision of professional pharmacy services for people taking the most complex and expensive medicines, including those listed on the PBS. Twenty per cent of PBS expenditure is managed by pharmacists based in public or private hospitals, so The Society of Hospital Pharmacists of Australia (SHPA), Australia’s fastest growing professional pharmacy organisation welcomes the opportunity to make a submission to the Pharmacy Remuneration and Regulation Review.

For nearly 80 years SHPA has represented and advocated for pharmacists working in hospitals and other healthcare settings in relation to ensuring the best possible care for patients. Whilst not as numerous as pharmacists in community pharmacy hospital pharmacists operate at the highest levels of pharmacy and healthcare, and represent the greatest expertise in the design and development of professional pharmacy services to support positive patient health outcomes.

SHPA members lead the Pharmacy Departments at all 29 of the principal referral hospitals in Australia, as well as the vast majority of both Public Acute A and Public Acute B hospitals. This includes the largest and most highly regarded hospitals in the country including the Alfred Hospital, Royal Brisbane & Womens’ Hospital, Prince of Wales Hospital, Monash Medical Centre, Royal Perth Hospital, Austin Hospital, Royal Hobart Hospital, Westmead Hospital, Concord Repatriation General Hospital, Canberra Hospital and Townsville Hospitals and many others. Furthermore, 75% of all hospitals (public and private) have their Pharmacy Departments led by a SHPA member. SHPA members are also employed in a range of innovative outreach and liaison services in community healthcare settings.

The Review of the Pharmacy Remuneration and Regulation Discussion Paper provides a welcome opportunity for pharmacists who work in healthcare settings including hospitals to draw on their expertise in providing patient-centred care. Often dispensing the same medicines, facing some of the same challenges and utilising many of the same bureaucratic structures, pharmacists working in hospitals provide care for people at their sickest. The expertise of our members in the development, provision and prioritisation of pharmacy services in constrained fiscal environments, including the funding of medicines is extremely relevant to the remuneration and regulation of Australia’s pharmaceutical landscape and broader healthcare system.

In Australia pharmacy services have traditionally been divided into largely separate spheres of pharmacy activity: those within a community retail pharmacy; and those in institutional setting such as hospitals. Despite many shared elements SHPA recognises that pharmacy
reflects the challenge of fragmented care seen broadly throughout the health sector. The structure and development of remuneration for medicines and community pharmacy services is a key contributor to this. Policy tools such as the 6CPA reverberate through the pharmacy environment in a practical way, influencing practice, determining priorities and sometimes distracting our fellow practitioners.

SHPA believes strongly that as a health service remuneration for services provided by pharmacists must focus on delivery of good patient outcomes rather than process delivery. In this submission, we discuss how this could be implemented. Ideally it would involve a single funder for all medicines, and uniform remuneration across pharmacy with clearly funded expectations and evaluation of these services regardless of setting. This type of integrated approach would be most capable of supporting Australia’s growing need for care for people with chronic diseases and our ageing population with the increased risk of medicine mismanagement.

In order to achieve this aim Australia needs a skilled pharmacy workforce with expertise as medicines specialists. With a wide continuum of workplaces offering professional pharmacy services SHPA does not currently believe that all pharmacists are medicines specialists, and further credentialing and accreditation is required for delivery of more comprehensive cognitive services. Hospital pharmacists, accredited pharmacists and those working in other healthcare settings have supported the development of increased credentialing for pharmacists with the strategic aim of a capable and competent workforce. SHPA’s Workforce Transformation projects have introduced opportunities to increase the skills of early career pharmacists through a pharmacy residency, to improve links with evidence-based research through the National Translational Research Collaborative and to build capacity in pharmacy teams by supporting the role redesign of Pharmacy Technicians. Our members are already undergoing Advanced Practice credentialing to ensure they have the research and leadership capacities needed to support pharmacy as it enters a period of transition.

SHPA fully supports the fantastic contributions to patient care that thousands of pharmacists provide in community pharmacies across Australia every day. However, constraints in existing funding models but also the commercial priorities of some owners are both factors that must be acknowledged as barriers to the practice of pharmacists.

Healthcare services by healthcare practitioners, in this case pharmacists, must be provided in settings conducive to the delivery of professional services. As outlined in the Australian Charter of Healthcare Rights consumers deserve high quality and safe care, wherever and whenever it is provided (ACSQHC, 2008). The community retail pharmacy setting must be significantly reformed to enable this to consistently occur.

In this submission SHPA has attempted to focus the response to the specific questions raised. SHPA has refrained from an approach that describes, or provides the evidence, for all the potential clinical activities and services for which there is evidence. A select number of papers and guidelines have been acknowledged to highlight particular points. In addition to these SHPA has many other practice standards, position papers, submissions and literature to inform this review.

SHPA welcomes the opportunity to have the expert role fulfilled by SHPA members more broadly considered in the development and implementation of pharmacy remuneration and regulation policy, for the benefit of the Australian community.

Professor Michael Dooley
Federal President
The Society of Hospital Pharmacists of Australia

SHPA submission to Pharmacy Remuneration and Regulation Review (September 2016)
Recommendations

SHPA is Australia’s only professional pharmacy organisation with more than 4000 members leading pharmacy practice in public and private hospitals and other health service facilities.

These recommendations are made to support the quality use of medicines for all Australians, with pharmacists practicing as health care professionals in the most appropriate setting, to deliver the best care possible. In many cases this will be within a community pharmacy however in others it will be in the patient home, in General Practice or a community healthcare service.

SHPA response to the specific questions within this review are based on the following fundamental recommendations:

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 20% of the PBS is expended. 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. Remuneration of cognitive services must include recognition that not all practising pharmacists can be considered medicine specialists and further credentialing and accreditation is required 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 distinct 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 hospitals 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.
About Pharmacist Contribution to Care

In this submission SHPA has attempted to focus the response to the specific questions raised. SHPA has refrained from an approach that describes, or provides the evidence, for all the potential clinical activities and services for which there is evidence. A select number of papers and guidelines have been acknowledged to highlight particular points. In addition to these SHPA has many other practice standards, position papers, submissions and literature to inform this review.

Figure 1. Overview of the medicines management pathway (SHPA, 2013)

Pharmacists play a vital role in today’s healthcare system. A pharmacist in a hospital, or another healthcare setting such as primary health care or outreach, is responsible for making sure that patients receive the most appropriate medicines in the most effective way.

Pharmacists prepare and dispense medicines, advise doctors, nurses and other health professionals on correct dosage, when and how medicines should be given, potential unwanted effects of medicines and possible interactions between medicines. The work of pharmacists is highly clinical but also personally rewarding. They consult with patients at the bedside, in clinics and in their own homes. They often work as part of a team of pharmacists – maybe 2 or 3 in smaller hospitals, or as many as 60 to 80 in larger ones. In larger hospitals, pharmacists work in specialist teams embedded in the multidisciplinary healthcare teams, treating people of all ages with complex medical needs such as those receiving organ transplants, being treated for cancer or recovering from surgery. Hospital pharmacists are employed by all types of general, specialist and teaching hospitals, regardless of location.
Figure outlines how hospital pharmacy services support the medication management pathway, shown in Figure 1.

**Figure 2. Overview of Hospital Pharmacy Services that support the Medicines Management Pathway** (SHPA, 2013)

**SHPA model of care**

Quality use of medicines (QUM) principles are pivotal to the provision of care provided by a pharmacist. SHPA has built on the QUM principles to provide a framework for care based on four elements that are required to deliver patient outcomes, as shown in Figure 3. These can be evaluated based on the complexity of patient need and the setting in which the services need to be provided. Depending upon the level of complexity involved a different professional may be involved: i.e. an accredited pharmacist, a pharmacist in a hospital, pharmacist in a community pharmacy, or a pharmacy technician.

**Figure 3. SHPA model of care**

SHPA submission to Pharmacy Remuneration and Regulation Review (September 2016)
Definition of Pharmacy Services

In this document we refer to ‘pharmacy services’ as described in the SHPA Standards of Practice for Clinical Pharmacy Services (SHPA, 2013). This refers to evidence-based clinical pharmacy activities which minimise the inherent risks associated with the use of medicines, increase patient safety at all steps in the medicines management pathway and optimise health outcomes.

These clinical pharmacy activities include:
- medication reconciliation
- assessment of current medication management
- clinical review, therapeutic drug monitoring and adverse drug reaction management
- contributing to the Medicines Management Plan
- providing medicines information
- facilitating continuity of medication management on discharge or transfer
- participating in interdisciplinary ward rounds and meetings
- training and education
- participating in research
- quality improvement activities and peer review.

A clinical pharmacy service is delivered by an appropriately skilled pharmacist, practicing in the appropriate setting, with the correct clinical information and collaborating with patient, carer and medical team. This is often, but not always, a team of pharmacists (with support from pharmacy technicians and assistants) who are involved in the delivery of a combination of these activities to individual patients or groups of patients.
Pharmacy and Pharmaceutical Services in Australia

Question 1.
In your opinion, is the ratio of community pharmacies to population optimal? What data would you use to support this opinion?
SHPA supports the delivery of high quality pharmacy services which facilitate quality use of medicine activities in addition to dispensing and professional clinical services (refer Figure 1). The number of community pharmacies is not a metric that describes the quality of the service provided or the healthcare needs of the community. Consequently, the ratio of community pharmacies is therefore an inadequate measure of the access of the community to appropriate pharmacist and pharmacy services to meet their health needs. As an example, there is no doubt that parts of regional and remote Australia do not have adequate access to pharmacy services through a community pharmacy despite a population to pharmacy ratio greater than some metropolitan areas. More appropriate measures would be those that evaluate the timely delivery medication availability and the provision of professional services (such as those recommended in this submission) that deliver evidence-based consumer outcomes.

Question 2.
If it is desirable for the ratio of community pharmacies to population to increase or decrease in some areas, what in your opinion is the best way to encourage this?
As outlined above SHPA believe 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. SHPA believes it is important to ensure that ‘unintended’ service gaps for consumers are not created across the continuum as a result of location rules or funding models. The ratio of community pharmacies is an inadequate measure of the access of the community to appropriate pharmacist and pharmacy services to meet their health needs.

Question 3.
In your opinion, should there be a maximum ratio of retail space to professional area within pharmacies to maintain the atmosphere of a health care setting for community pharmacies receiving remuneration for dispensing PBS medicines?
SHPA believes strongly that all pharmacies are places of healthcare and therefore the only appropriate setting is one conducive to the delivery of professional healthcare and support. The community pharmacy retail setting must be significantly reformed to enable this to occur. To achieve this SHPA recommends a focus on developing greater standards and requirements related to the professional pharmacy services, alongside an increased focus on staff training and accreditation, rather than a ratio of retail to professional space. In particular the current minimum standards regulated for community pharmacies do not provide sufficient privacy or space for professional services to consumers and especially those with special needs. It is not possible to reform the services provided within this setting without major reforms around community pharmacy facilities. The focus must be on providing appropriate facilities for professional services rather than maximum ratios to retail space.
Question 4.
Should Government funding take into account the business model of the pharmacy when determining remuneration, recognising that some businesses receive significant revenue from retail activities?
As a health service pharmacy services must be focused on outcomes rather than process. Hence the funding for services provided should be directed to the healthcare practitioner whose expertise guides service delivery, focusing on medicine dispensing and professional service. Remuneration should not be determined by aspects unrelated to health outcomes, such as the model of the au spicing organisation.

Regulatory Landscape
Question 5.
Is the CPA process consistent with the National Medicines Policy? Is it consistent with the long term sustainability and affordability of the PBS? Is it consistent with good government practice in terms of value for money (for both patients and taxpayers), clarity, transparency and sustainability?
SHPA believes that the CPA process is not consistent with the National Medicines Policy (NMP), nor is it consistent with the philosophy of healthcare service delivery or patient-centred care.

The NMP aims to bring about better health outcomes for all Australians, focussing on timely access to medicines, appropriate standards of quality, safety and efficacy, quality use of medicines and supporting a responsible medicines industry. To achieve this it engages a wide range of stakeholders recognising the contributions made by partners and providers across different jurisdictions of government, health service providers, the medicines industry, consumers and the media. The process of negotiating the Community Pharmacy Agreement (CPA) is not transparent, and involves only a narrow group of stakeholders who represent a single commercial interest. This ensures a narrow representation of pharmacy expertise and avoids clarity in relation to vested interests as well as discouraging innovations that challenge traditional practice.

SHPA believes the CPA offers questionable value for money. Its results are measured only in relation to the volume of medicines and services delivered, rather than being correlated with clinical or patient outcomes. SHPA believes a greater focus on the quality of health outcomes achieved would be more appropriate.

In relation to the long-term sustainability of the PBS, it is important to note that the CPA is only one of several policies affecting PBS expenditure. The relationships with manufacturers outlined in the CPA, including the requirement for price disclosure, have significant impacts on the price and availability of medicines throughout Australia. SHPA does support efforts that encourage the viability of Australia’s medicines industry and contribute to greater sustainability.

Question 6.
What would be a preferable approach? Why would this be preferable?
SHPA believes that a broader consultation with pharmacy and health stakeholders would deliver a more patient-focused outcome. The programs of the CPA do not meet community need, and due to their reliance on commercially oriented community pharmacies are often not available where they are needed most. This is not surprising given their focus on process rather than outcomes, ad-hoc development and lack of broad evidence-base.
Consultation with pharmacy 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.

**Question 7.**

**Should the CPA be limited to dispensing and professional programs provided by community pharmacy only? If so, how can contestability and effectiveness be ensured in professional programs? If not, why not?**

The CPA should not be limited to dispensing and professional programs provided by community pharmacy only, similar to the current CPA. Any future models must ensure equity of access that includes the private and public hospital sector. To achieve optimal health outcomes for the community the pharmacy sector, alongside the primary care and acute sectors, needs greater collaboration and shared activity not less. Already contemporary innovation has begun to blur the lines between community and hospital pharmacy with the outsourcing of private hospital pharmacy services to pharmacy companies who operate under community pharmacy regulations to support hospital wards. Further limiting CPA funding would create additional gaps in an already complex system.

Appropriate stakeholder consultation can assist remuneration and program design to ensure these complications are addressed. This level of policy assistance and expert advice cannot be provided by the Guild or Pharmaceutical Society of Australia which do not represent this expertise. SHPA provides expert representation of pharmacists working in the development of innovative programs to address consumer health needs.

**Question 8.**

**Is it appropriate that the Government continues to negotiate formal remuneration agreements with the Guild on behalf of, or to the exclusion of, other parties involved in the production, distribution and dispensing of medicines? If so, why? If not, why not, and which other parties should be involved? Is there currently an appropriate partnership with these other parties, including consumers?**

SHPA believes it is not appropriate for a commercial body such as the Guild to have exclusive arrangements with the government to negotiate remuneration agreements which impact on the entire pharmacy sector and broader community health for a wide range of reasons which include conflicts of interest, representation of the broader sector and relevant expertise.

Hospitals remain a significant sector for the purchase and supply of PBS medicines dispensing 20% across public and private hospitals nationally (PBS correspondence). Hospital pharmacists therefore are well placed to advise on remuneration for both medicines through the PBS but also pharmacy services as determined in the CPA, through SHPA. To ensure good clinical and community outcomes, remuneration and regulation negotiations for pharmacy services must involve multiple stakeholders representing different parts of the workforce, consumers and relevant jurisdictions of government. In particular hospital pharmacy, pharmacists who lead clinical pharmacy practice and facilitate care for patients in hospitals, outpatient services and other healthcare settings, must be provided with opportunities to provide expert advice and direction on clinical pharmacy service remuneration currently denied under the CPA process. This could most easily be facilitated through inclusion of SHPA, alongside any other pharmacy and primary care workforce representatives.
With more than 4000 members across Australia SHPA represents and advocates for expert pharmacists who work in healthcare settings including hospital services. A simple measure to illustrate this is that SHPA members lead the pharmacy department at all 29 of the Principal Referral hospitals in Australia, as well as the vast majority of both Public Acute A and Public Acute B hospitals. This includes the largest and most highly regarded hospitals in the country including the Alfred Hospital, Royal Brisbane & Women’s Hospital, Prince of Wales Hospital, Monash Medical Centre, Royal Perth Hospital, Austin Hospital, Royal Hobart Hospital, Westmead Hospital, Concord Repatriation General Hospital, Canberra Hospital, Townsville Hospital and many others. Furthermore, 75% of all hospitals (public and private) have their pharmacy departments led by a SHPA member. SHPA members are also employed in a range of outreach and liaison services in community healthcare settings not represented by other pharmacy bodies. SHPA also provides the Standards of Practice for all areas of hospital pharmacy and works with jurisdictional bodies to lead clinical pharmacy care in all states and territories of Australia.

Whilst the pharmacy sector does have a number of workforce organisations that claim to represent the entire sector, the divisions between community and hospital or healthcare pharmacy are substantial when considering the impact of remuneration on pharmacy activity and patient care. Community pharmacy organisations such as the Pharmaceutical Society of Australia cannot provide the expert clinical knowledge of all pharmacy practices relevant to these broad policy discussions. SHPA is the only national organisation that represents the hospital pharmacy sector, a major provider of PBS expenditure, and is a key partner and stakeholder in delivering innovation and reform.

The Review of the Pharmacy Remuneration and Regulation Discussion Paper provides a welcome opportunity for hospital pharmacists, and other pharmacists who work in healthcare settings, to draw on their expertise in providing patient-centred care to both inpatients and outpatients of Australian hospitals. The expertise of our members in the funding of the dispensing of medicine and the use of pharmacy services is extremely relevant to the remuneration and regulation of Australia’s pharmaceutical landscape and broader healthcare system.

**Question 9.**

**Should the Government move away from a partnership arrangement? If so, what would take its place? For example, should the Government move to a more standard contracting or licensing approach with individual pharmacies or groups of pharmacies? How would such alternative arrangements be implemented?**

The partnership arrangement approach is not appropriate for a $19-billion-dollar industry that is essential to the health of our nation. SHPA would like to see the CPA process completely revised and that the future reforms which replace the existing CPA:

- place the consumer at the centre of each program
- support contemporary pharmacy practice
- ensure timely access to quality pharmacist services
- anticipate and respond to community needs and expectations
- support the continuum and transfer of care between different environments and providers
- ensure best value for expenditure of taxpayer monies.
Therefore, SHPA proposes that the public-private partnership between the Commonwealth and pharmacists be redefined so that:

1. it includes the pharmacist-provided services required to support the safe and effective use of PBS medicines
2. the agreement would be made with the pharmacy profession as a whole, rather than one or more organisations, using the same approach used for services provided by the medical profession where:
   - quality, evidence-based services are identified, costed and funded when they are delivered to an individual consumer
   - authorised pharmacy practices are supported through a block funded / grant arrangement to ensure access to primary and preventive healthcare services
3. red tape and unintended waste is minimised (i.e. reduced administrative, operational and clinical inefficiency)
4. constraints on pharmacy location would be replaced with appropriate incentives to support market equilibrium.

Question 10.
Is the current system of dispensing of medicines in Australia that focuses predominantly on community pharmacies operating as small businesses, the best way to achieve the objectives of the NMP? Should there be alternative approaches for the dispensing of PBS medicines beyond a community pharmacy, such as through hospitals or different pharmacy arrangements? If so, what could these alternative approaches look like?

SHPA acknowledges that the current model of dispensing medicines through both small and larger business community pharmacies successfully supports the timely access of the broader community to medicines and limited pharmacy services in the community setting. This meets, to some degree, the aims of the National Medicines Policy to meet service need in order to achieve optimal health care and economic objectives, albeit in a particular setting. However, according to SHPA’s model of care (Figure 1), patients with greater complexity would benefit from alternative approaches which enable increased access to skilled pharmacy practitioners.

SHPA believes that pharmacy services, as well as dispensing, should be funded to be delivered where care is needed. For many people a community pharmacy approach is sufficient for minor ailments and standard medicine supply. Yet feedback from SHPA members and the community indicates that professional pharmacy services for people at high risk of medicines mismanagement are not always provided in the most efficient or effective way in community pharmacy settings. This may be due to the skill and experience of staff in a community setting, or complications related to retail priorities. In addition, elements of CPA-driven implementation of clinical services such as Home Medicine Reviews (HMRs) are limited by supplier measurements rather than patient need. This has the potential to reduce optimal community health and flags that supporting innovation in a community setting by healthcare pharmacists may be an appropriate response.

SHPA members have made it clear that many hospital pharmacies are operating at capacity and are unlikely to be interested in growing their dispensing capacity for community access unless a specific need has been identified. Specialist hospital pharmacies are frequently referring simple dispensing and associated counselling tasks to community pharmacies. This recent approach has enabled greater clinical pharmacy capacity to be achieved, albeit at the cost of continued fragmentation of health services. Hospital services have the expertise to
provide alternative approaches, however further capacity would be required and this would need to be addressed through an appropriate remuneration and clinical care model.

Question 11.
Is the 6CPA achieving appropriate ‘access to medicines’ as defined in the NMP? If so, why? If not, why not and how could access be improved?
According to the National Medicines Policy ‘access to medicines’ includes elements essential to ensuring appropriate use as well as financing and supply arrangements. SHPA believes that the 6CPA does not achieve this outcome particularly in relation to the delivery of pharmacy services such as clinical review and patient counselling.

SHPA members report a lack of innovation in the delivery of clinical services in community settings over recent years which can be attributed to the absence of incentives in the 6CPA for clinical pharmacy services. The inclusion of funding for the Home Medicines Review in the 6CPA looked promising but has been severely limited by arbitrary caps on supplier measures indicating that as a tool the 6CPA is not appropriate for facilitating much-needed community interventions. There is presently no incentives within the 6CPA to implement new models of care in a general practice setting for example, nor to engage through the new Health Care Homes in team-based care for patients with chronic disease. The current CPA focuses on the supply component of medication and does not provide innovation and quality associated with health profession practice and delivery of healthcare by the practitioner (in this case a pharmacist). This can be improved through the recommendations made by SHPA throughout this submission.

Question 12.
Do current arrangements under the 6CPA lead to the appropriate creation and distribution of information relating to the use of medicines? If so, how and why? If not, why not and how could the distribution of this information be improved?
A focus on dispensing at the expense of other pharmacy activities involved in the supply of medicines has prevented the creation and distribution of use of medicine information under the 6CPA. Community pharmacists regularly express the perspective that they are not remunerated for patient counselling or consumer medicine information, indicating the important role of the CPA in determining activities. SHPA acknowledges that remuneration within the CPA does in fact fund these services as a component of every dispensing process. Without regular evaluation it is difficult to know the extent of this problem, but greater promotion of the full process of medicine supply would be beneficial.

Question 13.
Is this requirement a significant impediment to online ordering and remote dispensing? If so, should this impediment be removed? In this scenario, what compensating arrangements would need to be implemented to ensure that there is appropriate oversight and control over dispensing and patient choice of pharmacy?
Yes, this must be removed and must be a key focus as SHPA looks forward to the ADHA plans for reform across the all the sectors. As detailed elsewhere in the submission there must be evidence of the provision of the three components of prescription dispensing to be remunerated, and an audit and evaluation program in place.
Pharmacy Remuneration for Dispensing

Question 14.
To what degree is it appropriate that community pharmacies be protected from the normal operations of consumer choice and ‘protected’ in their business operations? Is such protection required to achieve the NMP objective of access to medicines? If so, why? If not, why not?
Pharmacy and the supply of medicines is an essential service, however it can be delivered in numerous different ways. SHPA supports the continuation of a viable pharmaceutical industry as outlined in the National Medicines Policy. Pharmacists expect to be a valuable member of the healthcare team and SHPA believes that appropriate remuneration must be provided by the Government, in line with any allied health service. SHPA does not think that community pharmacies require ‘protection’ in meeting their service objectives.

Question 15.
Is the ‘swings and roundabouts’ approach to remunerating pharmacists for dispensing appropriate? Does it lead to undesirable incentives?
The ‘swings and roundabouts’ approach to remunerating pharmacists does not recognise the continuum of different types of dispensing and associated activities, instead rewarding minimal efforts regardless of the complexity of the medicine or the risk of mismanagement by the patient. Undesirable incentives include a focus on remuneration for supply, irrespective of whether supply is required. Pharmacists and community pharmacies providing excellent professional services are disadvantaged compared to those pharmacies that provide minimal professional services and are remunerated to the same level.

In patient-centred care, care should be tailored to address the individual needs of the person and the situation. The ‘swings and roundabouts’ approach is essentially the opposite of a tailored approach, and therefore not supported by SHPA. For this reason, SHPA has recommended throughout this submission a focus on delivery and remuneration of specific components of the dispensing process, and not just the supply component.

Question 16.
Should dispensing fee remuneration more closely reflect the level of effort in each individual encounter through having tiered rates according to the complexity of the encounter? For example, should dispensing fees paid to pharmacists differ between initial and repeat scripts?
Current dispensing fee remuneration does not reflect the levels of effort involved in hospital pharmacy practice and should be addressed as a matter of urgency. Dispensing fee remuneration which more closely reflects the level of effort sustained in each encounter would be beneficial to the practice of pharmacy and the sustainability of the health system. For example, the dispensing fee paid for a prescription of a new complex high risk medication in a complex patient requiring education should not be remunerated equally with the dispensing of a repeat prescription which requires no patient interaction.

Tiered fees which reflect the complexity of the encounter would incentivise greater provision of clinical review and counselling when required and accurately remunerate routine transactions which are very simple. ‘Standard’ and ‘Extended’ classification of services would better reflect the level of complexity required, and assist pharmacists in correctly identifying the level of professional expertise required. A ‘not provided’ option would also recognise encounters such as dispensing for people in aged care, where review and counselling services are not provided. Repeat prescriptions could fit into any of the
categories depending upon the complexity of the medicine, or risk of the patient. Currently dispensing and other practice-related fees are only paid to community pharmacists, however if wholesale mark-up remuneration for hospitals was to be diminished payment of dispensing and other practice-related fees to hospital pharmacists would be necessary.

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 (Tables 1 and 2). 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

<table>
<thead>
<tr>
<th>Dispensing prescription tasks</th>
<th>Current 6CPA model (one set payment)</th>
<th>Proposed (tiered payments)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical review</td>
<td>Applies for all dispensing, irrespective of complexity and time required for preparation, clinical review and patient counselling episode</td>
<td>Simple (low risk medicine in low complexity patient)</td>
</tr>
<tr>
<td>Medication preparation and labelling</td>
<td>Dispensing fee = $6.93</td>
<td>Simple (Prepared medication ready for use, requiring labelling only)</td>
</tr>
<tr>
<td>Patient counselling</td>
<td>AHI fee = $3.49 plus 3.5% for medicines over $180, capped at $70</td>
<td>Wholesale-mark up = 7.52% of the ex-manufacturer price, capped at $69.94</td>
</tr>
</tbody>
</table>
Table 2. Example of implementation of proposed dispensing remuneration model

<table>
<thead>
<tr>
<th>Task</th>
<th>Repeat prescription for bisphosphonate for osteoporosis in aged care facility</th>
<th>Short term course of an antibiotic for uncomplicated skin infection</th>
<th>Initial prescription for hepatitis C medicine</th>
<th>Chemotherapy medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical review</td>
<td>Not provided</td>
<td>Standard</td>
<td>Extended</td>
<td>Extended</td>
</tr>
<tr>
<td>Medication preparation and labelling</td>
<td>Standard</td>
<td>Standard</td>
<td>Standard</td>
<td>Extended</td>
</tr>
<tr>
<td>Patient counselling</td>
<td>Not provided</td>
<td>Standard</td>
<td>Extended</td>
<td>Extended if not stabilised</td>
</tr>
</tbody>
</table>

A single funding source for medicines used in hospitals as well as in the community would unify the disparate pharmacy system to the benefit of all Australians.

**Question 17.**
Are the current fees and charges associated with the dispensing of medicine appropriate? In particular, do they provide appropriate remuneration for community pharmacists? Do they provide appropriate incentives for community pharmacists to provide the professional services, such as the provision of medicine advice, associated with dispensing?

Dispensing is a three-step process and includes clinical review, dispensing and patient counselling. Consumer need is best identified through effective clinical review which then informs appropriate patient counselling. Clinical review is a crucial component of dispensing and involves the review of patient-specific clinical information including patient parameters to evaluate their response to medication therapies and to detect and manage potential or actual medicine-related problems. It may include interpreting biochemical and other tests, evaluating the patient’s signs and symptoms identified from interviews with the patient and review of the health record.

The consistent performance of both clinical review and patient counselling offer significant value in the prevention of medicine misadventure, improved patient wellbeing through reduced side-effects, and efficient fiscal management through tighter management of valuable resources. However, there are situations currently where these elements of dispensing are not performed. A tiered system would be able to effectively recognise this and in these cases they would not be remunerated.
Question 18.
Currently community pharmacists have discretion over some charges. For subsidised PBS prescriptions, should community pharmacists be able to charge consumers above the ‘dispensed price’ for a medicine in some circumstances? Should community pharmacists be allowed to discount medicines in some circumstances? If so, what limits should apply to pharmacist pricing discretion? If not, why not?
As SHPA recommends a complete overhaul of the PBS remuneration system for dispensing in community pharmacies this is not a topic SHPA has a fixed position on. SHPA notes that the discounting of PBS prescriptions may lead to perverse incentives and also have the potential to further reduce the quality of dispensing services that have not been fully considered.

Question 19.
Is the RPMA the best way to encourage pharmacies in locations where they would not otherwise be viable? Is community need a more appropriate measure than geographical location?
SHPA believes that equitable access to medicine and professional pharmacy services is essential for the Australian community. SHPA does not have a fixed position on whether RPMA is the appropriate process to achieve a positive outcome. SHPA believes using a combination of parameters to reflect the community serviced by that community pharmacy may be worth considering specifically adjusting for:
- 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%, outer regional 107%, remote 115% and very remote 121%)
- 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.

Question 20.
Is the Electronic Prescription Fee achieving its intended purpose of increasing the uptake of electronic prescribing and dispensing?
SHPA does not have a fixed position on this.

Question 21.
Is the Premium Free Dispensing Incentive achieving its intended purpose of increasing the uptake of generic medicines? Are there better ways to achieve this?
SHPA supports the use of generic medicines and notes they are extremely widely used in hospital settings. There are multiple proven approaches in other sectors and internationally for increasing the use of generic medicines. As with all innovations this will require an integrated approach which incorporates education and engagement with consumers. SHPA does not have access to specific quantitative data to comment specifically on the Premium Free Dispensing Incentive, however our expertise to assist translation of initiatives for broader pharmacy adoption.
Question 22.
Should the timeframes for payment settlements for very high cost medicines be lengthened throughout the supply chain and mandated by Government?
Appropriate processes should be established to ensure timely access to medicines including high cost PBS medicines. In the rare case when urgent supply of a medicine can make a clinical difference this should be stipulated in the PBS listing and supported by appropriate business rules. SHPA members have indicated that this has occurred in practice since Hepatitis C medicines have become more widely available.

Question 23.
Are there better ways of achieving patient access to very high cost medicines through community pharmacy that reduce the financial risks to the supply chain and facilitate consumer choice?
SHPA believes that there has been significant business process reform since the introduction of Hepatitis C medicines to the PBS, and that therefore this is not a major barrier to the timely access of very high cost medicines. For effective supply it is imperative that improved processes are in place prior to the listing of new medications on the PBS.

Question 24.
Given that very high cost drugs are likely to become more common on the PBS, should this remuneration structure for hospitals change to more closely reflect the remuneration structure of community pharmacy?
SHPA appreciates that a uniform remuneration structure for the supply of all PBS medicines to both hospital and community pharmacies would reduce complexity and apparent anomalies. In the interest of simplicity and patient access SHPA supports the introduction of a single funding mechanism for all medicines, including those for inpatient use, which equate to approximately $2.7 billion annually (ABS, 2012).

SHPA believes that consumer need should be the central driver for all medicine funding and pharmacy programs regardless of the care setting. A single funder and uniform remuneration structure for the supply of all PBS medicines would remove confusion regarding the disparate funding mechanisms, give certainty to pharmacists and contribute to better patient outcomes. Substantial evidence from previous SHPA submissions regarding the CPA demonstrates that the current PBS remuneration structure is burdensome in hospitals where 14 different funding elements must be managed to supply PBS medicines (SHPA, 2013).

The PBS is a world-renowned and highly effective mechanism for making medicines available and affordable and, alongside the Medicare Benefits Schedule, can play a significant role in supporting the delivery of enhanced health care. With rising PBS expenditure and an increase in the number of Australians living with multiple chronic illnesses, it is reasonable to assume costs will continue to grow. However, SHPA member feedback indicates that the current anomaly with some very high cost medicines may not be an ongoing issue as patents expire. Demand for Hepatitis C medicines is likely to substantially decrease over the next three – five years as the patient group stabilises. This means that concerns around major ongoing increases in demand for high cost medicines may not be a solid basis for significant change.

Hypothetically a uniform remuneration approach would involve the standardising of all government paid fees involved in making a medicine accessible to a patient including any manufacturing or compounding, clinical review and patient counselling, for pharmacists in all settings – hospital, community or primary care across all medicines (both S85 and S100). In
addition, this would involve the restructuring of the wholesale manufacturer mark-up and the pharmacy mark-up fees as currently received by public and private hospitals.

Therefore, this would be a substantial change in pharmacy funding, and not one to be undertaken lightly. Hospital pharmacy and community pharmacy, despite some similarities in day-to-day practice, are structured very differently. Purchasing of pharmaceutical products (and other medicine-related materials) is centralised for public hospital pharmacy through state-based tendering systems that prioritise scale and avoid brand loyalty. Due to the requirements of high numbers of outpatients and inpatients, stock is delivered daily or as required, voiding the need for a CSO or any similar schemes. Importantly many products ordered do not attract PBS funding at all. Additionally, private hospitals are tending to outsource their pharmacies to private companies with different hospital buying arrangements, or supply hospital-purchased medicines to local community pharmacies with whom they have a contract to support a targeted patient group.

It is SHPA’s perspective that by reviewing fees paid across the board to community and hospital pharmacy for all PBS medicines, recognising the importance of clinical review and counselling, and correctly weighting transactions for level of effort, complexity and consultation time, pharmacy remuneration could address short-term anomalies for the benefit of efficient funding across the pharmacy sector. Basic modelling of what this might look like indicates there would be a greater cost to the government and a higher return to hospitals. However, seeking to reduce the wholesale mark-up received by public hospitals without making other fee sources available such as the dispensing fees will reduce funding available for hospital pharmacy services and have an adverse impact on the quality use of medicines and clinical care.
Table 3. Contrast of current CPA PBS medication funding model with uniform model

<table>
<thead>
<tr>
<th>Scenario: 400 bed public hospital (Principal Referral) with 400 S85 items daily and 25 S100 items daily @ mean $15.00 wholesale price</th>
<th>Public hospital (dispensed price)</th>
<th>Community pharmacy</th>
<th>Current hospital remuneration model</th>
<th>Current community remuneration model applied</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S85 Medicine</strong></td>
<td>Per prescription</td>
<td>Per prescription</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wholesale Mark Up</td>
<td>11.1% of the ex-manufacturer price</td>
<td>7.52% of the ex-manufacturer price, capped at $69.94</td>
<td>$.74</td>
<td>$.50</td>
</tr>
<tr>
<td>AHI fee</td>
<td>$0.00</td>
<td>$3.49 plus 3.5% for medicines over $180, capped at $70</td>
<td>$0.00</td>
<td>$3.49</td>
</tr>
<tr>
<td>Dispensing fee</td>
<td>$0.00</td>
<td>$6.93</td>
<td>$0.00</td>
<td>$6.93</td>
</tr>
<tr>
<td><strong>S100 medicine</strong></td>
<td>$600 (e.g. only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mark Up</td>
<td>0%</td>
<td>4-tier capped at $40*</td>
<td>$0.00</td>
<td>$40.00</td>
</tr>
<tr>
<td>AHI fee</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Dispensing fee</td>
<td>$0.00</td>
<td>$6.93</td>
<td>$0.00</td>
<td>$6.93</td>
</tr>
<tr>
<td>Annual remuneration</td>
<td>$750k pa</td>
<td>$1200k pa</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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

Question 25.
As medicine specialists, what are the professional programs and services that pharmacists should or could be providing to consumers in order to best serve the consumers?

As medicine specialists, hospital and healthcare pharmacists provide a range of evidence-based programs and clinical cognitive services which meet patient need. SHPA believes that whilst all registered pharmacists are qualified to dispense medicines that does not inherently mean they are medicine specialists. Accreditation, professional experience and advanced training are core to achieving professional recognition of expertise in medicines and the provision of clinical services.
Remuneration of cognitive services (professional programs) must include recognition that credentialing and accreditation is required for delivery of more comprehensive cognitive services.

SHPA believes that there are a range of professional programs and services that pharmacists should or could be providing to consumers in order to best serve the consumers. However, every professional program must include:

- clear evidence of impact on clinical outcomes
- defined requirements and assessment of the skills and experience of the pharmacist necessary for delivering those services
- no link of cognitive pharmacist services to the supply of medicines; these should be funded separately
- remuneration of individual pharmacists directly as a provider of a cognitive service in line with other health professionals

SHPA has led the development of programs translating innovation into practice which reinforces our members’ reputations as medicines specialists e.g. antimicrobial stewardship. SHPA agrees with the comments made in the Review that pharmacists are under-utilised, and the implication that greater use of pharmacy skills should be considered in a range of community and healthcare settings. This expansion or extension of the pharmacy role should build on best pharmacy practice as evidenced in SHPA Standards of Practice of Clinical Pharmacy Services (2013) which outlines key responsibilities and support a collaborative approach (with patients, carers, prescribers and other health professionals) to medicines management. This represents the best contribution to healthcare based on contemporary evidence made by a team of pharmacists, with support from pharmacy technicians and assistants.

A pharmacist as a medicines specialist relates to the type of medicine/therapeutic groups supplied to the patient, in the various settings. Being a medicines specialist depends on the context of the medicine given in a given setting. For example, a pharmacist who provides chemotherapy and services in a chemotherapy day centre, is different to a pharmacist who provides Hepatitis C medicines in an outpatient clinic, which is different to an accredited pharmacist who visits patients in their homes to provide comprehensive HMRs and collaborates with GPs to provide care. Many of these services do not involve the supply of the medicines, and thus it is imperative that the remuneration of the supply of medicines is decoupled and not tied to the clinical pharmacy services provided. Not every pharmacist is a medicines specialist, nor must every pharmacy position be filled by a medicines specialist. General pharmacy expertise can efficiently address a wide range of everyday community concerns. For more information see ‘SHPA Model of care’ Figure 2.

As healthcare professionals with a health science qualification, pharmacists are trained to evaluate and understand a comprehensive evidence-base related to medicines and individual health management. These skills equip pharmacists to provide important services that improve quality and safety, medicine adherence and health literacy, rather than a wide range of other non-medical services which are not supported by evidence. SHPA believes that it is imperative for the profession that future programs and services seeking to optimise the role of pharmacists should build on these skills and qualifications rather than diluting them by spreading into areas of work outside our professional brief.

Clinical pharmacy activities described in the SHPA standards include:

- medication reconciliation
- assessment of current medication management
- clinical review, therapeutic drug monitoring and adverse drug reaction management
Hospital pharmacy has traditionally led the innovation of pharmacy services in response to patient need. The implementation of Home Medication Reviews began with the establishment of pharmacy outreach or liaison services from hospital pharmacies seeking to improve medicines management. In contemporary practice hospital pharmacists are continuing to innovate in a hospital and community setting in a range of ways.

**Multidisciplinary team care**

In a hospital, primary or community healthcare setting pharmacists are well placed to contribute to many different types of outpatient clinics. Examples include: pharmacist-led clinics for rheumatoid arthritis (Helen Trenerry, 2015), oral chemotherapy (Buete, 2015), elective surgery pre-admission clinics (Janelle Penno, 2015), smoking cessation clinics (Emma Dean, 2014), opioid de-escalation and pain management in postoperative orthopaedic patients (Thuy Bui, 2014). Whilst these are not community pharmacy services, as professional services they demonstrate the potential gain for health management when pharmacists separate from dispensing and use their clinical skills as part of a multidisciplinary team.

**Clinical medication review**

Medication management and review is a vital professional service performed by both community and hospital pharmacists that has the potential to significantly impact on patient outcomes. Current 6CPA funding limitations on both supply and demand sides prevent Home Medication Reviews and Residential Medication Management Review from being implemented at a scale that would enable an efficient return on investment. At a minimum accredited pharmacists should be able to conduct medication reviews for elderly Australians post-discharge, as recommended by the Campbell Report into the HMR Program (Consulting, 2008) and on referral from Aged Care Assessment Teams or Community Nurses.

This medication review should include a follow-up with the consumer and related healthcare providers including General Practitioner. This would enable a greater continuum of care and reduce fragmentation through different healthcare settings.

**Primary health care pharmacy**

In primary healthcare settings such as General Practice, SHPA supports the inclusion of pharmacists to assist medical staff by providing medication reviews, medicines information and counselling, and acting as a resource for prescribers. However, SHPA strongly believes that this role of primary healthcare pharmacy would be most appropriately filled by Accredited Pharmacist, to ensure they have demonstrated experience and clinical knowledge appropriate to conducting medication reviews and support primary care. International evidence of pharmacist medication reviews conducted in a primary health care setting show strong improvements in medication adherence (Goh Quiling Bandy, 2013).

**Transitions of care**

SHPA members are particularly keen to see greater pharmacy oversight of transitions of care, such as regular medication information sharing and updates for patients transitioning
from hospital to community or aged care. These transitions can otherwise represent significant risk to patient wellbeing as information about changes to medication are not successfully shared with community pharmacists, General Practitioners, Residential Aged Care facilities and carers. Greater involvement of pharmacists during care transitions has been proven to reduce medication errors and readmission (Arti Phatak, 2016).

**Existing services**

In addition, SHPA supports the continuation and scaling up of the following patient-focused professional services via hospital, outreach/liaison and community pharmacy, in the setting most appropriate for the patient:

- Providing National Diabetes Services Scheme supplies with appropriate counselling
  - Medication management programs: HMRs, RMMRs
- Medication adherence programs:
  - Dosage administration aids
  - Staged supply
- Clinic pharmacist services including:
  - Medication reconciliation at all transitions of care both into and out (i.e. hospital, home, residential care)
  - Hospital discharge liaison
  - Community pharmacy liaison
  - Medication counselling and advice
  - Provision of medication lists & written medication information
- Smoking cessation support programs
- Improving immunisation rates via pharmacist immunisation
- Hospital pharmacist community outreach programs
- Community pharmacist-led disease screening & GP referral (e.g. for hypertension, type 2 diabetes mellitus, heart failure etc.)

**Question 26.**

Should there be limitations on some of the retail products that community pharmacies are allowed to sell? For instance, is it confusing for patients if non-evidence based therapies are sold alongside prescription medicines?

SHPA believes strongly that all pharmacies are places of healthcare and therefore the only appropriate setting is one conducive to the delivery of professional healthcare and support. The display and sale of non-evidence based products is distraction to this. The Code of Conduct for Pharmacists (Pharmacy Board of Australia, 2014) makes this clear. SHPA recommends a focus on developing greater standards and requirements related to the professional pharmacy services, alongside an increased focus on staff training and accreditation. It is not possible to reform the services provided within this setting without major reforms around community pharmacy facilities and the retail products promoted.

**Question 27.**

Would a community pharmacy that solely focused on dispensing provide an appropriate or better health environment for consumers than current community pharmacies? Would such a pharmacy be attractive to the public? Would such a pharmacy be viable?

SHPA believes that pharmacies focused solely on dispensing and providing professional pharmacy services should be viable in Australia as they are internationally. This kind of innovation has not been prioritised in Australian pharmacies due to the remuneration structure of the 6CPA.
Question 28.
More generally, is there a need for new business models in pharmacy? If so, what would such a model look like and how would it lead to better health outcomes?
There is a fundamental need for new business models in pharmacy. Models must have the following components:

1. Funding for pharmacist and pharmacy services should focus on the delivery of health outcomes rather than the delivery of pharmacy processes to provide the service.
2. 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.
3. Pharmacists, in line with other healthcare professionals must be able to be deliver remunerated professional services in the setting that provides the best care for the patient.
4. Cognitive services by pharmacists should not be linked to the supply of medicines and should be funded separately.
5. Individual pharmacists should be remunerated directly as a provider of a cognitive service in line with other healthcare professionals.
6. 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 occur.
7. Remuneration of cognitive services must include recognition that not all practising pharmacists can be considered medicine specialists and further credentialing and accreditation is required for delivery of more comprehensive cognitive services.
8. The dispensing of medicines has three distinct components: clinical review, medication labelling and patient education, and these should be recognised and remunerated as distinct activities.
9. New business models must include, but not be restricted to, community retail pharmacies and must enable models that include independent pharmacists practicing in other settings.

Question 29.
Is it appropriate that the PBS links the remuneration for the provisions of professional advice to the sale of medicines?
It is inappropriate that the PBS links remuneration of professional pharmacy advice solely to the sale of medicine. Essential pharmacy treatment, such as ‘deprescribing’ is not remunerated when only medicine supply is explicitly funded. This has a significantly negative impact upon the community where there is substantial overuse of prescription medicines, especially among older people where, in one study, 20% had been prescribed at least one potentially inappropriate medicine in the preceding 6 months (EE Roughead, 2007).

SHPA believes that it would be appropriate if remuneration for the supply of a medicine, and remuneration for the cognitive aspects of professional advice, counselling and clinical review, were separated. These could be appropriately funded separately by the PBS and the MBS respectively.

While there are many instances where the professional advice is directly linked to the medicine being provided, such as the requirement to counsel patients on how to use a new inhaler device or how to use an adrenaline autoinjector, it is not appropriate to directly tie the remuneration for the provision of professional advice to the sale of the medicine as it devalues key clinical services. It does not correctly acknowledge the patient encounter, it
provides a perverse incentive to dispense and it does not encourage innovation in clinical service in a community setting. Unsurprisingly, according to anecdotal evidence ‘deprescribing’ is rarely undertaken in the community due to the lack of advanced clinical pharmacy services in community pharmacies.

SHPA recommends two different approaches to funding could be developed:

1. Remuneration for prescription dispensing services as outlined in Table 3 funded via the PBS, paid directly to the pharmacy providing the medicines supplied.
2. Remuneration for professional services not linked to supply as discussed further below defined and set by the Medicare Benefits Schedule and set by MSAC paid directly to the individual healthcare practitioner.

Question 30.
Would it be preferable when a medicine is dispensed if advice given to consumers is remunerated separately; for example, through a MBS payment? Would this be likely to increase the value consumers place on this advice?
Yes, it would be preferable to separate the remuneration for medicine supply and cognitive services.

As outlined above (Question 29) SHPA recommends that the remuneration for cognitive and clinical aspects of providing professional advice to consumers is separated from the supply of medicine. SHPA believes that, as a health service, cognitive professional services delivered by a pharmacist would be more appropriately managed through the Medicare Benefits Schedule and overseen by the MSAC. This would also ensure the evidence-base for clinical pharmacy services was maintained which would be influential in communicating the value of pharmacy advice to consumers. Remuneration for the supply of medicines should be supplied across the health system by the PBS.

In addition, SHPA believes that patient counselling should be provided as a funded, timed service (pharmacy consultation) in order to ensure that patients in all settings receive adequate information about medicines they are prescribed. Whilst hospital pharmacy services require medication reconciliation and patient counselling before patient discharge, significant evidence exists that sufficient medicines information is not provided in many community pharmacy settings. Services provided in any setting should be evaluated to ensure a high quality of service is provided, although care should be taken to ensure bureaucracy does not become burdensome.

Question 31.
If an MBS payment for professional pharmacy advice was introduced, what level of service should be provided? Should the level of payment be linked to the complexity of particular medicines? Should it be linked to particular patient groups with higher health needs?

An MBS payment for professional pharmacy advice should remunerate a clinically relevant intervention which addresses a gap for high level service provision for consumers in the community setting.

Clinical pharmacy services could be undertaken by pharmacists on a ‘fee for service’ model remunerated by the MBS similar to other allied health professionals. An MBS item for professional pharmacy advice would extend the tiered model discussed earlier in response to e Question 16 and reflect a higher level of clinical service received from a medicines
specialist or accredited pharmacist. These services should meet the evidence-base required by all MBS items and be assessed by MSAC.

Hypothetically MBS items for professional pharmacy advice would be valuable for people at a high risk of medicine mismanagement, and those taking a complex medicine (i.e. newly prescribed medicines, narrow therapeutic range medications, anticoagulants, antipsychotics, high-risk medicines including cytotoxic chemotherapy) where a gap exists for these groups in accessing community pharmacy expertise. In addition, those for whom an HMR would be useful but who do not meet the criteria might also benefit. Tasks closely related to medicine supply would remain the funding responsibility of the PBS.

Table 4. Model for MBS payment and tiered PBS payment for pharmacists’ services

<table>
<thead>
<tr>
<th>Dispensing prescription tasks</th>
<th>Proposed (PBS tiered payments)</th>
<th>MBS payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical review</strong></td>
<td>Simple (low risk medicine in low complexity patient)</td>
<td>Extended (high risk medicine e.g. chemotherapy)</td>
</tr>
<tr>
<td><strong>Medication preparation and labelling</strong></td>
<td>Simple (Prepared medication ready for use, requiring labelling only)</td>
<td>Extended Topical compounded, aseptic preparation (e.g. chemotherapy)</td>
</tr>
<tr>
<td><strong>Patient counselling</strong></td>
<td>&lt; than 5 minutes</td>
<td>&gt; 5 minutes</td>
</tr>
</tbody>
</table>

Question 32. What are appropriate ways for pharmacies to identify and supply the health services most needed by their local communities?

Like all service providers pharmacies should engage meaningfully with their local community on a frequent and ongoing basis to identify health services most in demand. Consultations with other health providers will also assist in this, but key is the parameter that it be performed as a healthcare agency rather than as a small business looking for a profit opportunity.

Question 33. Are pharmacy services accessible for all consumers under the current community pharmacy model? If not, how could pharmacy services be made more accessible?

Whilst community pharmacies are accessible for the majority of Australians residing in metropolitan centres, access in rural and regional Australia can be limited. In particular access to pharmacy services facilitated community pharmacies such as HMRs can be difficult to obtain. The arbitrary cap of 20 HMRs per month per provider, combined with the concentration of accredited pharmacists in metropolitan areas, means that patients in rural and regional areas often miss out on the only CPA funded clinical service. Member feedback indicates that accredited pharmacists are generally supplying HMR services for multiple General Practitioners in one region.
Broadening their services by supporting innovations in telehealth, and enabling greater provision of HMRs by community or hospital pharmacists would be beneficial. In particular enabling hospital referred medication reviews on discharge for regional patients, especially Indigenous patients, would be beneficial for increasing access to much needed pharmacy services.

Question 34.
How should government design the provision and remuneration of new programs that are offered through community pharmacy to ensure robust provision, value for taxpayers and appropriate supply for patients in need? For instance, should all patients be entitled to an annual HMR? Should HMRs be linked to a health event, such as following hospital discharge? Should they only occur following referral from a medical practitioner?

Philosophically SHPA supports the development of pharmacy programs to target key areas of patient need (complex medicine consumers or high-risk for medicine mismanagement) for pharmacy expertise. Strict adherence to criteria for MBS and PBS funding will assist evaluation to ensure value for taxpayers.

New pharmacy programs offered through community pharmacy should be assessed in line with other health services, by an independent non-statutory committee for evidence of efficacy, safety and cost-effectiveness. The Medical Services Advisory Committee assesses all medical technologies and medical and health services which are funded through the MBS. SHPA believes that pharmacy services, regardless of setting, funded by the government should also be evaluated by MSAC and consequently funded through the Medicare Benefits Schedule.

Whilst wider use of Home Medication Reviews by high-risk groups would be beneficial, SHPA does not believe all patients should be entitled to an annual HMR, instead preferring greater use as referred by healthcare professionals and on discharge from hospital. In relation to medication reviews, SHPA provides the following expert feedback and recommendations on future implementation.

**Medication Review**
Clinical review of a patient’s medication independent of medicine supply is an innovation of hospital pharmacy which has now been successfully adopted by the community pharmacy sector. Originally delivered by outreach pharmacists working in a non-hospital healthcare setting, they are now also delivered by accredited community pharmacists who receive funding through the 6CPA. Reviews can either directed at achieving a specific outcome (e.g. to manage anticoagulant medicines or a treatment cycle of cytotoxic chemotherapy), or comprehensive to review and improve the consumer’s use of their all of their medicines and optimise health outcomes.

Very strong evidence of the benefits of ‘medication reviews’ and their efficacy in preventing medicine-related problems and reducing morbidity, presentations to GPs and medicine-related hospital admissions exists. Delivered by a pharmacist with the appropriate skill and capabilities, medication reviews facilitate promotion of medicines safety and quality, promote and uphold evidence-guided practice and enhance continuity of care and use of evidence-based therapies, particularly in complicated or chronic disease patient management. Essentially, medication reviews are a pharmacy consultation which provides an opportunity to optimise medicines management (Vaishali Padhye, 2012).

SHPA believes it is imperative that PBS funded pharmacy consultations incorporating medication reviews and medicine management recommendations be able to be referred by
a wider range of healthcare professionals whose patients meet the criteria. This would include aged care assessment teams (Rohan Elliott G. M., 2012), community nurses (Rohan Elliott C. Y., 2016) and hospital pharmacists as well as general practitioners. Evidence shows that hospital-initiated medication reviews, referred by discharging doctors or hospital pharmacists in outreach roles, can reduce hospital readmissions by 25% among people aged between 51 and 65 years (Mary Hanna, 2016). Whilst it is preferable that medication review services should be delivered in the consumer’s home (so that the pharmacist has the opportunity to identify all medicine-related issues e.g. hoarding) this is not always practical. It would be appropriate for medication review services to be conducted in primary care facilities when pharmacists are co-located, or in an outpatient clinic.

Criteria such as that outlined below can be used to identify appropriate patients and limit demand for medication review and medicines management, rather than the existing caps which can be arbitrary and introduce perverse incentives.

Table 5. Risk categories that guide service selection

<table>
<thead>
<tr>
<th>Consumer-specific risk factors</th>
<th>Higher-risk consumer groups</th>
<th>High-risk medicines</th>
</tr>
</thead>
<tbody>
<tr>
<td>• recent medicine-related problem</td>
<td>• aged 65 years or older</td>
<td>• insulins and / or oral hypoglycaemic medicines</td>
</tr>
<tr>
<td>• have suboptimal response to treatment with medicines</td>
<td>• take 5 or more medicines</td>
<td>• opioid analgesics</td>
</tr>
<tr>
<td>• have multiple chronic conditions or co-morbidities</td>
<td>• take more than 12 doses of medicines per day</td>
<td>• immune suppressant therapy</td>
</tr>
<tr>
<td>• are suspected or known to be non-adherent with their medicines</td>
<td>• have difficulty managing their medicines because of literacy or language difficulties</td>
<td>• anticonvulsants</td>
</tr>
<tr>
<td>• have clinically significant changes to their medicines or treatment plans within the last 3 months</td>
<td>• have difficulty managing their medicines because of dexterity problems, impaired sight or cannot read medicine labels</td>
<td>• anticoagulants and antithrombotics</td>
</tr>
<tr>
<td>• recent attendance to emergency department for medicine-related problem</td>
<td>• have difficulty managing their medicines because of confusion / dementia or other cognitive difficulties</td>
<td>• cytotoxic chemotherapy</td>
</tr>
<tr>
<td>• recent hospital admission for medicine-related problem</td>
<td>• have swallowing difficulties or require medicines to be administered through an enteral feeding tube (e.g. PEG) that requires alteration to how medicines are administered</td>
<td>• medicines that require therapeutic monitoring, or specific biochemistry or haematology monitoring (e.g. digoxin, clozapine, antiretrovirals used in HIV/AIDS)</td>
</tr>
<tr>
<td>• multiple presentations or admissions to hospital or healthcare organisation in past 12 months or unplanned readmission with 28 days of discharge</td>
<td>• have impaired renal or hepatic function</td>
<td>• intravenous potassium</td>
</tr>
<tr>
<td></td>
<td>• have problems using medication delivery devices or require adherence aid</td>
<td>• aminoglycosides or vancomycin</td>
</tr>
<tr>
<td></td>
<td>• is classified as obese class 2 or 3 i.e. BMI &gt; 35</td>
<td>• non-steroidal anti-inflammatory drugs (NSAIDS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• beta blockers</td>
</tr>
</tbody>
</table>
Question 35.
Are there non-medicine-related services that pharmacists can or should provide to consumers due to their expertise as pharmacists or for other reasons (e.g. consumer ease of access to community pharmacies)? If so, why are these services best provided by community pharmacy?

Non-medicine related services should be provided by pharmacists only where they have the appropriate expertise and the service reflects their skills and training in evidence-based medicine. The distribution of community pharmacies across Australia ensures that most Australians have convenient access to medicines and pharmacy services. This means that pharmacists can provide health services related to minor ailments and first aid when required. In many cases this is appropriate use of pharmacy skills and expertise. However, pharmacy education and training is based in the analysis and understanding of health information, and broadening the range of non-medical services provided risks diluting clinical pharmacy expertise. SHPA believes that building on clinical pharmacy expertise through increased accreditation or additional training, is preferable to expanding non-medical services in community pharmacy.

SHPA believes that there are a range of professional programs and services that pharmacists could provide to consumers in order to best serve the consumers. However, every professional program, whether medicine-related or not should include clear evidence of impact on clinical outcomes and defined requirements and assessment of the skills and experience of the pharmacist necessary for delivering those services.

In particular SHPA would draw attention to our support for the Australian Pharmacist Leadership Forum’s position statement (Australian Pharmacy Liaison Forum, 2015) which states that pharmacists should not support or recommend homeopathic treatments.

SHPA supports the continuation of the following patient focused professional services via hospital, outreach/liaison and community pharmacy:

- patients who are isolated with limited capacity to self-manage
- have multiple prescribers for their medicines
- does not have a regular GP
- Providing National Diabetes Services Scheme supplies with appropriate counselling
- Smoking cessation support programs
- Improving immunisation rates via pharmacist immunisation
- Other services within community pharmacies:
  - First aid and minor ailments
  - Health advice and health promotion activities
  - Health aid and equipment provision
  - Screening and referral services for chronic diseases

**Question 36.**
Would any of these remuneration models be generalizable to other medicine services offered by pharmacies? Why or why not?
SHPA has made several recommendations relating to remuneration models which are applicable across medicine services more generally. As stated in the submission, any additional services must be evidence-based and the decision to fund must be made through an appropriate assessment model i.e. MSAC as an example.

**Question 37.**
Is cost a barrier to accessing worthwhile health services offered by pharmacy?
Widespread evidence exists of cost being a barrier to healthcare for people with limited income. Even very sick people with a wide range of chronic diseases including mental illness or diabetes are likely to cut back on medicines due to costs incurred through co-payments or miss appointments (L Zullig, 2013). SHPA members report this is a key issue when treating Indigenous patients from remote communities with chronic conditions. In fact, frequent workarounds are reported to enable Indigenous patients to access much needed CTG medicines due to their lack of requirement for co-payments for the patient, despite substantial impact on time for GPs and pharmacists.

Indigenous patients at S100 RAAHS are able to access their PBS medicines with no co-payment to facilitate the access of medicines to this population group with high rates of chronic disease. However, these arrangements only apply to remote area AHSSs and do not take into account the mobile lifestyles of this population group. When Indigenous patients travel to rural, regional or metropolitan areas, they are faced with co-payments when trying to purchase PBS medicines. Anecdotal evidence from our members suggests that many Indigenous patients from remote area AHSSs often do not fill their prescriptions when faced with co-payments.

**Question 38.**
If particular health services were deemed to be of clinical value and delivered good patient outcomes, what other mechanisms could allow these programs to be disseminated around the country to relevant communities and groups on an affordable basis?
SHPA members support the dissemination of assessment reports of cognitive pharmacy services which have sought to be listed by MSAC (if this model was applied to pharmacy). The sharing of impartial evidence-based assessment of pharmacy services would enable smaller hospitals and community pharmacy services to consider programs for uptake without the extensive research and advocacy currently required. This type of innovation would be welcomed by SHPA.
Question 39.
Should both direct consumer remuneration and government-based remuneration be applied for particular services or access arrangements?
SHPA believes a model involving both consumer and government-based remuneration is appropriate for the supply of medicines, and for pharmacy services. As outlined in the Australian Charter of Healthcare Rights all people have the right to access health care and the requirement for direct consumer remuneration should not be a barrier to this. SHPA supports models that ensures people otherwise disadvantaged retain access to high quality and safe care.

Regulation
Question 40.
What pharmacy services should be fully or partially PBS funded and what is best left to market or jurisdiction demands?
Fundamental pharmacy services for government funding are those related to clinical review, dispensing and patient counselling for all patients taking PBS medicines in the community or in hospital. In addition, SHPA believes that additional pharmacy support for consumers taking complex medicines, or those at high-risk of medicine mismanagement, should be fully or partially funded by the government.

In line with the principles detailed previously the delivery of pharmacy services can be separated into two areas:

1. Prescription dispensing services (as described in Table 3) should be funded via the PBS and paid directly to the pharmacy providing the service. This would include advice solely associated with the prescription and should be partially government funded (as also include patient co-payment) and funded via the PBS as shown to be evaluated to be cost effective, irrespective of setting where care is provided (i.e. hospital, community)
2. Professional clinical pharmacy services which are not linked to supply and provide the cognitive services necessary should be assessed by MSAC and paid to the individual practitioner in line with other allied health services.

SHPA believes that PBS and MBS funding for health is a scarce resource that should be judiciously managed for the benefit of Australians. This model would provide clarity for pharmacy innovation and development. Services not identified above could be supported by market forces. Future funding priority should be given to pharmacy services that are evidence-based and assessed as of clinical benefit by independent bodies such as the MSAC. This would also allow programs to be more easily adopted by smaller health services once they had been approved by MSAC voiding the need for duplicated proposals and ‘pilots’. Submissions could be made by pharmacists and other healthcare professionals as well as consumers for MSAC consideration.

Question 41.
What does innovation look like in community pharmacy? Is there sufficient scope and reward for innovation embedded in the current remuneration model? How could this be achieved?
Pharmacy, like other sectors, continues to innovate. As a pharmacy workforce stakeholder SHPA believes that activity in the area of retail pharmacy services has grown in recent decades primarily in areas of non-professional services such as homeopathy and
naturopathy, at the expense of community clinical pharmacy services. This has created gaps in service provision for clinical pharmacy services such as support for high-risk patients.

Recent commentary in mainstream and health media has challenged the priorities of community pharmacies. Whilst there is no doubt that many maintain a strong healthcare focus, the growth of competition from discount warehouses and supermarkets has redirected the efforts of many proprietors into retail innovation rather than health service innovation. Combined with increased rates of graduates seeking employment, it appears that proprietors have been able to cut remuneration in order to retain profit levels.

Whilst this has ensured that demand for hospital roles by the strongest pharmacy candidates has remained strong, SHPA recognises that consumers are disadvantaged by the gaps in cognitive services left by a weaker community pharmacy sector. Consumers, especially those with chronic conditions, commonly circulate between inpatient, outpatient and community health services over many years. Inexperienced pharmacists who work with limited supervision at ‘big box’ community pharmacies are unlikely to be able to provide the expert clinical services required for people with complex medication and monitoring needs in a community setting. This results in uneven pharmacy care and leaves gaps in which outreach and liaison pharmacists from hospitals innovate to ensure consumers get the care they require.

Innovation could be achieved by:
1. Translating the innovation of hospital pharmacy, as assisted by SHPA, into other settings such as community.
2. Developing enhanced educational programs which accredit expert pharmacy education and training such as the SHPA residency program.
3. Move away from remuneration of the site of service (i.e. pharmacy) to that of the individual practitioner.
4. Encourage professional service competition by enabling individual practitioners to be remunerated for professional services.
5. Reduce requirement of innovation to be based on “owner” of a pharmacy.
6. Reduce barriers to innovation i.e. ownership, location rules.
7. Support innovation by increasing the capacity of pharmacy technicians to enable greater pharmacist expansion of scope.

Appropriate remuneration is critical to the development of these approaches. A greater focus on credentialing and building staff expertise in both hospital and community services is essential to enable more innovative clinical services to be delivered by pharmacy staff.

42. Would the removal of the location rules with the retention of the current state ownership rules for pharmacies increase or decrease access and affordability for pharmaceuticals to the public?

SHPA supports a full review and revision of pharmacy ownership and location rules. 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 across the continuum as a result of 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.

If they 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. In
addition, location rules should not be used to define eligibility to pharmacist professional services. SHPA would be pleased to work with community pharmacy organisations to identify opportunities for collaboration with hospital pharmacies in areas of inequitable pharmacy access.

Question 43.
Would the removal of pharmacy location rules in urban areas with their retention in other areas, particularly rural and remote areas, increase or decrease access and affordability for pharmaceuticals to the public? Why and for what reasons?

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 to medicines and pharmacy services. A less standardised approach may enable greater incentives to be offered for pharmacy services to be delivered in regional and rural areas.

If they 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. In addition, location rules should not be used to define eligibility to pharmacist professional services. SHPA would be pleased to work with community pharmacy organisations to identify opportunities for collaboration with hospital pharmacies in areas of inequitable pharmacy access.

Question 44.
Would the removal of the location rules in urban areas with their retention in other areas, particularly rural and remote areas, discriminate against rural and regional consumers or benefit those consumers relative to consumers in urban areas? Why or why not?

SHPA supports a full review and revision of pharmacy location rules. It is critical in pharmacy planning that 'unintended' service gaps for consumers are not created across the continuum as a result of 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. SHPA would be pleased to work with community pharmacy organisations to identify opportunities for collaboration with hospital pharmacies in areas of inequitable pharmacy access.

Question 45.
If the states and territories were to amend the ownership rules so that any party could own a pharmacy, subject to requirements for dispensing only by a qualified pharmacist, how would your response to the full or partial removal of pharmacy location rules change?
SHPA is consistent in believing that the priority for regulation around the location and ownership of pharmacies should be to ensure equitable and optimal access for the Australian community. This means that our support for review and evaluation of the location and ownership roles is also consistent.
Question 46.
Is the short distance relocation rule appropriate? Please provide examples to explain your reasoning.
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. If they are to be maintained, the aims and objectives of the location rules should be shifted to become more consumer outcome focused rather than addressing details of pharmacy business development such as the ‘short distance relocation rule’.

Question 47.
It has been suggested to the Review that this creates unintended consequences in locking pharmacies into specific shopping centres and transferring effective ownership of the pharmacy approval number to the shopping centre. Is this a reasonable assessment of the effect of the location rule regarding short distance relocation from a shopping centre? Should this rule be modified, and if so, why? If not, why not?
SHPA supports a full review and evaluation of the pharmacy location rules in relation to their contribution to consumer outcomes. 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 across the continuum as a result of 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.

Question 48.
A similar requirement exists with the same rule for relocation of pharmacies from within medical centres. Is this requirement for medical centres desirable or undesirable?
SHPA supports a full review and evaluation of the pharmacy location rules, including those related to medical centres, in relation to their contribution to consumer outcomes. 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 across the continuum as a result of 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.

Question 49.
It has been suggested to the Review that pharmacies should be allowed to enter new locations subject to the payment of an appropriate approval fee to Government to prevent excessive entry to the pharmacy market. Any pharmacy then having been competitively impacted by a new entrant, or who would prefer to exit the market, would be able to receive compensation for surrender of its own approval number. Would such an approach be desirable or undesirable?
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 not the protection of existing businesses. SHPA would prefer to review modelling of the impact of any new model proposed before endorsement.
Question 50.
It has also been put to the Review that by limiting competition for existing pharmacies, the pharmacy location rules raise the profitability of some or all community pharmacies. Is this a reasonable expectation of the effect of pharmacy location rules? Please provide examples to explain your reasoning. SHPA does not have a fixed position on this topic.

Question 51.
Should an approved pharmacy operating in an area for which the pharmacy location rules preclude the operation of a second pharmacy be required to provide a minimum level of services in addition to the dispensing of PBS medicines? Should such pharmacies also be required to maintain minimum opening hours in addition to those typically offered by community pharmacy?

SHPA supports a full review and evaluation of the pharmacy location rules, including those related to medical centres, in relation to their contribution to consumer outcomes. 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. Therefore, SHPA is encouraging of the provision of additional pharmacy services and increased hours which are beneficial to the community, and increased credentialing of staff. However, SHPA would prefer to review modelling of the impact any new model before endorsement.

Question 52.
The current pharmacy location rules do not preclude a pharmacist from operating more than one pharmacy within a particular area. To the extent that this may allow an approved pharmacist to restrict local competition by opening a second pharmacy in the same area, should the rules be amended to support choice and value for money for consumers?

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. This means that greater choice and value for money for consumers would be encouraged, however to avoid unintended consequences SHPA would prefer to review modelling of the impact of any new model before endorsement.

Question 53.
Recognising that restrictions on co-location of pharmacies and supermarkets exist under state and territory legislation, would the removal of this restriction from the pharmacy location rules be desirable or undesirable?

SHPA supports a full review and evaluation of the pharmacy location rules in relation to their contribution to consumer outcomes. 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 across the continuum as a result of 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. SHPA would prefer to review modelling of the impact of any new model before endorsement.
Hospital Pharmacies

Question 54. Could hospital pharmacies complement medicine dispensing and related services currently provided through community pharmacy or other public and private hospital pharmacies?

Hospital pharmacies currently play an important role in complementing medicine dispensing and services from community pharmacies. Hospital pharmacies provide advanced clinical expertise for community pharmacists in relation to managing complex patients and complex medicines, leading innovative outpatient clinics which transfer to community settings and facilitating ‘transitions of care’ for patients returning to the community system.

A strong network of hospital and community pharmacies working in collaboration to provide patient-centred pharmacy care is key to the achievement of the objectives of the National Medicines Policy and optimal community health. SHPA members in hospital and healthcare settings play an important role in linking pharmacy services between primary and tertiary healthcare and access to medicines specialists is a crucial element of effective community healthcare. Collaboration that enables community pharmacists efficient access to the expertise and innovations of hospital pharmacists will improve patient care, e.g. medicines information services for community pharmacists relating to new hepatitis C medicines.

Outreach services and shared care are two additional methods through which hospital pharmacies complement community pharmacy services, and support general practice and primary care. Outreach pharmacy is crucial to providing ‘wraparound’ health care and is currently funded by multiple jurisdictional governments in order for pharmacists to visit discharged patients with the goal to ensure quality use of medicines and prevent hospital readmission. Any issues detected are relayed to the patient’s community pharmacy and GP for appropriate management. In addition, hospital pharmacists also provide shared care arrangements for many patients taking S100 medicines such as clozapine and HIV antiretrovirals whilst living in the community. These arrangements rely on access to the advanced clinical pharmacy expertise found in specialist hospitals.

Given the growing number of people in the community with chronic diseases and those on high-risk medicines, it is possible that hospital pharmacists, or those employed in a healthcare setting, could complement community pharmacy services by accredited pharmacists for people taking complex medicines or with high-risk of medicine mismanagement if funded where gaps in service exist. These patients often do not meet the eligibility criteria for an HMR due to a prior review within 12 months, or provider caps. Additionally, funding for provision of hospital initiated medication reviews for patients residing in the community could reduce hospital readmission of 51-65 year olds by 25% (Mary Hanna, 2016). Determined by consumer need, medication reviews and medicine management sessions could be conducted in a variety of hospital, primary care or patient home locations by hospital pharmacists, pharmacists working in outreach programs, in addition to accredited community pharmacists.

Additional dispensing is not a priority for hospital pharmacies at this time. Experienced hospital pharmacists working in Principal Referral, Acute A and Acute B hospital pharmacies across Australia have flagged for the Review the substantial strain they are currently experiencing upon their clinical capacity due to the burdensome requirements of addressing the administration required for PBS reimbursement. This has led in some cases to the referring of simple dispensing tasks away from hospitals towards community pharmacy, in order to free up capacity for increased clinical review and patient counselling. In this environment community pharmacy is able to complement hospital pharmacy. Hospital
services have the expertise to provide alternative approaches, however further capacity would be required and this would need to be addressed through an appropriate remuneration model.

Question 55.
If pharmacies operating out of private hospitals were required to operate 24-hours a day, would this be beneficial for consumer access? Would it be viable or economical for private hospitals to provide this service?
Pharmacy services should be available when patients require them, 7 days per week and for extended hours as required. Whilst 24-hours a day service is optimal it is unlikely private hospitals would have the demand to justify this.

Limiting services to business hours and 5 days per week reduces the timeliness of service delivery and may impact on patient care. SHPA believe that 24 hour a day, 7 day a week hospital pharmacy services in major hospitals would be beneficial in increasing capacity for expert pharmacy services, particularly for the benefit of inpatients.

This would be beneficial in regional or rural areas where 24/7 pharmacy services are already limited. However, few private hospitals fit these parameters and therefore our members think it unlikely private hospitals would find it either viable or economic to provide this kind of service. In addition, it would require a review of security for each facility similar to that considered for community pharmacy which could be burdensome.

Question 56.
How might broadening the services provided by hospital pharmacies improve consumer access in rural and regional Australia?
Hospital pharmacy services in rural and regional Australia remain limited with regional hospitals less likely to have their own hospital pharmacy department and more likely to provide fewer services. Broadening their services by supporting innovations in telehealth, and enabling greater provision of HMRs by community or hospital pharmacists would be beneficial.

It is well evidenced that consumers in rural and regional areas have poorer health outcomes and higher rates of chronic disease compared to metropolitan areas. While rates of ill health are higher among people in rural and remote areas compared with those in major cities, medicines are supplied to them at a lower rate through the PBS (AIHW, 2005). Hospital pharmacies have innovated and attempted to fill the gaps in consumer access to clinical pharmacy services where possible, but the limited resources continue to be a barrier. For example, Atherton District Memorial Hospital currently provides telehealth medication review services to discharged patients, akin to the Home Medicines Review program, and is a service that is funded by the Queensland Government (Rothwell, 2015).

While the HMR program provides comprehensive medication reviews for eligible patients, and is likely to be a key component of the Health Care Home models, it is at times difficult for patients in rural and regional areas to access them when required. The arbitrary cap of 20 HMRs per month per provider, combined with the concentration of accredited pharmacists in metropolitan areas, means that patients in rural and regional areas often miss out on the only CPA funded clinical service. Member feedback indicates that accredited pharmacists are generally supplying HMR services for multiple General Practitioners in one region.
Question 57.
If hospital pharmacies were able to complement the services provided by community pharmacy, should all pharmacies be able to access similar purchasing arrangements?

This question is based on the premise that hospital pharmacies
1. complement services provided by community pharmacy and
2. have preferential purchasing arrangements to community pharmacy

Both of these are not necessarily valid as outlined below. Increased dispensing for non-hospital patients is not a priority for hospital pharmacies at this time. Therefore it is unnecessary for similar purchasing arrangements to be pursued on this basis.

Hospital and community pharmacies dispense substantially different medicines and currently purchase via different business models. The volume of medicines ordered by hospitals reflects their combined need for medicines for both inpatient and outpatient need – frequently outside the PBS model of funding. *Australia’s Health 2012* reports that in 2009-10, of the $19 billion spent on pharmaceuticals, $2.7 billion (14.2%) was for admitted hospital patients. $2.4 billion was for public hospital admitted patients and $0.3 billion for private hospital admitted patients (ABS, 2012). Public hospitals purchase generic medicines and pharmaceutical supplies including intravenous fluids on a large scale through state/territory-based tendering contracts, which contrasts directly to how community pharmacies order branded medicines and retail products from a variety of suppliers as a small or large business. Due to the requirements of high numbers of outpatients and inpatients stock is delivered daily or as required, removing the need for a CSO which is crucial to community pharmacies. Importantly many products ordered by hospitals do not attract PBS funding at all. Additionally, private hospitals are tending to outsource their pharmacies to private companies with different hospital buying arrangements, or supply hospital-purchased medicines to local community pharmacies with who they have a contract to support a targeted patient group voiding the need for the contracted pharmacy to purchase hospital medicines if inconvenient.

Anecdotal feedback from community pharmacies indicates a widespread belief that hospital pharmacies access considerably better prices on a wide range of medicines, however feedback from SHPA members including Directors of Pharmacy of public and private hospitals, does not support this. The purchasing power of large pharmacy banner groups such as Chemist Warehouse are larger than those of some state-based public purchasing contracts. Further information about this area of pharmacy activity would be welcomed by SHPA.

It is SHPA’s perspective that by reviewing fees paid across the board to community and hospital pharmacy for all PBS medicines, recognising the importance of review and counselling, and correctly weighting transactions for level of effort, complexity and consultation time, pharmacy remuneration could address short-term anomalies for the benefit of efficient funding across the sector. However, seeking to reduce the wholesale mark-up received by public hospitals without making other fee sources available such as the dispensing fees, will put patients’ health at risk. At this time SHPA does not support the purchasing agreements negotiated for hospital pharmacy as outlined in current CPA models being extended to community pharmacy.
Question 58.
Should hospitals be able to open dispensing pharmacies in the community?
Should hospitals be able to contract with specific community pharmacies?
Under these arrangements, should community pharmacies be able to access medicines through hospital supply arrangements?

Hospital pharmacies welcome the opportunity to better support their communities. Whilst additional dispensing is not a priority for most hospital pharmacists there may be communities where a dispensing hospital pharmacy would be beneficial. SHPA believes that hospitals should not be prevented from providing this service by regulation.

Hospital pharmacies use a variety of implementation plans to address service need. Many hospitals provide outreach clinical services, usually as part of Hospital Admission Risk Programs (HARP), to support patients postadmission and discharge to reduce the risk of readmission. Other hospital pharmacies with highly specialist services refer patients with less complex medicine needs to community pharmacies for dispensing. This enables them to work predominantly with those who most need advanced pharmacy care.

As discussed previously dispensing is not always the priority for hospital pharmacists who perform a wide range of clinical services including bedside consultations, patient counselling and medication review, so it is unlikely many hospitals would explore this option. An exception is hospital pharmacies based in regional and rural areas, and where consumer access to pharmacy services is already limited.

SHPA members are generally supportive of community pharmacies continuing to dispense medications for the broader population rather than the establishment of hospital pharmacies in the community. When outpatient services are outsourced to a community pharmacy it is appropriate that the hospital assist by providing access to the medication at an appropriate cost, however this does not necessitate community pharmacies accessing the hospital supply arrangements which would create confusion in the supply chain.

Anecdotal feedback from community pharmacies indicates a widespread belief that hospital pharmacies access considerably better prices on a wide range of medicines, however feedback from SHPA members including Directors of Pharmacy, does not support this.

Question 59.
Should hospital pharmacies be able to establish limited dispensing arrangements, either in-pharmacy or through a delivery or mail order service, to enable post-discharge services and continuity of care to patients in the community setting?

With the increased use of high-risk medicines by the population this is an area of practice which would benefit from greater flexibility in regulation and remuneration.

Hospital pharmacies in most states already provide limited dispensing arrangements by mail order or delivery as required to support continuity of care, to ensure efficient discharge and to address gaps in service incurred in New South Wales and the Australian Capital Territory due to the lack of PBS funding for medicines for outpatient use. However, this is a limited service and not ideal for patients who would also benefit from medicines information and counselling which is not optimised in the current remuneration model.

Improvements to the remuneration model already discussed would assist in the development of standardised response. In some cases the employment of a Liaison or Outreach Pharmacist who manages patients’ post-discharge and will involve dispensing as required.
Greater support for flexibility in hospital dispensing via these methods would also be beneficial at times of unexpected demand for medicines such as crises.

**Question 60.** Could dispensing arrangements by hospital pharmacies to patients be extended to the broader community to complement access to medicines through community pharmacy?

In a revitalised pharmacy sector with a single funder of medicines and uniform dispensing fees major hospitals may wish to extend their services to support the broader community. However current limitations on remuneration and capacity make this unlikely.

SHPA supports the ongoing development of relationships between hospital and community pharmacies for the benefit of patients. With the 5,300 community pharmacies far outnumbering the number of hospital pharmacies, community pharmacies remain a more convenient option for the majority of ambulatory Australians. Hospital services have the expertise to provide alternative approaches however further capacity would be required and this would need to be addressed through an appropriate remuneration model.

It is possible that hospital pharmacies could perform a role as a community dispensary at times of emergency, and that for some patients with complex medicine requirements a hospital pharmacy may be the most appropriate provider of this service. In these rare cases it should not be prevented.

**Question 61.** What other opportunities are there for public and private hospital pharmacies in securing supply options for greater access to PBS subsidised medicines?

Whilst the quality of and access to medicines for Australians is generally excellent, the continued exclusion of outpatients and inpatients in NSW and ACT, and public hospital inpatients in the rest of Australia, from accessing medicines through the PBS diminishes its achievement.

It is an urgent priority that NSW and ACT should become signatories to the Pharmaceutical Reform Agreements to improve access to PBS medicines and ensure continuity of treatment for consumers. SHPA NSW Branch believes that patients are negatively affected on a daily basis by the exclusion of PBS medicines from NSW and ACT outpatient services. This results in reduced quantities of medicines dispensed to patients on discharge, enforces additional unnecessary visits to General Practitioners and penalises patients for particular conditions which is contrary to all principles of treatment equity. By securing NSW and ACT engagement with the PBS, the Commonwealth Government would be in a stronger negotiating position for discussions with the medicines industry. Although smaller revisions could be made to secure greater access, this is the most significant opportunity for the benefit of public and private hospital pharmacies.
Aboriginal Health Services

Question 62.
Although S100 AHSs are able to fund the employment of a pharmacist from their primary health care budget, there are no specific funds to employ a pharmacist to conduct Quality Use of Medicines activities and manage the S100 program within the AHS. Do these arrangements impact on health outcomes?

Lack of access to pharmacy services is one of many factors negatively affecting Indigenous health outcomes. Adequate funding for Quality Use of Medicines could address many of the risk factors leading to poor patient outcomes from preventable conditions among Aboriginal Health Services patients.

Unfortunately not having access to clinical pharmacy services in AHSs can adversely impact on health outcomes. While the review panel is technically correct in saying that AHSs can fund the employment of a pharmacist from their budget, the limitation and size of the budget most often means that they are not at liberty to employ a pharmacist as a priority appointment. SHPA believes that AHSs should receive funding to employ pharmacists to provide direct patient care through medication review and counselling services. The most disadvantaged Australians with a heavy chronic disease burden and limited health literacy have reduced access to primary health care and almost no access to a pharmacist. As noted in the Campbell Research & Consulting report into Home Medicines Review (HMRs) the extremely high incidence of medication misadventure, non-adherence and resulting hospitalisation among Indigenous consumers as well as the flow-on effects such as organ damage and amputations were matters of grave concern to those respondents who work with Indigenous consumers. The co-morbidities because of the lack of adherence to medications were considered to be as high as three to four times that of non-Indigenous consumers.

As well as working one-on-one with patients, pharmacists work in teams on system-wide approaches. This means that pharmacists are actively involved in many healthcare teams and if available for remote Australia, typical functions could be:

- Participating in local drug and therapeutics committees to determine which medicines will be used in a healthcare facility [or Aboriginal Health Service (AHS)].
- Developing local prescribing protocols to support the safe use of medicines.
- Administering agreed protocols and ‘coaching’ prescribers (or Aboriginal Health Workers (AHWs) in AHS) locally, as the pharmacist can actively monitor and review the medicine orders as part of their usual role.
- Undertaking evaluations of the use of certain medicines and working with other healthcare team members (especially AHWs) to improve the use and monitoring of medicines.
- Having a strong focus on appropriate antibiotic use to support safe care and to reduce the emergence of resistant microorganisms.
- Medicines information services via a pharmacist’s specialised literature review skills.
- Supporting the establishment and administration of any clinical trials involving medicines.
- Administering requirements for government information about highly specialised drugs and subsidy systems.
- Developing protocols with a focus on the safe use of medicines and avoidance of harm.
- Adverse drug reaction management and recording systems.
Question 63.
The S100 Support Program supports increased involvement of pharmacists in the supply of PBS medicines to AHSs. Is there further scope for pharmacists to be more involved without impacting on access to medicines? Should pharmacists be able to directly claim an MBS type payment for QUM activities conducted in AHSs? Could this be a trial program under the 6CPA?

Yes, there is more scope for pharmacists to be involved in quality use of medicines and clinical pharmacy activities patients in AHSs. Currently there are different care models observed in the Section 100 Remote Area AHS (RAAHS) program given the constraints for funding QUM activities.

The eligibility criteria for AHSs to participate in the program has a significant quality use of medicines (QUM) risk attached to it as it only stipulates that “the AHS must employ or be in a contractual relationship with health professionals who are suitably qualified under relevant state or territory legislation to supply all pharmaceutical benefits covered by these arrangements”. The criteria does not explicitly say that the supply of medicines to a patient at an AHS must be undertaken by a pharmacist, and it is widely known that as many AHSs cannot afford to fund the position of a pharmacist from their federal disbursement, medicines are provided to patients by nurses or AHWs and not pharmacists.

This means that at some Section 100 RAAHS Indigenous patients are experiencing subpar care models where their medicines are labelled and dispensed by a nurse or Aboriginal Health Worker. Furthermore, Indigenous patients, who have low levels of health literacy and the highest rates of chronic disease, are not able to receive pharmacists’ advice with respect to how to use their medications, and also miss out on any chance of clinical review by a pharmacist. Previously the margins and revenue from the supply of PBS medicines to Section 100 RAAHS has been used to fund clinical pharmacist services to RAAHSs, however price disclosure policies and erosion of PBS revenue has meant these services are no longer provided. At most, if pharmacists’ advice is deemed to be absolutely necessary, the RAAHS is able to call the community pharmacy who supplied the PBS medicines, but this is generally discouraged as it is an unfunded service.

This is a significant QUM issue that affects medications adherence and clinical outcomes, and is a risk that is recognised by the Northern Territory government who stipulate the need for pharmacists supplying medicines to RAAHS under the control of the NT Department of Health are required to provide a clinical review of prescriptions, liaison with the prescriber and a dispensing service Members believe this is a major cost-shift for the NT government which is unsustainable. SHPA believes that these critical clinical pharmacy and QUM services should be funded, as the absence of these services undermines the policy intent of the Section 100 RAAHS program.

Question 64.
Could general improvements in remote dispensing improve the delivery of medicines in Aboriginal and Torres Strait Islander communities?

SHPA believes that the delivery of medicines to Indigenous patients in remote areas is a significant QUM issue that can be improved.

The program specific guidelines of the Section 100 Allowance for Support Services to RAAHS funded in the CPA treats the pharmacy supplying medicines to the RAAHS as the preferred option to perform these services, even though they may not be the most optimal or well-resourced community pharmacy to meet the needs of the RAAHS. The guidelines state that service providers must visit the AHS a minimum of twice a year to be eligible for
payment, however SHPA believes a service where the pharmacist only visits twice in any twelve month period would be of questionable value.

The guidelines also state that Where an AHS is being supplied medicines under the S100 supply arrangements by a Hospital Authority, consideration for provision of the S100 Allowance for Support Services will be given in the first instance to an Approved Pharmacy which only serves to fragment the care that is provided to patients of S100 RAAHS. The payment provided to service providers is as little as $6,000 per annum. Generously assuming it costs $50/hr to contract a pharmacist to provide these services, the funding under the Section 100 Allowance for Support Services to RAAHS program provides 120 hours of pharmacist services per year, or just over 2 hours per week. This is not adequate to undertake high quality and meaningful pharmacy services that ensure Indigenous patients in remote areas are using their medicines correctly and achieve good health outcomes.

Question 65.

Should the S100 RAAHS program be extended to include non-remote AHSs? Similarly should the CTG Co-Payment measure and QUMAX programs be extended to include AHSs in remote areas?

SHPA believes that the S100 RAAHS program should be reviewed in their entirety in order to improve their achievement of stated purposes, in lieu of that, SHPA suggests that at a minimum:

- the arrangements for the S100 RAAHS program are extended to all AHSs
- the arrangements for the CTG Co-payment measure (Measure) are:
  - extended to all Indigenous patients with chronic disease
  - eligibility status is registered through patients’ Medicare/Centrelink cards
  - extended to all prescribers in all settings to prescribe under this measure

The intent of the S100 RAAHS program, QUMAX program and Measure were implemented in the faith of increasing access to medicines and improving quality use of medicines to improve health outcomes in Indigenous patients. However, the arbitrary restrictions and limitations in the eligibility criteria of the program have caused further confusion amongst Indigenous patients. Indigenous patients at S100 RAAHS are able to access their PBS medicines with no co-payment to facilitate the access of medicines to this population group with high rates of chronic disease. However, these arrangements only apply to remote area AHSs and do not take into account the mobile lifestyles of this population group. When Indigenous patients travel to rural, regional or metropolitan areas, they are faced with co-payments when trying to purchase PBS medicines. Anecdotal evidence from our members suggests that many Indigenous patients from remote area AHSs often do not have PBS compliant prescriptions with them (as they are not required under the S100 RAAHS programme) and do not have the capacity to fill their prescriptions when faced with co-payments.

The Measure is another initiative where the restrictions and design does not achieve the policy intent of facilitating access to PBS medicines. To be eligible for the Measure, an Indigenous patient must be from a metropolitan, rural or regional area – patients in remote areas are not eligible. Furthermore, the measure does not provide for Indigenous patients to have their eligibility and status documented, and have to prove to new GPs each time that they are eligible for the Measure. This is a significant administrative and unnecessary burden on patients and a large barrier in patients accessing the measure. SHPA believes that once a patient’s eligibility for the measure is accepted, that it be documented and attached to a form of identification, similar to how a patients’ concessional/pensioner/DVA status is denoted through cards issued by the Department of Human Services.
The limitations of prescriber types for the Measure is also severely limiting and resulting in administratively burdensome workarounds. Currently, only GPs can prescribe under the Measure, and excludes specialist prescribers and hospital based prescribers. This is inconsistent with the policy intent of the program given that Indigenous patients have higher rates of chronic diseases such as blindness, kidney disease and diabetes. It follows that these cohort of patients would be seeing specialists and having medicines prescribed by specialists, however these prescriptions are not eligible for the Measure and the patient is expected to pay the co-payment, which is a known barrier to them using the medicine. Indigenous patients who are discharged from hospitals are also unable to access their discharge medicines under the Measure which impinges on access to PBS medicines, especially given that patients have many changes to medications after a hospital admission. The same issues are observed for Indigenous patients who visit outpatient clinics.

It has been brought to SHPA’s attention that to facilitate access to PBS medicines under the Measure, workarounds involving presenting the specialists’ or hospital prescription to a GP, only to have the GP transcribe the prescription and endorse it as CTG for the patient to access their new medicines regimen under the Measure. This is an onerous and administratively burdensome workaround that does not facilitate access to PBS medicines, and potentially costs the health system more through unnecessary GP visits.

Question 66.
Should AHSs in all states and territories be able to operate a pharmacy business?

SHPA supports in principle for AHSs to be a health service where patients can access their medicines. This would greatly improve services for the community and enhance community health.

If AHSs were able to employ pharmacists and operate a pharmacy, it could remove the limitations currently experienced with AHSs as suppliers with medicines such that:
- medicines funded under the Section 100 Highly Specialised Drug Program and other Section 100 programs could be supplied
- Schedule 8 medicines could be supplied, particularly pertinent with higher rates of chronic pain in this cohort
- non-PBS medicines and complementary medicines can be supplied
- HMRs could be conducted more broadly (Barclay, 2015)

It would also then follow that pharmacists can provide a full range of clinical pharmacy services to promote and enhance the quality use of medicines in this population group, provide medication reviews, and allow pharmacists to work alongside members of the multidisciplinary healthcare teams.

Question 67.
How could appropriate QUM activities be provided in all remote areas at a comparable level of quality to those provided in non-remote services?

Appropriate QUM activities can be provided in all remote areas by funding and remunerating pharmacist activities and services. By embedding the roles of pharmacists into all AHSs, not just remote areas, this means that all patients can have direct contact with pharmacists to discuss their medicines and is an opportunity for pharmacists to identify any issues that require management or referral.
On a wider scale, pharmacists in AHSs would also be able to undertake health service wide QUM and governance activities through drug use evaluations, antimicrobial stewardship activities, formulary management, and educating AHS staff on QUM principles.

SHPA is sympathetic to the geographical challenges that remote area AHSs present to the delivery of clinical services comparable to non-remote areas, and recognises telehealth services as a potential solution. Recent research published by the CSIRO found that using telehealth services in the setting of chronic diseases can save up to $3 billion per year for the healthcare system (Branko Celler, 2016). SHPA also believes that funding for the position of a pharmacist in AHSs should be proportionately adjusted for the number of patients that visit the AHS.

Question 68.
Would it be desirable if remote S100 Aboriginal Health Services were also able to write CTG scripts?

SHPA believes that all prescribers relevant to remote S100 Aboriginal Health Services should be able to write CTG scripts, that the arrangements for the CTG Co-payment measure (Measure) should be extended to all Indigenous patients with chronic disease, and that eligibility should be registered through patients’ Medicare/Centrelink cards.

The intent of the S100 RAAHS program, QUMAX program and Measure were implemented with the aim of increasing access to medicines and improving quality use of medicines to improve and achieve health outcomes in Indigenous patients. However, the arbitrary restrictions and limitations in the eligibility criteria of the program have caused further confusion amongst Indigenous patients. The limitations of prescriber types for the Measure is also severely limiting and resulting in administratively burdensome workarounds. Currently, only GPs can prescribe under the Measure, and excludes specialist prescribers and hospital based prescribers. This is inconsistent with the policy intent of the program given that Indigenous patients have higher rates of chronic diseases such as blindness, kidney disease and diabetes. It follows that these cohort of patients would be seeing specialists and having medicines prescribed by specialists, however these prescriptions are not eligible for the Measure and the patient is expected to pay the co-payment, which is a known barrier to them using the medicine. Indigenous patients who are discharged from hospitals are also unable to access their discharge medicines under the Measure which impinges on access to PBS medicines, especially given that patients have many changes to medications after a hospital admission. The same issues are observed for Indigenous patients who visit outpatient clinics.

Question 69.
Could the arrangements for S100 and CTG co-payments be merged to allow Indigenous people who travel to access both S100 while they are at home and CTG co-payments when they travel?

SHPA supports the merger of S100 and CTG co-payments program in order to improve Indigenous people’s access to vital medicines. As discussed previously a large number of barriers exist which have prevented optimal care. Significant steps need to be taken to improve access to medicines and medicines management for Indigenous people.
Question 70.  
Should access to electronic patient health records be required for all health professionals treating Indigenous patients across all locations? 
SHPA believes that patient health records, electronic or paper-based, should be made available to and accessed by health professionals wherever it is required to provide quality care to the patient, regardless of their Indigenous status and regardless of the location.

Question 71.  
Should hospitals be allowed to write CTG co-payment scripts for out-patients? 
Given the extremely high rates of chronic disease and need for medicines experienced by Indigenous people, increasing hospital access to CTG prescription co-payments is essential. Currently extensive ‘workarounds’ exist to facilitate access to PBS medicines for Indigenous people. These involve presenting the specialists’ or hospital prescription to a GP, only to have the GP transcribe the prescription and endorse it as CTG for the patient to access their new medicines regimen under the Measure. This is an onerous and administratively burdensome workaround that does not facilitate access to PBS medicines, and potentially costs the health system more through unnecessary GP visits.

Question 72.  
Could there be more scope for tendering for the supply of medicines through AHSs? 
SHPA believes that in principle there could be more scope for tendering the supply of medicines through AHSs if that also included the provision of pharmacy services to support the quality use of medicines and optimising medicines management. It is important that service providers for AHSs who supply medicines as well as provide clinical pharmacy services deliver these services in a culturally appropriate and responsive manner and take a population health approach involving understanding the social determinants of health for Indigenous patients.

Wholesaling, Logistics and Distribution Arrangements

Question 73.  
Is the current approach to CPA negotiations, as adopted in the 6CPA, an appropriate way to meet wholesalers’ needs? If so, why? If not, why not? 
SHPA has not had specific member feedback in response to this question.

Question 74.  
Are there alternatives to the current CSO rules that would enable wholesalers to improve the efficiencies of their services without detracting from the consumer experience and access? 
SHPA has not had specific member feedback in response to this question.

Question 75.  
Pfizer supply direct and do not provide their medicines for supply through the CSO. Should all PBS medicines be available through the CSO, or is it appropriate for a manufacturer to only supply direct to the pharmacy? 
SHPA believes that including further supply chain constraints on all manufacturers including those who distribute directly may have unintended consequences. Consequently SHPA welcomes further consideration into potential impacts of this recommendation.
Question 76.
Should s100 and RPBS items be included in normal wholesale arrangements and in the CSO? If so, why? If not, how do the current arrangements support consumer access to all PBS and RPBS items?
SHPA has not have a fixed position on this and welcomes further consideration into potential impacts of this recommendation.

Question 77.
Have recent changes to the CSO, such as the extension of the guaranteed supply period and introduction of minimum order quantities, had an impact on consumer access or choice? If so, what evidence is available to demonstrate this?
SHPA is not aware of any impacts around this. Before SHPA supported any changes further information about the impact of any model would be required.

Question 78.
Currently not all areas are covered by the 24-hours CSO obligations (such as Christmas Island, Derby (WA) and Mission River (QLD)). Are these exceptions leading to detrimental outcomes for patients? If so, why? If not, why not? If so, should they be included in the 24-hour rule? If so, how is this logistically possible? If not, are there other areas of Australia that could be excluded from the 24-hour rule without adverse patient impact?
SHPA has not had a fixed position on this matter and welcomes further consideration into the potential impact of any recommendations.

Question 79.
Should CSO wholesalers have such discretion, or should they as part of the CSO arrangements be required to provide minimum terms and conditions for PBS items?
SHPA is not aware of any impacts around this. Before SHPA supported any changes further information about the impact of any model would be required.

Question 80.
In the 6CPA there was a change in the CSO requirements relating to 72-hour delivery for the 1000 highest volume medicines. Was this a desirable change? What impacts has this had and is there evidence available to demonstrate this?
SHPA is not aware of any major impacts in relation to this matter.
Question 81.
CSO wholesalers can require minimum ordering amounts for specific medicines. This is likely to reduce the cost to the wholesaler while increasing inventory costs and wastage for the pharmacy. Is this desirable or undesirable? Are there other parts of the wholesaling arrangements that create or encourage cost shifting that are undesirable for community pharmacy or consumers?
SHPA is not aware of this been a major impact however this may not be reflective of individual experience at small community pharmacies.

Question 82.
Should there be requirements on wholesalers relating to minimum usage dates of stock? Would such requirements increase or decrease wastage in the system? Would this shift costs to community pharmacy and reduce the efficiency of the system?
SHPA recommends that consideration be given to engaging with jurisdiction procurement expertise and state-based contract agreements in place not just relating to pharmaceutical supply chain for direction associated with this question.

Question 83.
Does the current CSO arrangement lead to strategic variation in trading terms by wholesalers that is detrimental to some community pharmacies and patients. If so, how? How could the current system be modified to remove such undesirable strategic behaviours?
SHPA has not had specific member feedback in response to this question.

Question 84.
Is a percentage mark-up paid by the pharmacist an appropriate way to compensate wholesalers? Would an alternative compensation arrangement be preferred? If so, please provide details of preferred arrangements.
SHPA has not had a fixed position on this but considered that alternative options may have potential. SHPA recommends that consideration be given to engaging with jurisdiction procurement expertise and state based contract agreements in place not just relating to pharmaceutical supply chain for direction associated with this question.

Question 85.
Could the Government provide either improved wholesale medicine delivery or equivalent wholesale medicine delivery at a lower cost to consumers and taxpayers by moving from a broad CSO system to an alternative system?
Medicines are a completely unique product, and timely distribution is core to achieving their purpose. Whilst wholesale medicine distribution has an extremely complex nation-wide supply chain that is not dissimilar to many contemporary suppliers of consumable products, SHPA is cautious about drawing too many parallels. Although we question the value to consumers received from paying wholesalers to guarantee metropolitan deliveries, we are reluctant to threaten an effective distribution system. SHPA recommends a cost-benefit analysis be undertaken to inform discussion in this area, but would not support a completely ‘free market’ solution that might reduce timely access to medicines.
Question 86.
Should the onus for the delivery of medicines to community pharmacy around Australia in a timely fashion (e.g. 24-hours) be imposed on the manufacturers as part of their listing requirements on the PBS?
Whilst recognition of importance of timely delivery as part of the PBS approval process might be useful in supporting more efficient delivery SHPA is concerned that additional regulation formalising this may risk the viability of medicine manufacturers in Australia.

Manufacturers are not currently in a position to implement robust mechanisms to ensure timely delivery of medicines. However, manufacturer stock levels are also a key concern and obstacle to timely medicine access. SHPA supports the inclusion of regulation around minimum stock holdings requirements for listing on the PBS.

Question 87.
Should the onus to negotiate the delivery of PBS medicines from manufacturers be placed on community pharmacies, either individually or as collectives? Would this be desirable or undesirable?
SHPA would recommend that where possible there are advantages to sector wide agreement associated with such supply chain efficiencies, and suggest this should be desirable.

Question 88.
Would an improved approach to wholesale medicine delivery involve the Government tendering delivery on a nation-wide basis to one or two wholesalers (with appropriate redundancies)? Should it be done on a national, state or local basis? Should tendering be limited to only Pharmacy Accessibility Remoteness Index of Australia (PhARIA) 2, 3 and 4 locations, with open competition in PhARIA 1 areas?

SHPA recommends that consideration be given to engaging with jurisdictional procurement expertise and state based contract agreements in place not just relating to pharmaceutical supply chain for direction associated with this question. Before SHPA supported any proposed change modelling of the impact would be required.

Question 89.
The Review Panel notes that state and territory governments already tender for the supply of medicines to public hospitals, should the Commonwealth and state and territory governments work together for a single tendering model for relevant public hospitals and community pharmacy in the relevant state? If so, should it be for all medicines or specific medicines (e.g. biosimilar or generic medicines)?
SHPA can see great value if this type of approach (similar to NZ’s Pharmac) was able to be implemented in Australia. However, we recognise that Australia’s geographic size and jurisdictional divisions makes its achievement unlikely.

Hypothetically having a single tendering model for all medicines would achieve greater price efficiencies that would increase the affordability of medicines to consumers and governments. SHPA members would support a single tendering model for relevant public hospitals and community pharmacy for medicines, and envisions significant benefits for the
sector based on international example. In particular high cost medicines could be approached from a national perspective enabling consistency in access. Hospitals would also welcome a national approach to the purchase of non-PBS medicines which are dispensed in large volumes. Any single tendering model would naturally need to manage the inherent risk in single supplier products and potential supply chain failure.

Accountability and Regulation

Question 90.
Are there any other regulatory arrangements that should be introduced to promote high standards of delivery and accountability amongst pharmacies, wholesalers, manufacturers and other entities receiving funding under the PBS?

Efficient and effective regulation is essential to high standards of delivery and accountability amongst PBS stakeholders. Whilst delivery and accountability of stakeholders receiving PBS funding is generally good, greater monitoring and evaluation would be beneficial.

Key concerns do exist in relation to the delivery of information from manufacturers and wholesalers regarding safety issues and shortages of PBS medicines, and the consistent inclusion and use of quality community medicines information. Minimum stock holding by manufacturers to avoid product shortages has already been recommended in this document. SHPA members have commented that some current regulations are not particularly well adhered to indicating that rather than additional regulation, greater monitoring and evaluation is required.

In addition, SHPA would like to see greater evaluation of 6CPA activities that relate to the supply of medicines and associated cognitive services. Concerns are held about the quality of service delivery and whether it is high enough to work effectively.

Question 91.
Are there any existing regulatory arrangements that are unnecessary or overly burdensome?

Pharmacy has always been a complex area, however as use of PBS medicines grow, and the list increases, the complications of adhering to funding requirements are becoming more onerous. Changes in the CPA have always impacted on private hospital-based services but they also directly impact on public hospital-based services and have done since 2002 when Victoria was the first jurisdiction to offer medicines through the PBS in its public hospitals. There is now significant use of the PBS through the hospital sector, equating to 20% of overall PBS expenditure, and substantial evidence of burdensome administrative requirements as outlined in our previous submission to the Australian National Audit Office submission (SHPA, 2013).

For consumers to access PBS-listed medicines through a hospital the pharmacist must understand and manage a myriad of access and funding rules assessing the medication order for legal and clinical appropriateness. Rules and stipulations cover 14 different elements outlined below, each with their own complexities.

The situation is more complex in NSW and ACT where funding agreements between these jurisdictions and the Commonwealth do not include access to PBS-listed medicines for consumers treated at NSW and ACT public hospitals.
For consumers to access PBS-listed medicines through a hospital the pharmacist must understand and manage the following:

- The list of medicines on the PBS
- Any specific requirements for access to that medicine
- The quantity of the medicine that can be supplied and how frequently it can be supplied
- When the medicine can be supplied to the consumer through the PBS and when it must be supplied outside the PBS
- Which brand of the medicine is required / suitable and the impact of that choice on the cost to the consumer and the hospital
- How to apply for / confirm authority requirements for each of the eight authority categories:
  - Section 85 authority medicines (e.g. Anzatax injection)
  - Section 85 authority required for access to increased quantities of medicines listed as restricted benefits (e.g. Solu-Medrol injection where more than one dose is required)
  - Section 85 authority 'streamlined' (e.g. Gantin capsules)
  - ‘Efficient funding of chemotherapy medicines’ listed medicines available only through public hospitals (e.g. Fludara injection)
  - Section 100 highly specialised drugs (HSD) authority medicines, public hospitals (e.g. Mabthera injection)
  - Section 100 HSD authority medicines, private hospitals (e.g. Neoral liquid)
  - S100 HSD authority ‘streamlined’ medicines available only through public hospitals (e.g. Neupogen injection)
  - S100 HSD Complex Authority Required medicines, public hospitals (CAR HSD) (e.g. Herceptin)
- Rules about the size and format of the prescription form that must be used for different PBS categories
- Rules about prescribers eligible to prescribe scheduled medicines and prescribers eligible to prescribe medicines that may be supplied through the PBS
- Rules about consumer eligibility, specifically if the consumer is eligible for benefits through Medicare
- Rules about the consumers financial contribution including if the consumer is eligible for a concession card or if the consumer has met safety net arrangements
- Rules about accessing medicines through the ‘closing the gap’ system
- Rules about claiming reimbursement for the supply of the medicines including the appropriate prescription form, compliance with formatting, compliance with details required (dependent on PBS category) and compliance with indications and PBS listings
- Which claiming process is required for each PBS category (manual, electronic or a combination) and the data requirements for each category
- If the consumer is eligible for ‘Closing the Gap’ funding

All of these are in addition to the usual considerations required for the safe and effective supply of medicines. SHPA believes that business rules written for the PBS in 1947 continue to drive how pharmacists provide services in 2016 are unnecessarily onerous. The complications of funding mechanisms and rules for medicines cause confusion, increase the risks of medication error and diverts doctors and pharmacists away from direct patient care.
Question 92.
What data is already available in pharmacy and other parts of the health system that could be used to inform the monitoring and assessment of standards of delivery and health outcomes? How might a patient’s existing My Health Record be used to support this?

Hospitals have begun the transition to using electronic medical records system-wide, which not only have the benefits of improving the safety and quality of healthcare, but also provides a platform for rigorous patient data to be collected. This can not only inform better decisions with respect to resource allocation, but also can provide a better snapshot of the health outcomes achieved and the type of healthcare that is delivered.

With respect to outreach medication review services, hospital pharmacists routinely monitor the rate of presentation to emergency departments, readmission to hospital rates and length of stay, pre and post outreach services. This data provides justification for the outreach services to reduce readmission rates and improve health outcomes.

State/territory governments may require reporting of such data and metrics to their databases to inform the allocation of resources as well as to identify key population areas at risk of poorer health outcomes. For example in Victoria, the data obtained from outreach services is reported to the Department of Health and Human Services for the Victorian Integrated Non-Admitted Health (VINAH) dataset.

More rigorous healthcare system wide collection of data can also have benefits in improving the judicious use of antimicrobials and other related antimicrobial stewardship activities and objectives described by the Australian Commission on Safety and Quality on Health Care. ACSQHC work in partnership with the National Centre for Antimicrobial Stewardship who conduct the National Antimicrobial Prescribing Survey each year.

In hospitals, pharmacists routinely document the care provided to patients and interactions with members of the multidisciplinary care team in progress notes and reports. In community pharmacies, the collection of data and documentation of patient care is not adequate, due to both a lack of infrastructure with respect to pharmacy software, and remuneration of community pharmacy services being linked to the supply of the medicine, and not the service provided.

Question 93.
Is there a role for pharmacists to work with patients and other health professionals, possibly relating to individual medicines or specific conditions, to better create the data to analyse the health outcomes for that particular patient or group of patients, including through the use of a patient’s existing My Health Record?

The inclusion and active involvement of all health professionals will be critical to ensure that My Health Record facilitates better teamwork and communication amongst all healthcare providers, especially for community pharmacists where documentation of patient care is severely lacking. The outcomes from this should be better health outcomes for consumers, a safer system that improves continuity of care and is able to inform governments on standards of delivery and health outcomes.

As described in the question above, outreach medication review services are only one arm of Hospital Admission Risk Programs (HARP). The HARP model also has branches covering mental health, diabetes, airways disease, heart failure and other disease groups. These
models are patient-centred and multidisciplinary and already report to jurisdictional departments who are able to analyse health outcomes for particular patient groups.

It is envisaged that scaling these data collection systems to a national level such that they work synergistically with My Health Record would mean that better data is collected to inform national priorities and targeted resource allocation to population groups in need.

Question 94.
If this data collection and analysis is desirable, would funding be needed from Government or from another source? If so, what would be the avenue for such funding?
SHPA believes that it is in the Government’s interest to adequately fund and facilitate data collection and analysis. The data collection tools and mechanisms should be streamlined and strengthened by investments in infrastructure, such that it is a passive activity that does not impinge on the time that clinicians have to provide direct patient care.

Currently data on health services and outcomes is collected from federal agencies such as the ACSQHC, Independent Hospital Pricing Authority, National Health and Medical Research Council and the Australian Institute of Health and Welfare. To achieve this, significant funding and investment would be required from the Australian Government to facilitate collaboration from federal agencies that already collect data, as well as facilitating clinicians, such as pharmacists, to start recording and reporting data to inform governments on health outcomes and priorities.

Question 95.
Are consumers aware of what programs and general pharmacy services they are entitled to? Is there enough information available regarding the services for which they are eligible?
Feedback from SHPA members indicate that they see a poor level of understanding of pharmacy services such as HMRs amongst consumers, or that they do not appreciate its role as a health promotion mechanism. Some hospital pharmacists themselves stated a lack of knowledge about pharmacy services delivered in community settings which could impact on referral or effective provision of patient information. SHPA is concerned that people at high risk of medicine mismanagement, such as people without a GP, people with low incomes and people in rural, regional or remote locations, are potentially both likely to be in more need of pharmacy services, and less likely to be aware of what they are eligible for, and will struggle to find information pertaining to their options.

Question 96.
If they are not receiving the relevant service, do consumers know the avenues for feedback or complaint? Are these feedback mechanisms adequate or should they be improved? If so, are there ways of using technology to provide better feedback?
SHPA is unsure of this, but given the comments above, doubts awareness of feedback mechanisms is adequate.
Question 97.
Is the ability for the consumer to choose their pharmacist, and change pharmacists if they are dissatisfied, the appropriate or best mechanism to provide feedback?
As often there may not be another option for a consumer this is not the best or an appropriate mechanism to provide feedback. There must be options that facilitate feedback without the need to change provider. SHPA recommends that innovative approaches to consumer feedback (associated with the Australian Charted of Healthcare Rights) that have been implemented in the hospital sector be implemented.

Question 98.
Are there appropriate standards for the dispensing of medicines and delivery of services by community pharmacy? If so, are these standards being upheld? If not, how could the current standards be improved?
Clear standards exist from the Pharmacy Board of Australia, Australian Commission on Safety and Quality in Health Care, the Pharmacy Guild, Pharmaceutical Society of Australia and SHPA for the dispensing of medicines and delivery of professional pharmacy services. Evaluation of the adherence to these standards in community pharmacy would be useful in determining their appropriateness. Evaluation must be outcome focused to ensure it fits with a healthcare systems approach.

Consumer Experience

Question 99.
What services should a consumer expect to receive from a community pharmacist who dispenses their medicines? Why should the consumer expect these services?
As outlined in SHPA’s Model of Care (Figure 2), 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.

In a community setting consumers should expect to receive a complete dispensing service from a community pharmacist as outlined previously and funded through the CPA as this is what pharmacy training instils into pharmacy graduates. This service includes clinical review, dispensing of medicines and patient counselling as standard components. In addition, consumers could expect appropriate referral to evidence-based services that would assist them in their health if they requested.

The model of care (Figure 2) outlined by SHPA can be tailored to less complex patient needs or community pharmacy settings. However, all key elements of dispensing should be addressed in order to reduce the risk of medicine mismanagement.
Question 100.
What are the minimum services that consumers expect (and should receive) at the time of dispensing? Do these differ between initial and repeat prescriptions? Are these services being provided by all pharmacies?
SHPA believes that the standards of pharmacy service received by patients in hospital pharmacy are superior to those generally received in community pharmacy due to professional training, healthcare culture and team capacity. However, the range of complexities of care mean that the key determinant of the standard of care required is that it meets customer need regardless of setting.

This standard can be met in a wide variety of settings, and need not always involve a medicines specialist or accredited pharmacist. It should not substantially differ between an initial and repeat prescription however, as there is always a requirement for therapeutic monitoring. Sicker patients naturally require a higher level of pharmacy care. Patients being discharged from hospital should always be seen by a pharmacist before they leave the hospital to ensure their transition back into the community setting is supported.

Regardless of care setting, the minimum pharmacy services a consumer should receive at the time of dispensing are outlined by the Pharmacy Board of Australia (Pharmacy Board of Australia, 2015). Anecdotal evidence indicates that many experiences in community pharmacy fall below this standard – especially for marginalised population groups. It is known from consumer experience reports, that in some community pharmacies, it is the dispensary technicians that hand out the medication and there is no opportunity for the patient to receive professional advice from a pharmacist.

Question 101.
What does ‘transparently cost effective’ mean for consumers in the context of remunerated pharmacy services?
SHPA is unclear as to the intent of this question but suggests the terminology is jargon unfamiliar to consumers.

Question 102.
In your experience, are community pharmacies generally delivering these services?
SHPA is not in a position to provide specific comment on this question.

Question 103.
Are there currently some programs that are viewed as additional to dispensing which should be included as part of the service provided by a pharmacist when a prescription medicine is dispensed (for example, a medicines check or review)? If so, how should pharmacists be remunerated for providing these services? Should such services be included each time a prescription is filled or should ‘initial’ and ‘repeat’ prescription dispensing involve different services?
Good pharmacy practice outlines three steps of dispensing: clinical review, medicine preparation and labelling, and patient counselling including the provision of community medicines information. However, evidence indicates that some community pharmacies do not recognise these tasks as inherent in dispensing and instead consider them as optional.
A dispensing fee which more closely reflects the level of effort in each encounter would be beneficial to the practice of pharmacy and the sustainability of the health system. Tiered fees which reflect the complexity of the encounter would incentivise greater provision of clinical review and counselling when required, however repeat prescriptions should not automatically be considered to involve less effort. ‘Standard’ and ‘Extended’ classification of services would reflect the level of complexity required, and assist pharmacists in correctly identifying the level of professional expertise required. Currently dispensing and other practice-related fees are only paid to community pharmacists, however if wholesale mark-up remuneration for hospitals was to be diminished payment of dispensing and other practice related fees to hospital pharmacists would be necessary.

Dispensing is a three step process and includes clinical review, medicine preparation and labelling, and patient counselling. Clinical review is a crucial component of dispensing. Clinical review is the review of patient-specific clinical information including patient parameters to evaluate their response to medication therapies and to detect and manage potential or actual medicines-related problems. It may include interpreting biochemical and other tests, evaluating the patient’s signs and symptoms identified from interviews with the patient and review of the health record.

The consistent performance of both clinical review and patient counselling offer significant value in the prevention of medicine misadventure, improved patient wellbeing through the reduced side-effects, and efficient fiscal management through tighter management of valuable resources. However there are situations currently where these elements of dispensing are not performed. A tiered system would be able to effectively recognise this and in these cases they would not be remunerated.

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 (See Tables 1 and 2 on pages 17 and 18. This revised model would enable a hospital 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 enable pharmacists to acknowledge those simple episodes of care which do not require significant review or counselling.

Question 104.
Is there a variation in service standards between different pharmacy models?
SHPA fully supports the excellent contributions to patient care that thousands of pharmacists provide in community pharmacies across Australia every day. However, constraints in existing funding models but also the commercial priorities of some owners are both factors that must be acknowledged as barriers to the practice of pharmacists.

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.

Anecdotal experience of pharmacists working in different pharmacy models and pharmacists liaising between sectors, especially hospital and community interface would indicate that pharmacy models focusing on professional services rather than “retail discounting” provide a much greater health care service standard. SHPA is not in a position to provide formal evidence to support this.
Question 105.
Do community pharmacies that offer discount medicines provide lower levels of service? If so, what evidence is there available to support this?
As articulated previously SHPA fully supports the excellent contributions to patient care that thousands of pharmacists provide in community pharmacies across Australia every day. However, constraints in existing funding models but also the commercial priorities of some owners are both factors that must be acknowledged as barriers to the practice of pharmacists.

Anecdotal experience of pharmacists working in discount pharmacies demonstrate lower levels of service, in particular the diminished delivery of professional pharmacy services. Experience of pharmacist liaising between sectors, especially hospital and community interface reinforce this experience. SHPA would be pleased to have the opportunity to provide further insight regarding our comments.

Question 106.
How do we measure the level of service provided by the pharmacy?
Pharmacy services should be evaluated based on their delivery of evidence-based healthcare interventions to meet service quality requirements as determined by the funder. The community sector should learn from the current reforms within the hospitals sector regarding accreditation and approaches to measure the level of services. This has a focus on clinical outcomes, reduction in harm and patient experience. SHPA does not believe that patient satisfaction surveys are an appropriate measure of service level.

Question 107.
What do consumers expect from community pharmacy in relation to their medicines?
Healthcare services by healthcare practitioners, in this case pharmacists, must be provided in settings conducive to the delivery of professional services. Consumers, as outlined in the Australia Charter of Healthcare Rights, deserve high quality and safe care wherever and whenever care is provided.

SHPA position on this matter is that patients expect care that address their rights as described in the Australian Charter of Healthcare Rights:
- Access
- Safety
- Respect
- Communication
- Participation
- Privacy
- Comment

Question 108.
Has the $1 discount had an impact on the access and affordability of PBS medicines? Has the introduction of the $1 discount been a successful implementation of policy?
SHPA has not had specific member feedback in response to this question.
Question 109.
What examples can you provide of variation in prices for regular PBS prescriptions?
SHPA does not have specific data that would inform this answer.

Question 110.
How informed are consumers of the scope of medicines and related services that can be provided by pharmacists without referral to a General Practitioner?
SHPA has not had specific member feedback in response to this question.

Question 111.
To what degree do current advertising restrictions limit the ability of pharmacies to promote medicines and related services available to consumers?
SHPA does not believe that the current restrictions limit the ability of pharmacies to promote medicines and related services to consumers.

Question 112.
In your experience, do community pharmacists provide appropriate advice for schedule 2 and 3 medicines?
SHPA does not have evidence to provide clear guidance around this question. However, anecdotal evidence from members, and comments published from consumer groups in Pharmacy Guild and Pharmacy Board publications, indicate that community pharmacists are not always able to provide appropriate advice for schedule 2 and 3 medicines.

Question 113.
Are the current restrictions on the sale of schedule 2 and 3 medicines an appropriate balance between access and health and safety for consumers? If not, how could this balance be improved?
SHPA makes regular submissions to the TGA in relation to the scheduling of medicines. As Schedule 3 medicines are ‘pharmacist only’ medicines, and in essence a pharmacist’s prescription, SHPA believes that all supplies of these products should be dispensed, individually labelled and recorded by the pharmacist, to appropriately monitor and manage patient usage of codeine, as well as in the context of their other medicines.

SHPA believes that a national real-time recording and reporting system would mitigate many of the risks of the inappropriate use and diversion of medicines such as codeine.

Question 114.
Is the sale of schedule 2 and 3 medicines an important contributor to the income of community pharmacies?
Anecdotally SHPA believes this is a major contribution to the income of community pharmacies.
Question 115.
Does the availability and promotion of vitamins and complementary medicines in community pharmacies influence consumer buying habits?

SHPA believes that advice by healthcare practitioners influence behaviour and this must influence buying habits of consumers. However SHPA cannot provide quantitative evidence of this.

Question 116.
Should complementary products be available at a community pharmacy, or does this create a conflict of interest for pharmacists and undermine health care?

In line with SHPA’s support for evidence-based healthcare SHPA would draw attention to our support for the Australian Pharmacist Leadership Forum’s position statement (Australian Pharmacy Liaison Forum, 2015) which states that pharmacists should not support or recommend homeopathic treatments. SHPA believes reform is necessary but will not be possible without broader reform of service provision and remuneration.

Question 117.
Do consumers appreciate the convenience of having the availability of vitamins and complementary medicines in one location? Do consumers benefit from the advice (if any) provided by pharmacists when selling complementary medicines?

SHPA does not believe that convenience is an appropriate justification for selection of stock.

As stated earlier 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 and this includes not making available (just reasons of access alone) products that are not evidence-based.

Question 118.
Does the ‘retail environment’ within which community pharmacy operates detract from health care objectives?

SHPA believes strongly that all pharmacies are places of healthcare and therefore the only appropriate setting is one conducive to the delivery of professional healthcare and support. The display and sale of non-evidence based products is distraction to this. The pharmacy Code of Conduct (Pharmacy Board of Australia) makes this clear. SHPA recommends a focus on developing greater standards and requirements related to the professional pharmacy services, alongside an increased focus on staff training and accreditation. It is not possible to reform the services provided within this setting without major reforms around the community pharmacy facilities and the retail products that are promoted.

Question 119.
Are the current consumer payments for the supply and dispensing of PBS listed medicines transparent? Are they appropriate?

SHPA believes that the consumer payments for PBS listed medicines are very unclear and confusing for consumers, and that this is becoming a greater issue with the introduction of discounting and must be addressed as a priority.
Question 120.
Is the PBS Safety Net adequate to address the needs of low income consumers who face high pharmaceutical costs and other medical-related costs? If not, what other strategies can be employed to ensure access to cost-effective health care is protected and promoted?

SHPA believes that the current Safety Net arrangement is adequate for the majority of Australian who have access to the PBS. However, many groups in the community do not have access to the PBS.

Widespread evidence exists that cost remains a barrier to healthcare for people with limited income. These often include people with chronic conditions that mean their ongoing access to medicine is essential. The difficulty in paying PBS co-payments was specifically mentioned by SHPA members when discussing access to medicines by Indigenous patients who generally reside at S100 RAAHS and receive free PBS medicines, but have travelled to a different prescriber. It was noted that they most regularly don’t fill the prescription, presumably waiting to return home. This is a serious concern and SHPA would be pleased to assist in the development of a process or model which better addresses this matter.

Question 121.
What do consumers expect for the value of the PBS co-payment, noting it is intended to contribute to the price of the medicine, supply to pharmacy, a pharmacy handling fee and a professional dispensing fee?

SHPA believes consumers are entitled to expect the efficient delivery of the three elements of dispensing: clinical review, medication preparation and labelling and patient counselling. These three components are essential to the dispensing of any medicine and are not exclusive to the PBS.

Question 122.
What is the objective of the co-payment? Is it to ensure patients use PBS medicines appropriately, by setting a price signal? If so, is this objective enhanced or undermined by allowing co-payment discounts?

SHPA acknowledges that there are a range of fiscal reasons for introduction of co-payments. However the rationale and impact of co-payments is becoming less clear to the consumer in light of recent discounts and competition to reduce co-payment offered between different pharmacies. This contributes to the confusion and lack of clarity discussed above.

Question 123.
Should pharmacists be able to discount the co-payment by more than one dollar if they choose to do so? Would such competition benefit or harm consumers? If competitive discounting is expanded for the co-payment, should any limits be placed on the potential discounts?

Competitive discounting can provide unintended impacts on pharmacy practice and patient outcomes as it may introduce perverse incentives to dispense. These practices can reduce service quality and are not conducive to patient-centred care. As stated earlier, 20% of the PBS expenditure is through hospitals. Significant differences exist in co-payment processes between the public and private hospital sector, and community pharmacy, that must be considered. This contributes to the consumer confusion discussed earlier.
Question 124.
Is it reasonable for consumers to expect access to medicines outside of standard business hours? If so, why? What arrangements could be made to improve consumer access?

Pharmacy services are critical to a healthy community. Both hospital and community pharmacies should be accessible after hours and on weekends for community based consumers. Access to urgent, life-saving and critical medicines should be available at all times for patients, and this is often facilitated by emergency departments.

Pharmacy services should be available when patients require them, 7 days per week and for extended hours. Limiting services to business hours and 5 days per week reduces the timeliness of service delivery and may impact on patient care. SHPA believe that 24 hour a day, 7 day a week hospital pharmacy services in major hospitals would be beneficial in increasing capacity for expert pharmacy services as described previously, and in boosting access to medicines, counselling and advice generally. The provision of 24 hour community pharmacies are also supported by SHPA. The introduction of Victoria’s SuperCare pharmacy model with support from the Victorian government will hopefully encourage other states and territories to adopt a similar approach.

Question 125. What services do consumers expect and value from pharmacists outside of standard business hours? Are there other settings or mechanisms that could deliver these services after hours?

Consumers expect efficient and timely access to important medicines, and to patient counselling and medicines information, as well as treatment for minor ailments outside of business hours.

Access to dispensing services and treatment for minor ailments or first aid are key services that can be provided by community pharmacies in most cases. Technological solutions are also showing promise. In emergencies hospitals are able to assist. Whilst inpatients have access to limited clinical pharmacy services outside of standard business hours, consumers in the community often rely on community pharmacies as the first port of call for primary health care services after hours, and where access to a GP is limited. Community pharmacies can often act as a de facto triage service and refer consumers to emergency departments or other health services where required.

Principal referral hospitals will usually have on-call pharmacy services outside of standard business hours. Internationally ‘telepharmacy’ is showing promise in increasing pharmacy capacity for hospitals outside business hours (Rosenthal, 2016). Different state and territory governments are also offering telehealth services after hours where consumers can speak to a nurse or a GP to discuss health issues and give advice for both chronic and acute conditions which is relevant for medicine management concerns. Internet sites are also useful for consumers seeking medicine-related information such as allergic reactions or suspected drug interactions.

Question 126.
Does more need to be done to encourage greater access to medicines and professional services through the expansion of existing rural and remote programs?

SHPA believes that pharmacy access to both community and hospital pharmacies in rural and remote areas of Australia is not equitable with metropolitan areas and requires continual attention (REF).
Question 127.
Is it reasonable for consumers to expect that all community pharmacies provide these specialist services? If so, why? If not, why not?
SHPA believes that there is a basic level of professional service that all community pharmacies should provide around the dispensing of medicine which can be mandated. In addition, specialist medicine services or cognitive services can be provided by qualified pharmacists independent of a community pharmacy business if remunerated directly.

Question 128.
Would it be desirable to align the delivery of specialist services to population need in local communities? If so, what is the best way of coordinating appropriate and relevant services for populations of need?
Population need should inform service development for all pharmacies through a process of meaningful engagement driven by a healthcare philosophy rather than a retail supply model. Specialist services can be efficiently provided outside a community pharmacy environment by accredited pharmacists if directly remunerated. Collaboration between healthcare providers, including hospital and community pharmacists, is the most appropriate approach.

Question 129.
How might access and service barriers identified above be resolved and consumer needs be better met? Is additional training and support within community pharmacy sites needed?
SHPA has not had specific member feedback in response to this question.

Question 130.
Are there other inequities in terms of access to and quality use of medicines? If so, how should those be addressed and what population groups could be targeted?
SHPA has not had specific member feedback in response to this question.

Question 131.
What can be done to increase public awareness of available pharmacy programs and services, particularly specialist services?
Health promotion activities such as public awareness campaigns, online advertising, point of sale materials and public relations are all effective means of educating the public about available health services. Pharmacy services should be promoted through community health centres, in General Practices and in other health services.

Question 132.
How can we encourage and support consumers to engage more with their local pharmacy and what specific patient groups require more general awareness about available pharmacy services?
SHPA has not had specific member feedback in response to this question.
Chemotherapy Arrangements

Question 133.
It is the Panel’s understanding that the additional $20 payable for infusions compounded by TGA licensed compounders is remuneration for the cost of gaining and holding the TGA licence. Should the PBS provide additional remuneration for compounders that meet TGA licensing requirements?
SHPA supports additional PBS remuneration for compounders who meet TGA licensing requirements.

The overheads and costs of establishing and maintaining a TGA licensed compounding facility are understood to be higher than non-TGA licensed compounding facilities, thus it is appropriate for TGA licensed compounders to be remunerated for the cost of gaining and holding a TGA licence. However, the current remuneration model is volume-dependent, and does not commensurately address the overheads and start-up costs of TGA licensed facilities. While facilities that compound a higher amount of infusions will achieve economies of scale and ensure the viability and sustainability of their TGA licensed compounding facility, this may not be the case for facilities that manufacture lower volume of infusions. This may adversely impact access to chemotherapy treatments from TGA licensed facilities for consumers, especially in regional and remote areas.

Question 134.
It is unclear to the Panel that there is any therapeutic difference between chemotherapy medicines provided by TGA licenced compounders and non-TGA licensed compounders. Is there any therapeutic difference, if so, what are they? If there are no therapeutic differences, should the payment of chemotherapy compounding be the same regardless of whether the provider is TGA licensed? If there are therapeutic differences, why should the Government continue to subsidise sub-optimal medicine?
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. 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.

The difference in medicines compounded by TGA licensed compounders is in the quality of the product, and the certification of its development process. Due to the standards of the manufacturing facility, their products have longer shelf lives and expiry dates. For example, an infusion compounded by TGA licensed compounders may not ‘expire’ for several months, whereas a similar infusion compounded by a non-TGA licensed compounder, may have an expiry of 48 hours or not more than 7 days.

As such, TGA licensed compounding facilities are able to compound batch preparations of medicines and distribute to pharmacies and health services who do not have compounding facilities. Due to the cost of certification most hospital pharmacies are not TGA licensed, and therefore only compound medicines for individual patients.
Question 135.
Are the two compounding fees ($60 for TGA licensed, $40 for non-TGA licensed) reflecting a supply guarantee?
The introduction of the tiered compounding fees based on TGA certification does incentivise supply of chemotherapy meaning it is more likely to be provided onsite by hospitals. However, SHPA members indicate that the volume-dependent payment system does not commensurately reflect the significant costs of establishing a compounding facility due to the high establishment costs.
Facilities which compound lower volumes of medicines have lower cost efficiency and do not have the economies of scales achieved by other compounders. This puts the viability and sustainability of their services at risk, to the detriment of consumer access. In rural and regional areas this risk is amplified due to the lower output of compounded chemotherapy and simultaneous difficulty in accessing third-party compounders who are generally based in metropolitan areas.
Private hospitals and day procedure centres that have low chemotherapy compounding output are at risk of making the business decision to not provide chemotherapy services due to the cost inefficiency. This was an issue facing private providers of chemotherapy services in 2012 – who at the time were providing 60% of all chemotherapy services – when the impacts of price disclosure led to services becoming unviable until arrangements were established under the S100 Efficient Funding for Chemotherapy schedule.

Question 136.
If it is appropriate to have differential payments for chemotherapy compounders, what is the best way for those payments to be made? What should form the basis of the difference of the payment?
SHPA supports a simple payment system for chemotherapy compounding which is not administratively burdensome for both TGA and non TGA licensed compounders.
Compounders are capable of providing a unique identifier for every compounded product produced. This enables transparency of medication safety and meets relevant regulations. This unique identifier can be provided to the PBS as part of standard claim processing at the time of dispensing. The dispensing pharmacy can then be remunerated for that activity. The pharmacy service is then responsible for paying any external compounding costs or additional fees as commercially agreed.

Question 137.
Are the levels of these fees sufficient to ensure long term viability of compounding services?
SHPA member feedback stated that the continued impacts of price disclosure and stringent requirements for maintaining and upgrading facilities risk the sustainability of compounding services. This is particularly true for private providers who provide an estimated 60% of chemotherapy services.
Members were also concerned that there is a risk chemotherapy compounders may provide sub-optimal quality assurance and operate sub-standard facilities if under financial threat rather than closing facilities that are unsustainable. This would increase risk to patients.
Question 138.
Should non-TGA licensed public hospitals be allowed to provide chemotherapy compounding services to other public and private hospitals?
SHPA believes that non-TGA licensed public hospitals should be able to provide patient-specific chemotherapy compounding services to facilities and campuses within their own hospital network only.

Question 139.
Chemotherapy patients benefit from the ability of local chemotherapy manufacturing facilities to provide more timely medications to patients locally. These facilities generally do not hold a TGA licence. Is there a need for additional standards for non-TGA licensed compounders?
SHPA is confident in the quality and safety of chemotherapy manufactured in Australia and therefore does not support the introduction of additional standards for non-TGA licensed facilities. Non-TGA licensed compounders of chemotherapy are already required to follow stringent standards including:

- Australian Standards/New Zealand Standards ISO 14644.4:2002 (R2016) - Cleanrooms and associated controlled environments - Design, construction and start-up
- Pharmaceutical Inspection Co-operation Scheme (PIC/S) Guide to good manufacturing practice for medicinal products. PE 009-9
- International Society of Oncology Pharmacy Practitioners (ISOPP) - Standards of practice: Safe handling of cytotoxics
- Pharmacy Board of Australia – Guidelines on compounding of medicines
- COSA guidelines for the safe prescribing, dispensing and administration of cancer chemotherapy
- Controlled environments- Biological safety cabinets Class II-Design (AS 2252.2-2009)
- SHPA Guidelines for Medicines Prepared in Australian Hospital Pharmacy Departments
- SHPA Standards of Practice for the safe handling of cytotoxic drugs
- Relevant jurisdictional standards

Question 140.
Are there other issues with the production and delivery of chemotherapy medicines which the Panel should be aware of?
The supply of chemotherapy compounded medicines is only one part of the care provided to a cancer patient. The clinical pharmacy service provided to the patient is currently an unfunded, but crucial service. Administering chemotherapy services without a clinical pharmacy service can compromise the quality of care provided and adversely impact of patient outcomes.

A pharmacist must review the chemotherapy order to ensure the dosage and chemotherapy cycles are appropriate, this includes:

- reviewing blood counts and other relevant pathology results
- calculating body surface area and other relevant calculations to titrate chemotherapy doses
• reconciliation the chemotherapy cycles with the prescribed chemotherapy protocol
• checking for adverse reactions, drug-drug interactions and drug-disease interactions
• provide counselling and review on the medicines provided as part of the chemotherapy treatment. These include medicines for cancer-related pain, chemotherapy induced nausea and vomiting, oral chemotherapy medicines with complex dosing regimens and others.

In recent times, two jurisdictional inquiries into chemotherapy services – the Independent review of incorrect dosing of Cytarabine commissioned by SA Health and Off-protocol prescribing of chemotherapy for head and neck cancers by NSW Health – have highlighted the crucial role clinical pharmacists play in ensuring the appropriate delivery of chemotherapy services.

SHPA would also like to highlight the inconsistency and anomalies in payments made to compounders of chemotherapy medicines.

• There are other chemotherapy medicines, such as subcutaneous trastuzumab for breast cancer, that require compounding and Azacitadine for MDS and AML, but do not attract a chemotherapy compounding payment as the medicine is scheduled in Section 85 not under the Efficient Funding of Chemotherapy (EFC) schedule.
• Medicines such as rituximab will attract a chemotherapy compounding payment when the indication is for cancer, however when the indication is for rheumatoid arthritis, there is no remuneration even though it requires the same compounding process.
• The flat fee paid per infusion does not reflect the variations in complexity of compounding different medicines in the EFC schedule. For example, compounding a vincristine infusion is a 2-step process, but compounding a fluorouracil ambulatory infusion is a lengthier 10-step process.
Bibliography

In this submission SHPA has attempted to focus the response to the specific questions raised. SHPA has refrained from an approach that describes, or provides the evidence, for all the potential clinical activities and services for which there is evidence. A select number of papers and guidelines have been acknowledged to highlight particular points. In addition to these SHPA has many other practice standards, position papers, submissions and literature to inform this review.


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