



Inquiry into Community Pharmacy in Victoria

Legislative Council

Legal and Social Issues Legislation Committee

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Inquiry into Community Pharmacy in Victoria

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TERMS OF REFERENCE

On 27 May 2014, the Legislative Council agreed to the following motion:

That, noting the Australian Health Practitioner Regulation Agency 2012–13 annual report, particularly as it relates to the registration of pharmacists in Victoria, this House requires the Legal and Social Issues Legislation Committee to inquire into and report by 14 October 2014 on the role and opportunities for community pharmacy in primary and preventative care in Victoria.

CHAIR'S FOREWORD

On behalf of the Legal and Social Issues Legislation Committee I have pleasure in presenting this Report on the Inquiry into Community Pharmacy in Victoria.

Victoria faces a range of significant health care challenges including increased rates of chronic disease and disability and an ageing and growing population. This Inquiry enabled the Committee to review the role of community pharmacies and their potential, with appropriate training and support, to take pressure off general practice, the aged care sector, Victoria's hospital system and emergency departments.

Community pharmacists form an integral part of Victoria's health care system through their dispensing of medications, provision of expert advice, referral of patients to doctors or allied health professionals when necessary, as well as through primary and preventative health services provided within and outside the pharmacy setting. Pharmacists are highly trained and trusted and can be better utilised, particularly in rural and regional Victoria, where it can be more difficult to access various forms of health care.

This Report considers an expanded role for community pharmacists and makes 17 recommendations focussed on improving the experience of primary and preventative health care for the Victorian community.

During the course of the Inquiry it was highlighted to the Committee that community pharmacists could make an increased contribution to preventative care by offering influenza immunisations, which they are currently not able to do in Victoria. Evidence demonstrated that immunisation trials in other jurisdictions where pharmacists have received appropriate training have been well supported by patients and are making positive contributions to preventative care. A key recommendation from the Committee is that a pharmacist-administered adult only immunisation pilot be established in Victoria.

The Committee heard evidence that currently some pharmacies already act as a triaging service and manage some less complex health matters. This service could be further expanded and the Committee has recommended that, in close consultation with GPs, a pilot 'minor ailments scheme' be trialled in rural Victoria. Under such a scheme the number of visits to GPs or emergency departments could be reduced by pharmacists treating minor conditions that do not require prescription medication.

Evidence to the Committee also demonstrated that medication mismanagement is a significant issue for our health system and responsible for large numbers of hospital re-admissions. Reasons for this include greater complexity of some medication regimens and an increasing use of medications to treat chronic health conditions. Pharmacists are experts in this area and the Committee believes they could be better utilised to ensure patients are able to manage their medications appropriately.

The Committee received evidence that pharmacists provide a valuable service to the community for those patients who are unable to access their GP in a timely manner, through their dispensing of the emergency contraception pill and, under the Continued Dispensing initiative, certain other medicines, without a prescription from a medical practitioner. Taking this into account, the Committee has made recommendations in this Report that guidelines for pharmacists around the provision of emergency contraceptives are clarified and that the Continued Dispensing initiative is expanded where appropriate.

The Committee noted evidence that the Fifth Community Pharmacy Agreement remunerates pharmacists to undertake such vital services as the packaging of medications into dose administration aids and conducting medication reviews, especially for elderly patients. However, funding limitations have in some cases reduced the effectiveness of the various programs. Therefore, the Committee holds the view that the Sixth Community Pharmacy Agreement, which is currently under negotiation, presents an opportunity to address some of the concerns surrounding remuneration for this important work undertaken by pharmacists.

Despite this Report recommending an expansion of community pharmacists' roles, the Committee has emphasised that GPs should remain at the centre of primary care in Victoria. Indeed, this Report discusses the need for strengthened relationships and pathways between community pharmacy and GPs. For example, an improved and better utilised personally controlled electronic health record system could contribute to better communication between GPs and pharmacists through the sharing of appropriate patient information.

On the Committee's behalf, I would like to thank those individuals and organisations who contributed to this Inquiry in the form of submissions and public hearing evidence. I would also like to take this opportunity to thank all the members of the Committee for the professional manner in which the Inquiry was conducted.

GEORGIE CROZIER, MLC
CHAIR

FINDINGS AND RECOMMENDATIONS

Chapter Two: An overview of community pharmacy in Victoria

FINDINGS

- 1 Pharmacists receive funding from a variety of sources, however, unlike many other health care providers, pharmacists do not charge for advice, do not have Medicare provider numbers and patients cannot seek reimbursement for the cost of pharmacist services through private health insurance.

[Page 13]

- 2 The negotiation of the Sixth Community Pharmacy Agreement provides an opportunity for the Commonwealth Government to expand the scope of the primary health services provided by pharmacists.

[Page 13]

Chapter Three: Current roles of community pharmacy

FINDINGS

- 3 The prices consumers pay for Pharmaceutical Benefits Scheme medicines in recent years have not increased as much as other commodities and the Pharmaceutical Benefits Scheme represents value for money, especially in relation to other hospital and medical services.

[Page 16]

- 4 Community pharmacists play an essential role in primary health care through their provision of non-prescription medicines.

[Page 17]

- 5 Medication-related hospital admissions in Victoria are common and comprise a huge cost burden to the State.

[Page 25]

- 6 The evidence indicates that it is not commonly known that community pharmacists are able to provide sickness certificates as proof of legitimate absence from work due to illness.

[Page 30]

Chapter Four: An expanded role for community pharmacy

FINDINGS

- 7 A proportion of general practitioner visits are for 'less complex' conditions, some of which could potentially be treated within a community pharmacy.

[Page 39]

- 8 Dose administration aids are crucial tools to assist with the correct use of complex pharmaceutical regimens and therefore community pharmacists need to be adequately supported to provide this service.

[Page 43]

- 9 Medicines reviews are valued by health professionals as a tool to help ameliorate the occurrence of medication-related problems and the subsequent cost to the community.

[Page 45]

- 10 There is currently a gap in the range of medicines reviews available due to the Hospital-initiated Home Medicines Review not being funded.

[Page 47]

- 11 While community pharmacists do provide some chronic disease screening and management services, there is no formalised, government-funded service offered.

[Page 50]

- 12 In some areas of Victoria there remains a need for more community pharmacies to offer opioid dependence treatment and this is related in part to the cost to pharmacies of providing the service and the minimal remuneration available (other than Pharmaceutical Benefits Scheme payments for the actual medicines dispensed).

[Page 53]

- 13 Community pharmacists are currently unable to take part in shared care plans.
[Page 61]
- 14 There is support across the primary health system for the concept of locating non-dispensing pharmacists within general practice.
[Page 63]
- 15 The Return of Unwanted Medicines program forms a valuable part of community pharmacy's contribution to preventative health care in Victoria and requires adequate funding to ensure its ongoing existence.
[Page 66]
- 16 Many women are unaware that community pharmacies are able to provide emergency contraceptives without a prescription and pharmacists may not have a clear understanding of the guidelines around dispensing.
[Page 67]

RECOMMENDATIONS

- 1 That the Department of Health establish a pharmacy immunisation trial targeting adults and ideally commencing in time for the 2015 influenza season.
[Page 38]
- 2 That the Department of Health work with the Commonwealth Government and health care providers to pilot a minor ailments scheme in rural Victoria for selected and suitably trained community pharmacists.
[Page 40]
- 3 That the Department of Health work with the Commonwealth Government to expand the Commonwealth's Continued Dispensing initiative.
[Page 42]
- 4 That community pharmacies receive adequate remuneration through the Sixth Community Pharmacy Agreement for the ongoing delivery of dose administration aids.
[Page 43]

- 5 That community pharmacists be remunerated through the Sixth Community Pharmacy Agreement to provide medicines reviews on a needs basis.

[Page 45]

- 6 That the Sixth Community Pharmacy Agreement allocates funding for a medicines review program specifically addressing the post-acute care period.

[Page 47]

- 7 That the Victorian Government consider piloting an evidence-based chronic disease screening and management program in selected community pharmacies, including a formal requirement for communication between pharmacists and the patients' general practitioners.

[Page 50]

- 8 That the Victorian and Commonwealth Governments consider a funding model, such as the allocation of a Medicare provider number to pharmacists, to adequately recompense pharmacists for providing a standardised, evidence-based opioid dependence treatment.

[Page 53]

- 9 That the Victorian Government and pharmacy peak bodies jointly develop a program which helps community pharmacies support people with a dependence on over-the-counter analgesics containing codeine and/or prescription narcotics.

[Page 53]

- 10 That the Victorian Government investigate real cost incentives to encourage community pharmacies to offer the Needle and Syringe Program.

[Page 55]

- 11 That the Victorian Government investigate pre- and post-acute medication assessment models delivered by community pharmacists, with a view to implementation of a pilot program.

[Page 57]

12 That the Victorian Department of Health work with its Commonwealth counterpart to:

- conduct further research into the beneficial role of pharmacists in supporting the provision of aged care in the home
- investigate the costs and benefits of providing community pharmacists with provider numbers so that they can deliver specialised care services for residents of aged care facilities.

[Page 59]

13 That the Victorian Minister for Health advocate to the Commonwealth Government to consider including community pharmacists in shared care teams.

[Page 61]

14 That the Department of Health commission research into the costs and benefits of locating non-dispensing pharmacists in general practice, with a view to establishing a pilot program.

[Page 63]

15 That the Victorian Minister for Health encourage the Commonwealth Government to expedite the development and take-up of electronic health records and ensure that pharmacists are able to participate in the system to improve patient care.

[Page 65]

16 That the Pharmaceutical Society of Australia work with pharmacists to improve understanding of the guidelines on the provision of emergency contraception.

[Page 67]

17 That the Victorian Government advocate to the Commonwealth Government to consider the inclusion of community pharmacy within the Telehealth program.

[Page 69]

ACRONYMS

ACPA	Australian Community Pharmacy Authority
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
APC	Australian Pharmacy Council
CPA	Community Pharmacy Agreement
CPR	Cardiopulmonary Resuscitation
Cth	Commonwealth
DAA	Dose Administration Aid
EMML	Eastern Melbourne Medicare Local
GP	General Practitioner
HACC	Home and Community Care
HMR	Home Medicines Review
KYN	Know Your Numbers
MBS	Medicare Benefits Schedule
PBA	Pharmacy Board of Australia
PBS	Pharmaceutical Benefits Scheme
PCEHR	Personally Controlled Electronic Health Record
PGA	Pharmacy Guild of Australia
PHIAC	Private Health Insurance Administration Council
PPI	Pharmacy Practice Incentives
PSA	Pharmaceutical Society of Australia
RMMR	Residential Medication Management Review
Vic.	Victoria
VPA	Victorian Pharmacy Authority

CHAPTER ONE: INTRODUCTION

This Report focusses on the role of community pharmacies in delivering primary and preventative health care in Victoria.

Community pharmacies are private businesses found in retail strips, shopping centres and medical clinics in almost every suburb and town, with over 1,300 in Victoria. Community pharmacies (sometimes referred to as 'chemists') are to be distinguished from pharmacy departments within hospitals and other medical or research institutions. The *Pharmacy Regulation Act 2010* (Vic.) defines a pharmacy as premises in or from which a registered pharmacist supplies, compounds or dispenses medicines to the public, and includes the part of the premises where the registered pharmacist sells or offers to sell goods of any kind.¹

When an individual has a minor health concern, a community pharmacist is very often their first point of contact with the health care system. The pharmacist may give advice on self-treatment, suggest an over-the-counter medicine or recommend the person see a general practitioner or other health care provider.

Pharmacists are highly trained, primarily as medication experts. However, the role of pharmacy is shifting in response to many different factors, such as patient demands, the rise of chronic diseases, difficulties in accessing GPs, developments in pharmacist training, and financial pressures impacting on the pharmacy industry.

As this report describes, many pharmacists already participate in a range of primary and preventative health care services, extending from the everyday task of triaging patients, to medication reviews and advice, pharmacotherapy, chronic disease management and needle and syringe programs, among others.

A recent development in some Australian states and territories is the trialling of pharmacist-administered influenza, measles and whooping cough immunisations for adults. Overseas, administering vaccinations is a common role for pharmacists and in some jurisdictions they have also begun to treat minor ailments and provide other forms of primary health care.

Pharmacies play a crucial role within our health system and have the potential to take pressure off GPs and emergency departments. Currently, almost one in four people report having to wait too long for an appointment with their GP.² One of the

¹ *Pharmacy Regulation Act 2010* (Vic.), s.3.

² Grattan Institute, *Access All Areas: New solutions for GP shortages in rural Australia*, September 2013, p. 7.

key benefits that pharmacies can offer is convenience: they are well distributed throughout most parts of the State, are often open for extended hours and their services can generally be accessed without an appointment.

In Chapter Four of this report, the Committee has suggested areas where it believes the roles of community pharmacy can be further explored or enhanced. A key recommendation is that a trial of pharmacist-administered influenza vaccinations for adults be undertaken, ideally before the next influenza season. This has the potential to reduce pressure on other parts of the health system and has been shown to work well elsewhere.

In considering the opportunities for an extended role for pharmacies in primary and preventative care the Committee has been guided by a number of principles.

Firstly, patient safety must remain a paramount consideration. The Committee does not consider that all or even most pharmacies are ready to immediately begin providing expanded primary health services such as immunisation programs to patients. The necessary training, protocols and physical infrastructure needs to be put in place to ensure that safety and quality are maintained. More evidence developed through limited trials will be required to assess the effectiveness of additional roles that have been proposed for pharmacists.

Secondly, there is the potential for further fragmentation of the health system and a reduction in the quality of patient care unless measures are also put in place for pharmacists to support and collaborate with GPs, who should remain central to primary care.

Finally, the major part of the regulation and remuneration of pharmacists and community pharmacy falls within the responsibility of the Commonwealth Government. The Committee has recommended that the Victorian and Commonwealth Governments work together to further explore options, particularly on funding models.

1.1 The Legal and Social Issues Legislation Committee

This is the third report of the Legal and Social Issues Legislation Committee for the 57th Parliament.

The Committee's function, as described in Legislative Council Standing Orders, is to inquire into and report on any proposal, matter or thing concerned with community

services, education, gaming, health, and law and justice.³

The Committee has the power to investigate any annual report, estimates of expenditure or other document laid before the Legislative Council in accordance with an Act, provided these are relevant to its functions.

1.2 Terms of Reference

On 27 May 2014, the Legislative Council agreed to the following motion:

That, noting the Australian Health Practitioner Regulation Agency 2012–13 annual report, particularly as it relates to the registration of pharmacists in Victoria, this House requires the Legal and Social Issues Legislation Committee to inquire into and report by 14 October 2014 on the role and opportunities for community pharmacy in primary and preventative care in Victoria.⁴

The terms of reference for this Inquiry cite the 2012-13 Annual Report of the Australian Health Practitioner Regulation Agency (AHPRA). AHPRA is a national agency established by all states and territories under a July 2006 Council of Australian Governments (COAG) intergovernmental agreement and by state and territory legislation. The Committee has previously tabled a report inquiring into the performance of AHPRA.⁵

1.3 Conduct of the Inquiry

On 5 June 2014 the Committee called for written submissions in *The Age* newspaper, on the Parliament website and through the Parliamentary Committees Twitter account. The Committee also wrote to numerous organisations and individuals seeking input. The deadline for written submissions was 30 June 2014. The Committee was pleased to receive a total of 29 written public submissions to the Inquiry (see Appendix A). All submissions can be accessed on the Committee's website.

The Committee also held public hearings over three days in June and July with organisations and individuals (see Appendix B).

³ Legislative Council, *Standing Orders 2010*, 23.02, p. 70.

⁴ Legislative Council, *Parliamentary Debates*, 27 May 2014, pp. 1580-84.

⁵ Legal and Social Issues Legislation Committee, *Inquiry into the Performance of the Australian Health Practitioner Regulation Agency*, Final Report, March 2014.

The Committee gratefully acknowledges the valuable contributions made by all submitters and public hearing witnesses.

1.4 Report structure

This Report is divided into the following chapters:

- Chapter Two provides background information on community pharmacies and the pharmacist workforce. It then describes the main elements of the regulatory framework and outlines the various sources of remuneration for community pharmacies.
- Chapter Three discusses the range of primary and preventative health services and initiatives which community pharmacies already undertake in Victoria.
- Chapter Four examines the evidence received by the Committee on the opportunities for an extended role for pharmacies in primary and preventative health care.

CHAPTER TWO: AN OVERVIEW OF COMMUNITY PHARMACY IN VICTORIA

Community pharmacies are one of the most accessible and visited health care service providers, dispensing medicines and related products and providing general health care advice to the public from premises in main streets and shopping centres around Victoria.⁶ On average each Australian visits a community pharmacy 14 times a year, equivalent to around 300 million pharmacy visits per annum.⁷ Approximately 270 million prescriptions are dispensed annually.⁸

This chapter sets out some background information on community pharmacies and pharmacists. It also briefly describes the regulatory landscape and provides an overview of different sources of remuneration for pharmacies.

2.1 How many community pharmacies are there in Victoria?

There are around 1,400 registered pharmacy premises in Victoria.⁹ Approximately 100 of these are located in Victorian public hospitals and dispense medicines to admitted patients only. The remaining 1,300 are community pharmacies.

According to the Victorian Pharmacy Authority (VPA), 63 percent (or 824) of community pharmacies are located in the metropolitan area with the balance in rural and regional areas.

2.2 How many community pharmacists are there?

Pharmacists use their expertise in medicines to optimise health outcomes and minimise medication misadventure.¹⁰ Pharmacy Board of Australia (PBA) figures show that there are some 28,282 pharmacists nationally, with 6,985 registered in Victoria.¹¹ Some work in the hospital sector and others (281) are currently 'non-

⁶ The Pharmacy Guild of Australia, *Submission No. 13*, p. 7.

⁷ *Ibid.*, p. 1.

⁸ Department of Health, 'Australian Statistics on Medicines 2011', http://www.pbs.gov.au/info/statistics/asm/asm-2011#table_c, accessed on 16 July 2014. See tables B(ii) and B(iii).

⁹ Department of Health, *Transcript of Evidence*, 11 June 2014, p. 2.

¹⁰ Pharmaceutical Society of Australia, *National Competency Standards Framework for Pharmacists in Australia*, 2010, p. 3.

¹¹ Pharmacy Board of Australia, 'Statistics', <http://www.pharmacyboard.gov.au/About/Statistics.aspx>, accessed 16 July 2014.

practising'.¹² The Victorian Department of Health estimates that 62 percent of registered Victorian pharmacists are engaged in the community pharmacy sector,¹³ although the actual figure may be higher as many pharmacists work part-time in community pharmacies in addition to their primary job.¹⁴ As a point of comparison, Medicare figures indicate that there are 7,344 GPs operating in Victoria.

Data on the location of pharmacists shows that, Australia-wide, 76 percent work in the major cities, 15 percent in inner regional locations, seven percent in outer regional areas and one percent in remote or very remote areas.¹⁵

2.3 Training of community pharmacists

Australian-trained pharmacists complete four years of undergraduate study and an additional full-time internship year of 1,824 hours supervised practice before becoming eligible to sit for the Pharmacy Board registration exams.¹⁶ There are currently three universities in Victoria which offer degrees in pharmacy: Latrobe, Monash and RMIT. The annual total graduate output is estimated to be around 360 students.¹⁷

A submission from the Monash University Faculty of Pharmacy stated that the pharmacy curriculum educates students in the disciplines of enabling sciences, drug delivery, integrated therapeutics and pharmacy practice.¹⁸ Pharmacists may go on to post-graduate qualifications and/or acquire further training in specific areas, such as opioid replacement therapy, wound management, compounding, and diabetes

¹² 'Non-practising' refers to a type of registration that is open to pharmacists who have previously held a 'general registration' but have ceased to practice.

¹³ Department of Health, *Transcript of Evidence*, 11 June 2014, p. 2.

¹⁴ Pharmaceutical Society of Australia, *Submission No. 12*, p. 6.

¹⁵ HealthWorkforce Australia, *Australia's Health Workforce Series: Pharmacists in focus*, March 2014, p. 44.

¹⁶ The PBA is a national body that operates under complementary legislation enacted in all jurisdictions. Its functions are supported by the Australian Health Practitioner Regulation Agency (AHPRA).

¹⁷ Pharmaceutical Society of Australia, *Submission No. 12*, p. 5.

¹⁸ Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission No. 7*, p. 5.

management.¹⁹ There is a mandatory registration requirement for pharmacists to undertake continuing professional development.²⁰

Overseas-trained pharmacists have their knowledge and skills assessed by the Australian Pharmacy Council (APC) and if successful they also must be registered with the PBA before practicing. In 2012 around 14 percent of the pharmacy workforce earned their first pharmacy qualification outside Australia.²¹

The peak body representing pharmacists is the Pharmaceutical Society of Australia (PSA). PSA oversees professional development activities and issues professional competency standards and guidelines relating to clinical interventions. Among the competency standards is the expectation that pharmacists can assess primary health care needs, deliver primary health care and contribute to public and preventative health care.²²

2.4. Profile of community pharmacists

Australia-wide data indicates that in 2010 pharmacists had one of the youngest age profiles of all the health professions, with around 48 percent of pharmacists under the age of 35 years old and around 29 percent aged in their 20s. Almost 60 percent of the Victorian pharmacist workforce is female.²³

2.5 How are community pharmacies regulated?

Different aspects of community pharmacy are governed by Commonwealth and state legislation and overseen by a variety of agencies.

The physical location of pharmacies is subject to 'location rules' set by the Commonwealth Government and overseen by the Australian Community Pharmacy

¹⁹ During 2013, 558 pharmacists successfully completed the Victorian Pharmacy Pharmacotherapy Training Program in Harm Minimisation, 431 pharmacists attended Diabetes Management training or workshops, and 451 pharmacists attended Wound Care and Dermatology training or workshops: Pharmaceutical Society of Australia, Correspondence to the Committee, 15 August 2014.

²⁰ Pharmaceutical Society of Australia, *Submission No. 12*, p. 6; Cf. Pharmacy Board of Australia, 'Continuing professional development registration standard', p. 1.

²¹ HealthWorkforce Australia, *Australia's Health Workforce Series: Pharmacists in focus*, March 2014, p. 15.

²² Pharmaceutical Society of Australia, *National Competency Standards Framework for Pharmacists in Australia*, 2010, p. 12.

²³ Pharmaceutical Society of Australia, *Submission No. 12*; Cf. HealthWorkforce Australia, *Australia's Health Workforce Series: Pharmacists in focus*, March 2014, p. 10.

Authority (ACPA). The ACPA is established under the *National Health Act 1953* (Cth) and all applications to either open a new pharmacy or relocate an existing pharmacy are automatically referred to the ACPA. The Secretary of the Department of Health may also refer applications to expand or contract the size of an existing pharmacy to the ACPA. When considering an application the ACPA applies the *National Health (Australian Community Pharmacy Authority Rules) Determination 2011* (Cth). These rules set out location-based criteria which must be met in order to receive approval. Essentially they require new pharmacies in built up areas to be at least 1.5 km away from another community pharmacy, and at least 10 km in isolated areas.

The registration of pharmacists, matters concerning professional practice, complaint handling, discipline, competency, and approval of training of ancillary staff, are the responsibility of the Pharmacy Board of Australia.

In addition to registering premises as suitable for the provision of pharmacy services and issuing standards for the operation of pharmacies, the VPA also licenses the owner of the business. Essentially the *Pharmacy Regulation Act 2010* (Vic.) requires that a pharmacy business may only be owned by a registered pharmacist or a company whose directors are registered pharmacists.²⁴ Licences and registrations must be renewed annually, and require the payment of the appropriate fee. Permission must also be obtained from the VPA before the layout of a community pharmacy can be altered.²⁵

The 2014 VPA Guidelines cover a range of issues, such as staffing, access and security arrangements. These guidelines require the dispensary be no less than ten percent of the total trading area, with a minimum area of 20 m² and a maximum of 30 m².²⁶ They also require pharmacies to have a distinct area (such as a room or office) that permits the pharmacist to discuss any matter with a member of the public on a private and confidential basis and provide 'extended services such as disease screening, prolonged consultations or structured patient programs that, to be effective, require privacy and freedom from interruptions'.²⁷

²⁴ *Pharmacy Regulation Act 2010* (Vic.), s.5.

²⁵ *Ibid.*, s.43; Victorian Pharmacy Authority, *Guidelines 2013*, pp. 10-11.

²⁶ Victorian Pharmacy Authority, *Guidelines 2013*, p. 15.

²⁷ *Ibid.*, p. 13.

Table 1 below summarises the regulatory landscape for community pharmacies.

Government/agency	Summary of regulatory role
Commonwealth Government	<ul style="list-style-type: none"> • Negotiation of Community Pharmacy Agreement • Pharmacy locations
Therapeutic Goods Administration	Regulating therapeutic goods (including medications)
Pharmacy Board of Australia (supported by AHPRA)	<ul style="list-style-type: none"> • Practitioner registration and complaints handling • Standards and guidelines around pharmacy practice
Australian Pharmacy Council	<ul style="list-style-type: none"> • Independent accreditation of pharmacy under the National Registration and Accreditation Scheme • Accredits pharmacy schools and programs; intern training programs
State Government	Administer drugs and poisons legislation and Victorian therapeutic goods legislation
Victorian Pharmacy Authority	Premises licensing, ownership and operation

2.6 How are community pharmacies remunerated?

Community pharmacies derive most of their income from dispensing Pharmaceutical Benefits Scheme (PBS) medications.²⁸ The PBS is a Commonwealth Government program which provides subsidised medicines to Australian residents. It is managed

²⁸ The Pharmacy Guild of Australia estimates that approximately 70 percent of pharmacies' revenue is attributable to the dispensing of PBS medicines. See the Pharmacy Guild of Australia, *Submission in Response to Competition Policy Review Issues Paper*, June 2014, p. 30.

by the Commonwealth Department of Health and administered by the Commonwealth Department of Human Services.

Pharmacies also receive remuneration through delivery of programs on behalf of government or non-government organisations, from consumers via a co-payment for PBS-listed medications or the purchase of non-PBS medications and other products, and from the provision of services.

Since 1990, the remuneration that pharmacists receive for dispensing PBS medications has been governed by a series of agreements between the Australian Government and the Pharmacy Guild of Australia (the Guild). The Fifth Community Pharmacy Agreement (CPA) between the Government and the Guild started on 1 July 2010 and is in place for five years. The Agreement provides \$15.4 billion to around 5,000 community pharmacies for dispensing medicines, providing pharmacy programs and services and for the Community Service Obligation arrangements with pharmaceutical wholesalers. The Sixth CPA, due to commence on 1 July 2015, is currently being negotiated.

The Monash University Faculty of Pharmacy claims that the CPA-funded programs, despite being an effective health system intervention, have yet to have widespread impact, due to the limited overall amount of funding and the limited funding for any particular program. The funding for these programs is capped and, according to the Faculty, is inadequate for the demand.²⁹ Further discussion of services provided by pharmacists and remunerated through the Fifth CPA is in Chapter Three.

Community pharmacies also routinely provide some services to customers, such as advice and triaging, for which they are not remunerated. The Guild argues that the ability of pharmacists to continue to do this in the future and be sustainable is questionable and that improved outcomes could be delivered with a more structured system, rather than with the ad hoc, opportunistic approach currently experienced in pharmacies.³⁰

The Committee heard support for remunerating pharmacists similarly to other health care providers, that is, rewarding health care service provision rather than primarily via the PBS and the selling of products. In evidence to the Committee, the Department of Health noted that new models of care offered by pharmacists might

²⁹ Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission No. 7*, p. 9.
³⁰ The Pharmacy Guild of Australia, *Transcript of Evidence*, 25 June 2014, p. 20.

involve Commonwealth funding, specifically through the Medicare Benefits Schedule (MBS) and the PBS.³¹

The Monash University Faculty of Pharmacy sees ‘a major impediment to pharmacists being able to expand their primary care services’ is their very limited funding from the small amount of non-supply roles and from the PBS. The Faculty points out that Medicare funds at least 18 different kinds of health care providers including dieticians, diabetes educators, audiologists and chiropractors, but it does not fund pharmacists.³²

Similarly, a submission from Dr Sally Wilson argued that pharmacists should have a provider number and an MBS number for the clinical pharmacy (non-dispensing, medication management) services they provide.³³ National Pharmacies sees pharmacists being paid for their service provision as a ‘logical outcome.’³⁴ The PSA advocates that a systemised funding model be investigated which could deliver certain clinical and professional services.³⁵

The Committee received evidence predicting that community pharmacies face future viability challenges which necessitate exploring new funding sources. By one calculation, Commonwealth Government cuts to the amount it pays for generic medicines will cost the average pharmacy \$90,000 per year (see below).³⁶ Further motivators for pharmacists to look for other sources of remuneration have been listed by the Guild as cuts in PBS growth, direct distribution, rescheduling of pharmacist and pharmacy-only medicines, increasing rental prices and workforce shortages in rural and remote locations.³⁷

Price disclosure requirements, instituted in 2007, mean that pharmaceutical suppliers must advise the Commonwealth Government of the price at which PBS medicines are sold to pharmacies. This means that the price the Government and the

³¹ Department of Health, *Transcript of Evidence*, 11 June 2014, p. 4.

³² Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission No. 7*, p. 16.

³³ Dr S. Wilson, *Submission no. 24*, pp. 2-3.

³⁴ National Pharmacies, *Submission No. 4*, p. 4.

³⁵ Pharmaceutical Society of Australia, *Transcript of Evidence*, 25 June 2014, p. 25.

³⁶ The Pharmacy Guild of Australia, ‘Price Disclosure impact confirmed’, <http://www.guild.org.au/news-events/forefront/volume-4-number-23/price-disclosure-impact-confirmed>, accessed 15 July 2014.

³⁷ The Pharmacy Guild of Australia, *Submission no. 13*, p. 9.

consumer pay for PBS drugs is often less than what it would have been prior to price disclosure requirements.³⁸

In 2013 Simplified Price Disclosure was rolled out by the Government, which has shortened the time it takes for the disclosed prices to take effect. The Guild claims that Simplified Price Disclosure has led community pharmacies to shed more than 3,200 jobs nationally in the last 12 months, with 100 pharmacies closing down: more than the preceding several years combined. The Guild warns that a further 9,000 jobs nationally will be lost in the next 12 months.³⁹

The Committee also received evidence suggesting that the Commonwealth Government's proposed \$7.00 co-payment for GP consultations may lead to a greater burden being placed on pharmacies and accident and emergency departments as patients seek low or no-cost health care alternatives.⁴⁰

2.6.1 Private health insurance

Private health insurance represents a possible further source of funding for pharmacies. Approximately 50.6 percent of Victorians have 'general treatment' private health insurance and 48 percent have some form of hospital cover.⁴¹ Currently, insurers can only offer cover for prescription items not covered under the PBS or any other government funding scheme, and only if their usage is approved by the Therapeutic Goods Administration. The total amount that patients can claim from their insurer is generally limited.⁴²

In evidence to the Committee, the PSA stated that private health insurers could be a potential source of funding for expanded or new pharmacy primary health and prevention programs and that it is 'having discussions' with health insurers in relation to fees for services, particularly in relation to prevention.⁴³ The Monash

³⁸ Australian Department of Health, *Pharmaceutical Benefits Scheme Price Disclosure Arrangements: Procedural and Operational Guidelines*, July 2014, p. 8.

³⁹ The Pharmacy Guild of Australia, 'Media release: Job losses predicted in community pharmacy', 2 April 2014; *The Australian*, 'Pharmacies call for the doctor', 8 May 2014.

⁴⁰ The Pharmacy Guild of Australia, *Submission no. 13*, p. 9; Department of Health, *Transcript of Evidence*, 11 June 2014, p. 7.

⁴¹ Private Health Insurance Administration Council, *Membership and Coverage*, March 2014. 'General treatment' refers to cover for ancillary services, such as dental and optical. 'Hospital treatment' refers to cover for treatment to manage a disease, injury or condition provided to a person at a hospital or arranged with the direct involvement of a hospital.

⁴² Private Health Insurance Ombudsman, 'What is covered?', www.privatehealth.gov.au/healthinsurance/whatiscovered/, accessed 16 July 2014.

⁴³ Pharmaceutical Society of Australia, *Transcript of Evidence*, 25 June 2014, p. 25.

University Faculty of Pharmacy pointed out that private health insurers cover the costs of consultations with a wide range of primary health care providers including remedial massage, naturopathy and acupuncture, but not pharmacists.⁴⁴

FINDINGS

- 1** *Pharmacists receive funding from a variety of sources, however, unlike many other health care providers, pharmacists do not charge for advice, do not have Medicare provider numbers and patients cannot seek reimbursement for the cost of pharmacist services through private health insurance.*

- 2** *The negotiation of the Sixth Community Pharmacy Agreement provides an opportunity for the Commonwealth Government to expand the scope of the primary health services provided by pharmacists.*

⁴⁴ Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission No. 7*, p. 17.

CHAPTER THREE: CURRENT ROLES OF COMMUNITY PHARMACY

Community pharmacies operate at the front line of primary health care, with a pharmacy often being the first provider that a patient visits regarding a particular health issue. Pharmacists 'have served by default and without widespread recognition as an alternative to GPs as an entry point into the health care system.'⁴⁵

This chapter provides a snapshot of the roles, programs and initiatives undertaken by community pharmacists. In particular, the chapter focusses on: dispensing of PBS and non-PBS medicines and other products; the provision of lifestyle management programs; chronic disease monitoring and health checks; the provision of services encouraged through Pharmacy Practice Incentives; Medication Management Initiatives; sickness certificates; the provision of certain repeat prescription-only medications without a prescription (Continued Dispensing initiative); and harm reduction initiatives including pharmacotherapy.

Individual pharmacies decide which of these services they offer. Some services attract a form of remuneration from government while others are in-house initiatives either paid for by the consumer or by the pharmacy itself.

3.1 Dispensing of PBS medications

The PBS allows more than 700 medicines to be available to the Australian community at a subsidised cost to the consumer. Consumers pay a contribution, or co-payment, for a PBS-listed medicine and the Australian Government pays the remaining amount. As at July 2014 the co-payment was \$36.90, or \$6.00 for those with a concession card.⁴⁶

Pharmacists are paid by the Australian Government for dispensing PBS items. To claim their subsidy, pharmacists lodge claims with the Department of Human Services detailing PBS prescriptions dispensed.⁴⁷ Australian Bureau of Statistics data shows that over the last 20 years, PBS medicine prices have grown by 57 percent

⁴⁵ Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission No. 7*, p. 8.

⁴⁶ Department of Health, 'About the PBS', <http://www.pbs.gov.au/info/about-the-pbs>, accessed 16 July 2014; The Pharmacy Guild of Australia, 'Community Pharmacy and the Pharmaceutical Benefits Scheme', p. 1.

⁴⁷ Australian Department of Health, 'PBS frequently asked questions', <http://www.pbs.gov.au/info/general/faq#HowarepharmacistssubsidisedbythePBS>, accessed 16 July 2014.

compared to 70 percent for overall prices in the economy and 191 percent for medical and hospital services over the same period.⁴⁸

FINDING

3 *The prices consumers pay for Pharmaceutical Benefits Scheme medicines in recent years have not increased as much as other commodities and the Pharmaceutical Benefits Scheme represents value for money, especially in relation to other hospital and medical services.*

3.1.1 Continued dispensing

Continued dispensing of PBS medicines in certain circumstances was initiated under the Fifth CPA. It involves the supply of an eligible medicine to a patient where there is an immediate need for a previously prescribed medicine to continue, but it is not practicable for the patient to obtain a prescription from a medical practitioner. Other requirements for continued dispensing by the pharmacist are that the therapy is stable, there has been prior clinical review by the prescriber that supports continuation of the medicine, and that the medicine is safe and appropriate for the patient. Currently only oral contraceptives and cholesterol-lowering medications are included in the continued dispensing scheme.⁴⁹ The quantity supplied is generally limited to no more than that required for three days' treatment or the smallest standard pack available.⁵⁰ See Chapter Four for a discussion of evidence received concerning the continued dispensing initiative.

3.2 Provision of non-PBS medications and other products

The model of community pharmacy in Australia consists of privately-owned businesses, in which non-PBS prescription medications, pharmacist-only and pharmacy-only medications and other products are on offer to the public. The provision of non-prescription medications is an important public service: a 2011

⁴⁸ The Pharmacy Guild of Australia, 'The Pharmaceutical Benefits Scheme – value for consumers and taxpayers: Fact sheet'.

⁴⁹ Australian Department of Human Services, 'Continued Dispensing of PBS Medicines in Defined Circumstances (Continued Dispensing) initiative', <http://www.medicareaustralia.gov.au/provider/pbs/fifth-agreement/medication-continuance.jsp>, accessed 16 July 2014; Pharmaceutical Society of Australia, *Submission no. 12*, pp. 13-14.

⁵⁰ Pharmaceutical Society of Australia, *Guidelines for the Continued Dispensing of eligible prescribed medicines by pharmacists*, January 2010, p. 4.

report estimated that Australian pharmacies perform around half a million interventions each year when providing non-prescription medications, with approximately 20 percent of these interventions averting emergency medical attention or serious harm, and are potentially life-saving.⁵¹

The Committee notes that due to the excessive costs sometimes involved, some patients choose to acquire their non-PBS listed medications from a hospital dispensing pharmacy rather than from a community pharmacy.

The retail model within which community pharmacists work is uncommon in the health care sector in Australia, with professional and retail services being provided in the same premises. Rather than charge for the advice they routinely provide, pharmacists derive a portion of their income from the products sold in their pharmacy.

During the Inquiry the Committee became aware of the diversity of business approaches in the pharmacy industry, with some pharmacies (chains) concentrating on 'big box' discounting and others focusing on a more traditional, 'high service' approach to dispensing and advice.⁵² Online pharmacies are also rapidly growing.⁵³ The Committee heard that there is some criticism of the 'discounting' approach, although others acknowledge that pharmacy is increasingly competitive and pharmacists rely on the revenue of over-the-counter products, 'many of which have no place in community pharmacy'.⁵⁴

FINDING

4 Community pharmacists play an essential role in primary health care through their provision of non-prescription medicines.

⁵¹ K.A. Williams, L.M. Emmerton, R. Taylor, J. Werner and S.I. Benrimoj, 'Non-prescription medicines and Australian community pharmacy interventions: rates and clinical significance', *International Journal of Pharmacy Practice* (2011), vol. 19(3), pp. 156-165, cited in the Pharmacy Guild of Australia, *Submission in Response to the Competition Policy Review Issues Paper*, June 2014, p. 27.

⁵² *The Age*, 'Killing off the Chemist', 19 March 2014, <http://www.theage.com.au/small-business/franchising/killing-off-the-chemist-20140317-34wto.html>, accessed 16 July 2014.

⁵³ Chemist Warehouse, *Submission to the Competition Policy Review*, May 2014, p. 3, accessed at http://competitionpolicyreview.gov.au/files/2014/07/Chemist_Warehouse.pdf, on 17 July 2014.

⁵⁴ Dr C. Hirst, *Submission no. 2*, p. 2; Cf. Professionals Australia, *Submission no. 27*, p. 3.

3.3 Lifestyle management programs, health checks and screening and monitoring of chronic disease

3.3.1 Lifestyle management programs

Pharmacies commonly offer lifestyle management programs and services. Examples include weight loss or smoking cessation programs. In some cases these programs are developed by the pharmacies themselves, while in other cases pharmacies will align themselves with a specific organisation (i.e. Quit Victoria). Such programs are offered either free to the customer or on a fee-for-service model.

3.3.2 Chronic disease screening and monitoring

Many pharmacies currently offer health checks and screening, risk assessment and monitoring for conditions such as cardiovascular disease, diabetes, bowel cancer and respiratory diseases as well as lifestyle management programs and services (see Box 1 below). Under the terms of the Fifth CPA, pharmacies receive an incentive payment of \$850 per year if they offer three or more screening/risk assessment and disease state management programs for diabetes, respiratory problems, cardiovascular disease and mental health conditions.⁵⁵

⁵⁵ 5th Community Pharmacy Agreement, 'Primary Health Care', <http://5cpa.com.au/programs/pharmacy-practice-incentives/primary-health-care/>, accessed 30 July 2014; The Pharmacy Guild of Australia, Correspondence to the Committee, 19 August 2014.

Box 1: What services do pharmacies offer?

Community pharmacies already provide a range of health care services, in addition to their main role of dispensing medicines. The following is an indicative list of non-government-funded services derived from submissions and pharmacy websites:

- Kidney Health Program – Amcal & Guardian Pharmacies (with Kidney Health Australia)
- Blood pressure checks – Slade Pharmacy, Chemmart, Soul Pattison
- Bowel cancer screening – UFS Dispensaries, Slade Pharmacy (with BowelScreen Australia)
- Bone density testing – Quality Pharmacy, Chemmart
- Sleep apnoea – Terry White Chemist, Pharmacy777
- Naturopathy – Amcal, Community Pharmacies
- Type 2 diabetes check – Soul Pattison
- Cardiovascular disease screening – Soul Pattison
- Hearing checks – Amcal, Community Pharmacies
- Pain management plans – Slade Pharmacy
- Weight loss programs – various
- Smoking cessation – various (with the Quit Campaign)
- Atrial fibrillation screening – UFS Dispensaries

To illustrate the value of pharmacy-based health checks, a submission to the Inquiry from Slade Pharmacy advised that in the two weeks prior to the writing of their submission they had three customers accessing health checks, two of whom were referred on to GPs due to high blood glucose and blood pressure.⁵⁶ Another pharmacy chain, Priceline Pharmacy, conducted over 2,500 free health screening checks across Australia in 2013: all 240 Priceline pharmacies participated, regional locations were the first to book out and 25 percent of all customers were referred to their GP for further investigations.⁵⁷

Health checks are often offered through community pharmacies as part of an externally developed model by peak organisations such as beyondblue, the Heart Foundation and the National Stroke Foundation. The Stroke Foundation's Know Your Numbers (KYN) program screens for heart disease, stroke and diabetes mainly through community pharmacies. Data collected from the program shows that for

⁵⁶ Slade Pharmacy, *Submission no. 3*, p. 2.

⁵⁷ API, *Submission no. 15*, p. 5.

every 100,000 people checked at a blood pressure station, between 57 and 191 strokes can be averted.⁵⁸ An independent evaluation of the program found that knowledge about risk factors and health conditions associated with hypertension improved after participation, all those taking part in the study reported at least one health promotion activity and among those advised to visit their doctor, 81 percent did so within three months of participation in the KYN program.⁵⁹ At present the KYN program is not operating in Victoria, but is still operating in NSW and Queensland. In NSW the scheme costs almost \$2.8m for four years and over 75,000 health checks have been undertaken by the 500 participating pharmacies since the program was implemented.⁶⁰ Where currently being offered, the Know Your Numbers program is financed by state governments. However, the Stroke Foundation has previously proposed that the Commonwealth Government fund a national version of the program which consolidates disparate health checks that community pharmacies offer into one integrated service funded through the MBS.⁶¹

3.4 Pharmacy Practice Incentives

Under the Fifth CPA, \$344m is provided for the Pharmacy Practice Incentives (PPI) program. The PPI program recognises, through Commonwealth Government funding, the beneficial health outcomes that can be achieved by community pharmacies. The PPI program includes the following components: Dose Administration Aids (DAAs), Clinical Interventions, Staged Supply, Primary Health Care, Community Services Support and Working with Others. These are briefly outlined below.

3.4.1 Dose Administration Aids

The Dose Administration Aids program is aimed at reducing hospitalisation and adverse outcomes from medication problems through improving medication compliance.⁶² The use of multiple medications is becoming more common in Australia, particularly with the growing numbers of ageing Australians. People aged 65 years and older make up more than 13 percent of the population and 25 percent

⁵⁸ Stroke Foundation, *Submission no. 20*, p. 2.

⁵⁹ D.A. Cadilhac, M.F. Kilkenny, R. Johnson, B. Wilkinson, B. Amatya, and E. Lalor, 'The Know Your Numbers (KYN) program 2008 to 2010: impact on knowledge and health promotion behaviour among participants', *International Journal of Stroke*, vol. 8, 2013, p. 1.

⁶⁰ The Pharmacy Guild of Australia, *Submission no. 13*, p. 12.

⁶¹ See Stroke Foundation, *National Action Plan for Stroke*, December 2012.

⁶² 5th Community Pharmacy Agreement, 'Dose Administration Aids', <http://5cpa.com.au/programs/pharmacy-practice-incentives/dose-administration-aids/>, accessed 29 July 2014.

of this cohort take an average of 4.5 medications concurrently.⁶³ The DAA program is specifically aimed at those taking multiple medications or who are confused about their medications and are living in the community (it excludes those in government-funded Residential Aged Care Facilities).⁶⁴

The PSA describes DAA as a holistic service that entails the packing of dose administration aids and the professional support services provided to ensure optimal use of these aids.⁶⁵ Participating pharmacies are paid a periodic incentive payment by Medicare Australia when providing the DAA service.⁶⁶ An average pharmacy with an average prescription volume and an average number of DAA services claimed may receive approximately \$5,000 per year.⁶⁷ In 2004 the cost to a pharmacy of providing a DAA service was estimated at \$17.62 per week per patient.⁶⁸ See Chapter Four for further discussion of the DAA program.

3.4.2 Clinical Interventions

The Clinical Interventions program supports pharmacists to provide appropriate clinical interventions, and to document those interventions in a consistent manner. Such interventions involve making a recommendation in an attempt to prevent or resolve a medication-related problem. This may involve a change in the patient's medication therapy, means of administration or medication-taking behaviour.⁶⁹ It is intended that this program integrate with other services such as Dose Administration Aids, Medicines Use Reviews and MedsChecks.⁷⁰

⁶³ J.R. Mullan and J.C. Mullan, 'Blister-packed medications: improving compliance and reducing adverse events', *Australian Journal of Pharmacy*, 91, June 2010, p. 72.

⁶⁴ 5th Community Pharmacy Agreement, 'Dose Administration Aids', <http://5cpa.com.au/programs/pharmacy-practice-incentives/dose-administration-aids/>, accessed 25 June 2014.

⁶⁵ Pharmaceutical Society of Australia, 'Dose Administration Aids Service', <http://www.psa.org.au/supporting-practice/professional-practice-standards/dose-administration-aids-service>, accessed 25 June 2014.

⁶⁶ 5th Community Pharmacy Agreement, 'Dose Administration Aids', <http://5cpa.com.au/programs/pharmacy-practice-incentives/dose-administration-aids/>, accessed 25 June 2014; The Commonwealth of Australia and the Pharmacy Guild of Australia, *Fifth Community Pharmacy Agreement*, 2010, p. 32.

⁶⁷ The Pharmacy Guild of Australia, Correspondence to the Committee, 18 August 2014.

⁶⁸ Australian Government Department of Health and Ageing, *Effectiveness and Cost Effectiveness of Dose Administration Aids (DAAs): Phase 3, Final Report*, May 2006, p. 209.

⁶⁹ Pharmaceutical Society of Australia, 'Clinical Interventions', <http://www.psa.org.au/supporting-practice/5cpa/clinical-interventions-faq>, accessed 25 June 2014.

⁷⁰ The Commonwealth of Australia and the Pharmacy Guild of Australia, *Fifth Community Pharmacy Agreement*, 2010, p. 32.

Payments are made to participating pharmacists on a quarterly basis by Medicare Australia based on the number of clinical interventions performed and prescriptions dispensed.⁷¹ A pharmacy undertaking an average number of Clinical interventions may receive approximately \$3,000 per year.⁷² An independent study in 2009 funded by the Australian Government Department of Health and Ageing found that due to the extremely variable nature of Clinical Interventions the cost to a pharmacy was between \$44 and \$67 per service.⁷³

3.4.3 Staged Supply

The Staged Supply program supports pharmacies to provide dispensed PBS medications in instalments of less than the originally prescribed quantity, at agreed intervals. These intervals may be daily, weekly or as directed by the prescriber. Staged Supply can be initiated by the prescriber, other health care professionals, the pharmacist, the patient or their agent. The program is aimed at patients with a mental illness, drug dependency or those who otherwise are unable to manage their medication safely.⁷⁴

A flat rate payment of \$1,000 is made to pharmacies offering the Staged Supply service annually by Medicare Australia.⁷⁵

3.4.4 Primary Health Care

The Primary Health Care program encourages pharmacists via an annual incentive payment of \$850 to provide at least three of the following services in accordance with program guidelines:

⁷¹ Pharmaceutical Society of Australia, 'Clinical Interventions', <http://www.psa.org.au/supporting-practice/5cpa/clinical-interventions-faq>, accessed 25 June 2014.

⁷² The Pharmacy Guild of Australia, Correspondence to the Committee, 18 August 2014.

⁷³ Prof. G. Peterson et al., *Documenting Clinical Interventions in Community Pharmacy: PROMISE III*, 2010, p. 21.

⁷⁴ Pharmaceutical Society of Australia, 'Staged Supply', <http://www.psa.org.au/supporting-practice/5cpa/ppi-staged-supply>, accessed 25 June 2014; Pharmaceutical Society of Australia, 'Staged supply services', <http://www.psa.org.au/practice-standards/pharmacists-providing-staged-supply-services>, accessed 25 June 2014; Pharmaceutical Society of Australia, 'Staged supply service information sheet' at <http://www.psa.org.au/download/practice-guidelines/staged-supply-information.pdf>, accessed 25 June 2014; 5th Community Pharmacy Agreement, 'Staged Supply', <http://5cpa.com.au/programs/pharmacy-practice-incentives/staged-supply/>, accessed 25 June 2014; The Commonwealth of Australia and the Pharmacy Guild of Australia, *Fifth Community Pharmacy Agreement*, 2010, p. 32.

⁷⁵ Pharmaceutical Society of Australia, 'Staged supply', <http://www.psa.org.au/supporting-practice/5cpa/ppi-staged-supply>, accessed 26 June 2014; The Pharmacy Guild of Australia, Correspondence to the Committee, 19 August 2014.

- health promotion
- screening /risk assessment and disease management in regards to:
- diabetes
- respiratory problems
- cardiovascular disease
- mental health conditions.⁷⁶

3.4.5 Community Services Support

Pharmacies are paid an annual incentive payment of \$850 for providing at least three of the following elements:

- Needle and Syringe Programs
- Opioid Substitution Programs
- National Diabetes Services Scheme (NDSS) Access Point
- Pharmacy Delivery Service
- Mental Health First Aid Training (for pharmacists and staff)
- Return of Unwanted Medicines (RUM)
- Staff Training (including Certificate III or IV training in Community Pharmacy)
- eHealth.⁷⁷

3.4.6 Working with Others

An annual flat rate incentive payment of \$850 is made to pharmacists who document collaborations with other non-pharmacy health professionals from at least three different health professional groups in accordance with guidelines.⁷⁸

⁷⁶ 5th Community Pharmacy Agreement, 'Primary Health Care', <http://5cpa.com.au/programs/pharmacy-practice-incentives/primary-health-care/>, accessed 29 July 2014; The Pharmacy Guild of Australia, Correspondence to the Committee, 19 August 2014.

⁷⁷ 5th Community Pharmacy Agreement, 'Community Services Support', <http://5cpa.com.au/programs/pharmacy-practice-incentives/community-services-support/>, accessed 29 July 2014; The Pharmacy Guild of Australia, Correspondence to the Committee, 19 August 2014.

3.5 Medication Management Initiatives

A number of medication management initiatives are currently being funded by the Commonwealth Government. These are aimed at reducing the incidence of what is termed 'medication misadventure'. Medication-related hospital admissions are estimated to comprise two to three percent of all Australian hospital admissions, with rising estimates of prevalence when certain sub-populations are studied. For example, 12 percent of all medical admissions and 20-30 percent of all admissions of those aged 65 years and over are estimated to be medication-related.⁷⁹ It is further estimated that medication-related hospital admissions cost Victoria \$320m per year.⁸⁰

Two completed studies in veterans provide evidence for the effectiveness of collaborative medication management programs (specifically the Home Medicines Review) in the community setting in Australia. The studies suggest that Home Medicine Reviews can reduce hospitalisation rates for older people living in the community at high risk of medication-related hospital admissions: those with heart failure taking heart failure medicines and those taking warfarin.⁸¹

A submission from Eastern Melbourne Medicare Local (EMML) stated that GPs have a positive attitude towards medication reviews, believing that pharmacists' greater knowledge of pharmacology, dosage forms, adverse drug effects and drug interactions are an asset in helping to improve patient safety.⁸² EMML considers that a referral to a pharmacist as the complexity of a patient's medicines regimen increases should be seen as analogous to a GP referring to other specialists when required.⁸³

The medication management initiatives currently being offered in community pharmacies across Australia are discussed below. It is worth noting that the funding for these programs is only ensured until the end date of the Fifth CPA, 30 June 2015.

⁷⁸ 5th Community Pharmacy Agreement, 'Working with Others', <http://5cpa.com.au/programs/pharmacy-practice-incentives/working-with-others/>, accessed 29 July 2014; Pharmacy Guild of Australia, Correspondence to the Committee, 19 August 2014.

⁷⁹ Australian Commission on Safety and Quality in Health Care, *Literature Review: Medication Safety in Australia*, 2013, p. 22.

⁸⁰ Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission No. 7*, p. 7.

⁸¹ Australian Commission on Safety and Quality in Health Care, *Literature Review: Medication Safety in Australia*, 2013, p. 20.

⁸² Eastern Melbourne Medicare Local, *Submission no. 20*, p. 2. Cf. Hatah et al., 'General practitioners' views of pharmacists' current and potential contributions to medication review and prescribing in New Zealand', *Journal of Primary Health Care*, vol. 5 (3), pp. 223-33.

⁸³ Eastern Melbourne Medicare Local, *Submission no. 20*, p. 2.

See Chapter Four for a discussion of an expansion of medicine management initiatives.

FINDING

5 Medication-related hospital admissions in Victoria are common and comprise a huge cost burden to the State.

3.5.1 Home Medicines Reviews

The Home Medicines Review (HMR) program aims to enhance the quality use of medicines and to reduce the number of adverse medicine events. The program involves a comprehensive medication review conducted by an accredited pharmacist in the patient's home. HMR is only available following a referral from the patient's GP.⁸⁴

Pharmacists who provide this service must first obtain formal approval from the Guild. In order for a patient to be eligible, they must live at home and be considered at risk of experiencing 'medication misadventure'. The patient's GP must also confirm that there is an identifiable clinical need and that the patient will benefit from HMR.⁸⁵ Only one HMR may be conducted per patient per year unless the patient's GP specifically deems a subsequent review to be clinically necessary, for example where there has been a significant change in the patient's medication.⁸⁶

The payment rate to a pharmacist for an HMR session is currently set at \$204.34, with payments made by Medicare Australia.⁸⁷ Since March 2014 individual pharmacists are only able to undertake a maximum of 20 HMRs per month.⁸⁸

⁸⁴ The Commonwealth of Australia and the Pharmacy Guild of Australia, *Fifth Community Pharmacy Agreement*, 2010, p. 29; 5th Community Pharmacy Agreement, 'Home Medicines Review', <http://5cpa.com.au/programs/medication-management-initiatives/home-medicines-review/>, accessed 25 June 2014.

⁸⁵ Ibid.

⁸⁶ Australian Department of Health, *Programme Specific Guidelines: Home Medicines Review (HMR)*, p. 4.

⁸⁷ The Commonwealth of Australia and the Pharmacy Guild of Australia, *Fifth Community Pharmacy Agreement*, 2010, p. 29; 5th Community Pharmacy Agreement, 'Home medicines Review', <http://5cpa.com.au/programs/medication-management-initiatives/home-medicines-review/>, accessed 25 June 2014.

⁸⁸ Australian Department of Health, 'Changes to the Home Medicines Review (HMR), Residential Medication Management Review (RMMR) and MedsCheck Programmes', <http://www.health.gov.au/internet/main/publishing.nsf/Content/MC14-000966-changes-to-home-medicines-review-programme>, accessed 13 August 2014.

3.5.2 Medicines Use Reviews (MedsChecks)

The Fifth CPA established the new program Medicines Use Review, known by the name MedsCheck. A MedsCheck entails an in-pharmacy review of a patient's medicines, involving the pharmacist and the patient, with a focus on education and self-management, so that the number of adverse medicine events is reduced.⁸⁹

In order to undergo a MedsCheck a patient must not have received a medication review in the previous 12 months, must be living at home and must be taking five or more prescription medicines. Pharmacists are able to target patients whom they believe would benefit from this service and a referral from a GP is not necessary.⁹⁰

A set service fee (currently \$61.02) from the Australian Government is paid to pharmacists for each MedsCheck.⁹¹ Pharmacies may only conduct and claim up to ten MedsCheck (including Diabetes MedsCheck, see below) reviews per month.⁹²

To encourage uptake of this program in rural areas, funding of up to \$125 is available to cover transport costs of a pharmacist in order to conduct an interview at a patient's home.⁹³

3.5.3 Diabetes Medication Management Service (Diabetes MedsChecks)

A Diabetes MedsCheck provides an in-pharmacy review with a focus on the patient's type 2 diabetes medicines management, monitoring devices, education and self-management. The program aims to improve understanding of, and compliance with, diabetes medication therapy.⁹⁴

⁸⁹ 5th Community Pharmacy Agreement, 'MedsCheck & Diabetes MedsCheck', <http://5cpa.com.au/programs/medication-management-initiatives/medscheck-diabetes-medscheck/>, accessed 24 June 2014; The Commonwealth of Australia and the Pharmacy Guild of Australia, *Fifth Community Pharmacy Agreement*, 2010, p. 29.

⁹⁰ 5th Community Pharmacy Agreement, 'MedsCheck & Diabetes MedsCheck', <http://5cpa.com.au/programs/medication-management-initiatives/medscheck-diabetes-medscheck/>, accessed 24 June 2014.

⁹¹ Ibid.

⁹² Australian Department of Health, *Programme Specific Guidelines: MedsCheck and Diabetes MedsCheck*, 1 March 2014, p. 7.

⁹³ 5th Community Pharmacy Agreement, 'MedsCheck & Diabetes MedsCheck', <http://5cpa.com.au/programs/medication-management-initiatives/medscheck-diabetes-medscheck/>, accessed 25 June 2014.

⁹⁴ Ibid.

To be eligible for a Diabetes MedsCheck, patients must not have received a medication review in the previous 12 months, be living at home, have been recently diagnosed with type 2 diabetes or have less than ideally controlled type 2 diabetes and be unable to gain timely access to appropriate services in their community.⁹⁵ Pharmacies may only conduct and claim up to ten MedsCheck (including Diabetes MedsChecks) reviews per month.⁹⁶

Currently, pharmacists are remunerated \$91.53 per Diabetes MedsCheck by the Commonwealth Government.⁹⁷

3.5.4 Residential Medication Management Reviews

A Residential Medication Management Review (RMMR) is a service provided to permanent residents of an Australian Government-funded aged care facility. RMMRs are conducted by pharmacists on the request of the resident's GP. A comprehensive assessment is undertaken in relation to medication-related problems in collaboration with the resident's health care team and is provided to the resident's GP.⁹⁸

Pharmacists may only undertake an RMMR after a referral from a GP and may only conduct one RMMR per patient per year, unless the patient's GP deems otherwise.⁹⁹ The current payment to pharmacists from the Government per RMMR is \$103.33.¹⁰⁰

3.5.5 Hospital-initiated Home Medicines Review

Hospital-Initiated Home Medicines Reviews (HHMRs) were intended for patients who are considered at high risk of medication misadventure in the immediate post-

⁹⁵ Ibid.

⁹⁶ Australian Department of Health, *Programme Specific Guidelines: MedsCheck and Diabetes MedsCheck*, 1 March 2014, p. 7.

⁹⁷ 5th Community Pharmacy Agreement, 'MedsCheck & Diabetes MedsCheck', <http://5cpa.com.au/programs/medication-management-initiatives/medscheck-diabetes-medscheck/>, accessed 25 June 2014; The Commonwealth of Australia and the Pharmacy Guild of Australia, *Fifth Community Pharmacy Agreement*, 2010, p. 29.

⁹⁸ 5th Community Pharmacy Agreement, 'Residential Medication Management Review', <http://5cpa.com.au/programs/medication-management-initiatives/residential-medication-management-review/>, accessed 25 June 2014.

⁹⁹ Australian Department of Health, *Programme Specific Guidelines: Resident Medication Management Review Programme (RMMR) and Quality Use of Medicines Programme (QUM)*, 1 March 2014, p. 7.

¹⁰⁰ 5th Community Pharmacy Agreement, 'Residential Medication Management Review', <http://5cpa.com.au/programs/medication-management-initiatives/residential-medication-management-review/>; The Commonwealth of Australia and the Pharmacy Guild of Australia, *Fifth Community Pharmacy Agreement*, 2010, p. 29.

discharge period, where they do not have timely access to a GP. The HMMR is still pending implementation as part of the Fifth CPA and it appears unlikely to be rolled out before the completion of this Agreement cycle in June 2015.¹⁰¹ See Chapter Four for a discussion of an expanded role for community pharmacists in transition of care into and out of facilities, including in the post-acute care setting, for which the HMMRs were intended.

3.6 Aboriginal and Torres Strait Islander Programs

3.6.1 S100 Pharmacy Support Allowance

As at 24 May 2011 no S100 Pharmacy Support Allowances had been granted in Victoria, as no Remote Area Aboriginal Communities had been identified.¹⁰²

3.6.2 QUMAX – Quality Use of Medicines Maximised for Aboriginal & Torres Strait Islanders

The QUMAX program aims to improve Quality Use of Medicines by Aboriginal and Torres Strait Islander people and is provided by participating Aboriginal Community Controlled Health Services (ACCHSs) and pharmacies across rural and urban Australia. In June 2010 there were 7,312 QUMAX clients across Victoria and Tasmania.¹⁰³ The program incorporates the following seven support categories:

- DAA arrangements
- Quality Use of Medicines pharmacy support
- HMR models of support
- Quality Use of Medicines devices
- Quality Use of Medicines education
- Cultural awareness

¹⁰¹ Pharmaceutical Society of Australia, *Submission no. 12*, p. 16.

¹⁰² Australian Department of Health, 'Aboriginal Health Services - PBS Section 100 - Distribution of Services', <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-indigenous-dist>, accessed 25 June 2015.

¹⁰³ Urbis (prepared for the Department of Health and Ageing), *Evaluation of the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People (QUMAX) Program*, April 2011, p. 54.

- Transport.¹⁰⁴

QUMAX training for pharmacists is organised through the Guild and approved pharmacists then liaise with registered ACCHSs in their area.¹⁰⁵ Pharmacists receive incentive payments for their involvement in the program from the Government.¹⁰⁶

3.7 Sickness certificates

The *Fair Work Act 2009* (Cth), effective from 1 July 2009, leaves it open for pharmacists to issue certificates as evidence of legitimate absence from work due to illness.¹⁰⁷ Pharmacists are entitled to charge a fee for a consultation involved in the provision of a sickness certificate. The Guild recommends that each pharmacy determines its own fees based on the time the process takes.¹⁰⁸ The joint PSA and Guild guidelines on pharmacist-issued sickness certificates state that pharmacists must bear in mind that it is against the law to issue a certificate in relation to an illness or injury that is outside the pharmacist's scope of practice. Therefore, it advises, pharmacists should only issue certificates in relation to:

- the supply, compounding or dispensing of medications
- the provision of professional pharmacy services including advice on minor conditions and safe use of medications.¹⁰⁹

The guidelines further point out that due to the nature of the illness or injury which falls under the scope of pharmacists' practice, certificates ought not be issued for more than two days.¹¹⁰

¹⁰⁴ 5th Community Pharmacy Agreement, 'QUMAX – Quality Use of Medicines Maximised for Aboriginal & Torres Strait Islander People', <http://5cpa.com.au/programs/aboriginal-and-torres-strait-islander-initiatives/qumax-quality-use-of-medicines-maximised-for-aboriginal-torres-strait-islander/>, accessed 25 June 2014.

¹⁰⁵ Ibid.

¹⁰⁶ The Commonwealth of Australia and the Pharmacy Guild of Australia, *Fifth Community Pharmacy Agreement*, 2010, p. 30.

¹⁰⁷ *Fair Work Act 2009* (Cth), s.107.

¹⁰⁸ The Pharmacy Guild of Australia, 'Sick Certificates', <http://www.guild.org.au/issues-resources/pharmacy-issues/sick-certificates>, accessed 30 July 2014. The guidelines state that the consultation and the issuing of the certificate may take approximately 10 minutes: Pharmaceutical Society of Australia and the Pharmacy Guild of Australia, *Guidelines for pharmacists issuing certificates for absence from work*, October 2010, p. 4.

¹⁰⁹ PSA and the Pharmacy Guild of Australia, *Guidelines for pharmacists issuing certificates for absence from work*, October 2010, pp. 3, 5.

¹¹⁰ Ibid., p. 6.

The Committee has found that uptake of pharmacy-issued sickness certificates has not been considerable. Under some workplace agreements, sickness certificates are specifically required to be issued by a medical practitioner and this may have limitations for pharmacists issuing certificates in this context.¹¹¹ In addition, pharmacists are not encouraged to advertise that they issue sickness certificates, with the guidelines stating that '[a]ctive promotion (advertising) of the service is not encouraged.'¹¹²

FINDING

6 *The evidence indicates that it is not commonly known that community pharmacists are able to provide sickness certificates as proof of legitimate absence from work due to illness.*

3.8 Harm reduction initiatives

The Committee received evidence concerning two prominent harm reduction initiatives provided by many community pharmacies in Victoria: opioid dependence treatment (pharmacotherapy) and needle and syringe programs.

In Victoria, methadone and buprenorphine are used as treatments for opioid addiction, otherwise known as pharmacotherapy. This pharmacotherapy is delivered via a 'community-based' model, implemented in the 1990s in order to normalise the treatment of drug addiction. This involves treatment by GPs and community pharmacists rather than from a specialist dosing point or a specialist addiction treatment medical practitioner. The medications used in the treatment are funded by the PBS and by patients paying dispensing fees directly to pharmacies.¹¹³

In October 2012 there were 14,085 patients receiving pharmacotherapy in Victoria.¹¹⁴ The number of patients has increased by over 30 percent from 2007 to 2013.¹¹⁵ There are 487 pharmacies in Victoria providing these medications, which is approximately 37 percent of pharmacies.¹¹⁶

¹¹¹ The Pharmacy Guild of Australia, *Transcript of Evidence*, 25 June 2014, pp. 20.

¹¹² Pharmaceutical Society of Australia and the Pharmacy Guild of Australia, *Guidelines for pharmacists issuing certificates for absence from work*, October 2010, p. 4.

¹¹³ Department of Health, *Enhancing the Victorian Community Based Pharmacotherapy System: Directions Paper*, January 2013, p. 2.

¹¹⁴ *Ibid.*, p. 3.

¹¹⁵ *Ibid.*, p. 2.

¹¹⁶ Department of Health, *Transcript of Evidence*, 11 June 2014, p. 7.

To be a pharmacotherapy supplier, a pharmacy must submit an application to the Department of Health. The Department then conducts a review of the proposed systems and holds an induction prior to approval. Initial approval is limited to treatment of up to five patients. Further approval may then be granted for a maximum of 85 patients. The Department offers training free of charge to pharmacists involved in pharmacotherapy, including clinical updates and refresher courses. The Department advises that a discreet location is best for the administration of doses and customarily the pharmacist must observe the patient consuming their dose. However, if the prescriber authorises take-away doses, then this observation is not required.¹¹⁷

In Victoria, community pharmacies may also choose to participate in the delivery of the state-wide Needle and Syringe Program (NSP). Under the terms of the NSP, participating pharmacies provide: needles and syringes; sharps disposal containers; sterile swabs; condoms and water-based lubricant; and relevant health information. Pharmacies receive no funding for their delivery of the Needle and Syringe Program (other than a flat rate payment if offered alongside other services, under the Community Services Support element of the Fifth CPA – see 3.4.5).¹¹⁸

¹¹⁷ Department of Health, *Policy for maintenance pharmacotherapy for opioid dependence*, 2013, pp. 37-9.

¹¹⁸ Department of Health, 'Needle & Syringe Program (NSP)', <http://www.health.vic.gov.au/aod/about/needle.htm>, accessed 22 July 2014; 5th Community Pharmacy Agreement, 'Community Services Support', <http://5cpa.com.au/programs/pharmacy-practice-incentives/community-services-support/>, accessed 29 July 2014.

CHAPTER FOUR: AN EXPANDED ROLE FOR COMMUNITY PHARMACY

A strong primary care system can be the starting point for effective referral and discharge systems, ensuring integration between different levels of care. Across national health systems, strong primary care is also associated with better population health, lower rates of unnecessary hospitalisation and slower growth in health care spending.¹¹⁹

Primary care workers diagnose and treat many conditions, give advice and refer patients to the right kind of specialist.¹²⁰ According to the Grattan Institute, the skills and knowledge of pharmacists and other highly trained health professionals are not being fully used and at the same time, consumers report delays in getting access to primary health care services.¹²¹

Throughout the Inquiry the Committee was presented with suggestions for how the provision of primary care by community pharmacists could be recognised, improved or expanded. This chapter examines the potential increased participation of community pharmacists in the areas of adult immunisation, the treatment of minor ailments, continued dispensing, medication management, chronic disease screening and management, pharmacotherapy, the Needle and Syringe Program, the further integration of community pharmacists into the health care system, the Return of Unwanted Medicines program and the provision of emergency contraception.

4.1 Adult immunisation

Influenza vaccinations for persons at risk of complications of infection are the single most important measure to prevent or attenuate influenza infection and prevent mortality.¹²² The vaccination coverage rate for Victorians aged 65 and older (who are at increased risk from influenza) is estimated at 75 percent. This compares to a coverage rate of 81.3 percent in South Australia and 74.6 percent nationally.¹²³

¹¹⁹ EXPH (EXpert Panel on effective ways of investing in Health), *Report on Definition of a frame of reference in relation to primary care with a special emphasis on financing systems and referral systems*, 10 July 2014, p. 4.

¹²⁰ Grattan Institute, *Submission no. 21*, p. 3.

¹²¹ Ibid.

¹²² Department of Health, *Australian Immunisation Handbook*, 10th Edition, 2013, p. 246.

¹²³ Australian Institute of Health and Welfare, *2009 Adult Vaccination Survey: Summary results*, March 2011, p. 3. Influenza vaccinations are free for patients over 65 years of age: Ibid., p. 1.

According to the COAG Reform Council, potentially preventable hospitalisation for vaccine-preventable conditions has risen from 70.8 per 100,000 to 82.2 per 100,000, an increase of 16 percent.¹²⁴ Examples of these conditions are influenza, tetanus, measles, mumps, rubella and bacterial pneumonia.

The Committee notes that influenza vaccinations have been seasonally administered to children and adults by nurse immunisers within a pharmacy setting for a number of years. Several of the large pharmacy chains have offered the service to customers.

Pharmacists are not currently empowered under the *Drugs, Poisons and Controlled Substances Regulations 2006* to administer vaccinations to Victorian patients. Under Section 5(3) the Secretary of the Department of Health has authorised certain classes of registered nurses in certain circumstances to administer a range of vaccines without the direct supervision of a medical practitioner.¹²⁵

4.1.1 Queensland Pharmacists Immunisation Pilot

The Committee received evidence on the Queensland Pharmacists Immunisation Pilot Project (QPIP), which began in April 2014 and was ongoing during the course of the Inquiry. The QPIP is a research program which aims to investigate the benefits of community pharmacists providing influenza vaccines to members of the public.

The pilot was approved by the Queensland Department of Health under s.18 of the *Health (Drugs and Poisons) Regulation 1996*. It is being undertaken by the Pharmacy Guild of Australia (Queensland Branch) and the Pharmaceutical Society of Australia, in conjunction with Queensland University of Technology and James Cook University.¹²⁶

The QPIP is occurring in 80 selected pharmacies across Queensland. Pharmacies must meet a range of eligibility criteria to participate, including:

- At least two generally registered pharmacists must be on duty when immunisation is being provided
- The pharmacy must have appropriate facilities to host immunisation (e.g.

¹²⁴ COAG Reform Council, *Healthcare in Australia 2012–13: Five years of performance, Report to the COAG*, April 2014, p. 10.

¹²⁵ *Drugs, Poisons and Controlled Substances Regulations 2006* (Vic.), r.5(3); Victorian Department of Health, 'Drugs & Poisons Regulation in Victoria: Approved by the Secretary', <http://www.health.vic.gov.au/dpcs/approve.htm#nurse>, accessed 25 July, 2014.

¹²⁶ Department of Health, *Transcript of Evidence*, 11 June 2014, p. 8.

private counselling area)

- The immunising pharmacist must be a general registered pharmacist
- The pharmacist must have completed immunisation training (only provided through PSA Queensland for QPIP)
- The pharmacist must hold a current First Aid Certificate and CPR certification.¹²⁷

Interim data supplied to the Committee by the Pharmacy Guild of Australia suggests the pilot has been successful. As at 30 June 2014:

- 10,000 vaccinations had been delivered
- 52 percent of patients were aged 46-65 and six percent were over 65
- 14 percent of patients had never had an influenza vaccination previously; 17.5 percent would otherwise not have had the vaccination; 74 percent would have gone to a clinic/GP if immunisation in the pharmacy had not been available
- The main reasons given by those who had never had the vaccination or did not have it every year, were 'didn't think it was necessary' and 'inconvenient to attend a clinic/GP'
- 'Convenient location' and 'easy to get appointment' were the two main reasons for having the vaccination at the pharmacy
- Patients were satisfied (96-97 percent) with the service and the facilities in which it was provided.¹²⁸

On 9 July 2014 the Queensland Minister for Health announced an expansion of the pilot to cover vaccinations for measles and whooping cough for adults, as well as a second flu season in 2015.¹²⁹ It was reported that the expanded pilot would not

¹²⁷ See Appendix C for the full eligibility criteria for the pilot.

¹²⁸ The Pharmacy Guild of Australia, Correspondence to the Committee, 8 August 2014, data sourced from the QPIP steering committee. See Appendices C and D for further information on QPIP.

¹²⁹ Minister for Health, Media release, 'Pharmacy immunisation trial broadened', 9 July 2014, <http://statements.qld.gov.au/Statement/2014/7/9/pharmacy-immunisation-trial-broadened>, accessed 24 July 2014.

require participating pharmacists to undergo further training in addition to that completed for the initial pilot.¹³⁰

The Committee notes that, given that an end-of-project evaluation has not yet been completed, there is no information available on whether any adverse reactions have occurred or whether any safety concerns have arisen. However, the Guild informed the Committee that out of the 10,000 vaccinations administered, 'no significant adverse events' were reported.¹³¹

4.1.2 Other jurisdictions

Northern Territory

Recent changes to the Northern Territory *Medicines, Poisons and Therapeutic Goods Act* enable pharmacists with prescribed qualifications to give influenza and measles immunisations. However, as at June 2014, pharmacists had not started to administer these immunisations as practice protocols were still under development.¹³²

New Zealand

Pharmacists in New Zealand have been permitted to administer influenza vaccines since 2012. Last year more than 8,500 New Zealanders were immunised by a pharmacist. From February 2014 pharmacists were also permitted to begin vaccinating people aged 18 years and older against whooping cough, and to immunise people aged 16 years and older against meningococcal disease.¹³³

Europe

Pharmacists in some European countries, such as the United Kingdom¹³⁴, Portugal¹³⁵ and Ireland¹³⁶, have recently begun offering vaccinations or have done so for a

¹³⁰ *Pharmacy Daily*, 10 July 2014, <https://s3-ap-southeast-2.amazonaws.com/traveldaily/PD/2014/Jul14/pd100714.pdf>, accessed 24 July 2014.

¹³¹ The Pharmacy Guild of Australia, *Transcript of Evidence*, 25 June 2014, p. 14.

¹³² *Ibid.*; *The Australian*, 'NT pharmacists to immunise patients', 21 February 2014.

¹³³ *Western Leader*, 'Vaccinations available at pharmacies', <http://www.stuff.co.nz/auckland/local-news/western-leader/9844857/Vaccinations-available-at-pharmacies>, 20 March 2014; AMA, 'Jest a queck jeb from your local Kiwi pharmacist', <https://ama.com.au/ausmed/jest-queck-jeb-your-local-kiwi-pharmacist>, accessed 24 July 2014.

¹³⁴ C. Anderson and T. Thornley, "'It's easier in pharmacy": why some patients prefer to pay for flu jabs rather than use the National Health Service', <http://www.biomedcentral.com/1472-6963/14/35>, accessed 25 July 2014.

number of years. The evidence from reviews and evaluations suggests that community pharmacies can safely provide a range of vaccinations, although most of the evidence relates to seasonal influenza vaccinations.¹³⁷ These reviews report a high degree of patient satisfaction with the service, with the main advantage being the accessibility and convenience of the pharmacy as opposed to other health care settings.¹³⁸

4.1.3 Concerns raised in the evidence

The Committee received evidence from Australian Medical Association Victoria (AMA Vic.) and others expressing strong reservations about the safety of pharmacist-administered vaccinations.

Pharmacists have not undertaken the level of clinical training required to provide clinical services such as vaccinations. Immunisations are much more than simply administering vaccinations. It is about assessing whether the patient is well enough to receive the vaccine; whether the patient has any allergies that might cause any adverse effects; and, most importantly, the ability to respond to any unlikely adverse effects.¹³⁹

The Australian Nursing and Midwifery Federation (ANMF) and the Rural Doctors Association of Victoria argued that the demand for vaccination could be adequately met through the current use of qualified nurse practitioners within general practice or inside pharmacies.¹⁴⁰

However, evidence also put to the Committee suggests that safety concerns raised by medical practitioners and others can be addressed through the appropriate training of pharmacists. Some pharmacies will need to modify their physical layout to provide suitable facilities and not all will wish to provide the service. Nevertheless,

¹³⁵ *Vaccines Today*, 'Case study: Pharmacists & flu vaccines in Portugal', <http://www.vaccinestoday.eu/vaccines/case-study-pharmacists-flu-vaccines-in-portugal/>, accessed 24 July 2014.

¹³⁶ Pharmaceutical Society of Ireland, *Report on the Evaluation of the Seasonal Influenza Vaccination Service in Pharmacy 2013-13*, 2013.

¹³⁷ C. Anderson and T. Thornley, "'It's easier in pharmacy": why some patients prefer to pay for flu jabs rather than use the National Health Service', <http://www.biomedcentral.com/1472-6963/14/35>, accessed 25 July 2014.

¹³⁸ Ibid.

¹³⁹ The Australian Medical Association (Vic.), *Transcript of Evidence*, 28 July 2014, pp. 31-32.

¹⁴⁰ Australian Nursing and Midwifery Federation, *Submission no. 17*, p. 5; Rural Doctors Association of Victoria, *Submission no. 22*, pp. 1-2.

many patients receive their vaccinations in the workplace or in a pharmacy through nurse practitioners and are clearly 'open to sourcing their vaccines from places other than hospitals and medical clinics'.¹⁴¹ The Committee therefore believes that a move towards trialling pharmacist-administered vaccinations should be supported in Victoria. In saying this, the Committee considers that any expansion of community pharmacy be done carefully and incrementally. Preferably any trial should be undertaken in co-located facilities so that pharmacist-administered vaccinations could be carefully monitored.

RECOMMENDATION

- 1 That the Department of Health establish a pharmacy immunisation trial targeting adults and ideally commencing in time for the 2015 influenza season.**

4.2 Minor ailments

The Grattan Institute has identified that of the more than 122 million GP visits in Australia annually, around 19 percent (23 million visits) can be categorised as 'less complex' – that is, they involve management of only one problem, with only one or two medications prescribed, and do not involve referrals, tests or other treatment (apart from advice and explanation).¹⁴² This is broadly in-line with findings from elsewhere. Estimates from the UK suggest that around 20 percent of GP consultations in that country are for 'minor ailments', (defined as conditions that are easily recognised and described by the patient and could be managed in other ways, including self-care supported by community pharmacists).¹⁴³ A study from Ontario, Canada, estimated that 25–33 percent of GP visits could be dealt with by pharmacists.¹⁴⁴

¹⁴¹ API, *Submission no. 15*, p. 2.

¹⁴² Grattan Institute, *Submission no. 21*, p. 4. Similarly, an earlier study in the UK found that up to 18 percent of GP workload is related to 'minor ailments': Vibhu Paudyal et al., 'Are pharmacy-based minor ailment schemes a substitute for other service providers?', *British Journal of General Practice*, July 2013, p. 472.

¹⁴³ ASMI, 'Driving the Self Care Agenda: Minor Ailment Workload in General Practice', <http://www.asmi.com.au/documents/Fabian%20Dwyer2008.pdf>, accessed 30 July 2014; PSA *Submission no. 12*, p. 11.

¹⁴⁴ J. Noseworthy, 'Minor ailments across Canadian jurisdictions', *Canadian Pharmacists Journal*, accessed at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3785206/>, on 30 July 2014. There is also evidence that significant numbers of patients present to emergency departments with primary care-type conditions which could be treated within the community. A 2003 study of one emergency department in the UK concluded that eight percent of presentations were

Within the 'less complex' category of GP visits, the Grattan Institute calculates that at least four million involve a GP issuing a repeat for a prescription the patient is already taking. Nearly 1.3 million visits involve a vaccination to prevent a disease, with no 'diagnosis' or other treatment.¹⁴⁵ Around 2.7 million visits are for colds, 220,000 for hayfever and '53,000 are for excess ear wax'.¹⁴⁶

A separate survey also conducted by the Grattan Institute and presented to the Committee found that approximately 44 percent of GPs agreed that they 'often' perform tasks that someone less qualified could do, and that this is likely to be correlated with lower levels of job satisfaction.¹⁴⁷

FINDING

7 *A proportion of general practitioner visits are for 'less complex' conditions, some of which could potentially be treated within a community pharmacy.*

4.2.1 Other jurisdictions

Pharmacy-based minor ailment schemes have emerged in the past decade in the UK, in some provinces of Canada and elsewhere. Examples of conditions dealt with under these schemes include eczema, head lice, colds, herpes simplex, hayfever, constipation, sore throats, wound care and insect bites and stings.

Scotland introduced its Minor Ailments Service in 2006 to allow community pharmacies to provide direct care to registered patients for common conditions. Almost every community pharmacy in Scotland has patients registered for the service. To be eligible, patients must also be registered with a GP and meet other criteria. Between April 2011 and March 2013, over two million items were dispensed by community pharmacists under the scheme, with paracetamol the most frequently prescribed item, followed by ibuprofen and simple linctus.¹⁴⁸

suitable for management by a community pharmacist – see MINA study, *Community Pharmacy Management of Minor Illness: Final Report to Pharmacy Research UK*, January 2014, p. 9.

¹⁴⁵ Grattan Institute, *Submission no. 21*, p. 4.

¹⁴⁶ Ibid.

¹⁴⁷ Grattan Institute, *Transcript of Evidence*, 28 July 2014, pp. 18-19.

¹⁴⁸ MINA study, *Community Pharmacy Management of Minor Illness: Final Report to Pharmacy Research UK*, January 2014, p. 9.

A major review of the available evidence on minor ailment schemes found that consultations in pharmacy are less costly than GP consultations and provide favourable health outcomes.¹⁴⁹ Minor ailments schemes may also redirect patients from GPs, although the impact on GP workload was difficult to assess.¹⁵⁰ Another study reported similar findings, although a need for pharmacy staff to improve consultation and counselling skills was observed.¹⁵¹ Similarly, in another generally positive evaluation of a local minor ailments scheme in the UK, the reviewers, while recommending the scheme be expanded, noted that a lack of privacy in some pharmacies needed to be addressed.¹⁵²

The body of international and national evidence on these schemes suggests that there is scope for Victoria to pilot a scheme in which selected pharmacists receive training and support to address less complex ailments. This could build on the trusted relationships many customers have with their pharmacists and take pressure off GP services and, potentially, emergency departments. The design of the pilot should take into the account the evidence referenced in this report and should ideally be developed in close consultation with local GPs and/or primary health networks.

RECOMMENDATION

- 2** *That the Department of Health work with the Commonwealth Government and health care providers to pilot a minor ailments scheme in rural Victoria for selected and suitably trained community pharmacists.*

4.3 Continued dispensing

The Committee received evidence regarding the Continued Dispensing initiative (discussed in Chapter Three), most of which called for its expansion. The Pharmaceutical Society of Australia, the Grattan Institute, the Pharmacy Board of Australia (PBA) and the Victorian Pharmacy Authority (VPA) emphasised that

¹⁴⁹ V. Paudyal et al., 'Are pharmacy-based minor ailment schemes a substitute for other service providers?', *British Journal of General Practice*, July 2013, p. 472.

¹⁵⁰ Ibid.

¹⁵¹ MINA study, *Community Pharmacy Management of Minor Illness: Final Report to Pharmacy Research UK*, January 2014, p. 8.

¹⁵² S. Puntong et al., 'A multi-method evaluation of the Pharmacy First Minor Ailments scheme', *International journal of Clinical Pharmacy* at <http://www.ncbi.nlm.nih.gov/pubmed/21526411>, accessed 30 July 2014.

expanding the initiative to other drugs would support and reduce pressure on GPs.¹⁵³ The PBA and the VPA also stated that an expanded initiative would help reduce health care costs.¹⁵⁴ An evaluation of continued dispensing in the UK by the University of Manchester found that repeat dispensing can produce savings in drug costs since items not actually needed by the patient are not dispensed.¹⁵⁵

API, a major pharmaceutical manufacturer, wholesaler and retailer, supports expanding continued dispensing as it considers this would increase the incidence of patients taking their medicines properly: 87 percent of people over the age of 50 are taking at least one medication – according to API these people need to be able to continue to take their medication regardless of immediate access to medical prescribers.¹⁵⁶ The PBA agreed, stating that the Continued Dispensing initiative ‘has the capacity to contribute to positive health outcomes for the public by facilitating adherence to prescribed drug therapy.’¹⁵⁷

Mr Stephen Marty, Chair of the PBA and Registrar of the VPA, is supportive of extending the current limit of three days’ worth of medication available under the Continued Dispensing initiative. He stated that this limit is ‘nonsense’ because customers then have to return again to a pharmacy in three days’ time. Instead, he claimed:

[I]t would be much better if the pharmacist is able to give at least a month’s supply to a patient who is stable on their medications and be reimbursed on the Pharmaceutical Benefits Scheme for doing so.¹⁵⁸

The PSA recommended that a project be piloted in Victoria that extends the Fifth CPA Continued Dispensing initiative to include a limited number of additional medicines: medicines that could cause complications if doses were missed. It suggested that Warfarin (with in-pharmacy INR testing), antihypertensives (with in-

¹⁵³ Pharmaceutical Society of Australia, *Transcript of Evidence*, 25 June 2014, p. 24; Grattan Institute, *Transcript of Evidence*, 28 July 2014, p. 50; Pharmacy Board of Australia and Victorian Pharmacy Authority, *Transcript of Evidence*, 28 July 2014, p. 52.

¹⁵⁴ Pharmacy Board of Australia and Victorian Pharmacy Authority, *Transcript of Evidence*, 28 July 2014, p. 52.

¹⁵⁵ National Prescribing Centre, ‘Dispensing with Repeats: A practical guide to repeat prescriptions’, September 2008, p. 8. The study suggested that the savings are approximately £550 per 1,000 repeat dispensing batch issues dispensed compared to traditional prescriptions.

¹⁵⁶ API, *Submission no. 15*, pp. 3-4.

¹⁵⁷ PBA, *Submission no. 5*, p. 3.

¹⁵⁸ Pharmacy Board of Australia and Victorian Pharmacy Authority, *Transcript of Evidence*, 28 July 2014, p. 52.

pharmacy blood pressure testing) and oral hypoglycaemics (with in-pharmacy blood glucose monitoring) be included in the pilot.¹⁵⁹ The Monash University Faculty of Pharmacy also supports the idea that for some repeat prescriptions, blood pressure checks would need to be carried out by pharmacists, and if the blood pressure range is outside of the normal range, this would be communicated to the GP.¹⁶⁰

There is strong support for the Continued Dispensing initiative as a means to take pressure off GPs and increase medication adherence in patients who may have trouble accessing their GP in a timely manner. As such, the Committee believes that the initiative could be expanded to include further medications, and that these repeat prescriptions could cover a longer period of time. An extension to the initiative would only be possible with systems in place requiring the necessary communications between prescribers and pharmacists.

RECOMMENDATION

- 3** *That the Department of Health work with the Commonwealth Government to expand the Commonwealth's Continued Dispensing initiative.*

4.4 Medication management

As discussed in Chapter Three, community pharmacists are currently able to offer various medication management initiatives aimed at reducing rates of 'medication misadventure' in the community. These initiatives are provided for under the Fifth CPA, which concludes in June 2015. Improvements to, and potential expansion of, medication management initiatives are discussed below.

4.4.1 Dose Administration Aids

Increasingly, community pharmacists are packing their customers' medications into Dose Administration Aids (DAAs). As outlined in Chapter Three, participating pharmacies receive periodic incentive payments for providing DAAs to patients. The formula for calculating the incentive payment is complex, however an average community pharmacy with an average prescription volume and an average number of services claimed could receive approximately \$5,000 per year in incentive

¹⁵⁹ Pharmaceutical Society of Australia, *Submission no. 12*, p. 14.

¹⁶⁰ Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Transcript of Evidence*, 28 July 2014, p. 16.

payments.¹⁶¹ A study funded under the Third CPA identified that the cost to a pharmacy of a DAA service was \$17.62 per patient per week.¹⁶²

Monash University Faculty of Pharmacy sees great benefit in the provision of DAAs, particularly in aged care facilities where almost all residents receive their medication in these devices. Pharmacists have generally covered much of the costs of the DAA service (staff time, equipment and disposable materials) from the PBS dispensing income.¹⁶³ The Faculty argues that reductions currently being experienced to this dispensing income 'will potentially limit the capacity of pharmacists to provide these risk-mitigating DAA services unless an alternate funding source is identified.'¹⁶⁴ The Faculty recommended that a cost benefit analysis of DAAs for the aged care sector be undertaken to enable development of a sustainable model for ongoing delivery of DAA services.¹⁶⁵

FINDING

8 *Dose administration aids are crucial tools to assist with the correct use of complex pharmaceutical regimens and therefore community pharmacists need to be adequately supported to provide this service.*

RECOMMENDATION

4 *That community pharmacies receive adequate remuneration through the Sixth Community Pharmacy Agreement for the ongoing delivery of dose administration aids.*

4.4.2 Medication Reviews

The Committee received a range of evidence that the medication reviews provided for under the Fifth CPA, and outlined in Chapter Three, are inadequate in a number of respects. There are four categories of medication reviews:

¹⁶¹ The Pharmacy Guild of Australia, Correspondence to the Committee, 18 August 2014.

¹⁶² Australian Government Department of Health and Ageing, *Effectiveness and Cost Effectiveness of Dose Administration Aids (DAAs): Phase 3, Final Report*, May 2006, p. 209.

¹⁶³ Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission no. 7*, pp. 13-14.

¹⁶⁴ Ibid.

¹⁶⁵ Ibid.

- MedsChecks and Diabetes MedsChecks (undertaken within the pharmacy)
- Home Medicine Reviews (HMRs) (undertaken in the patient's home)
- Residential Medication Management Reviews (undertaken in residential aged care facilities)
- Hospital-initiated Home Medicines Reviews, which have not been rolled out.

As discussed in Chapter Three, HMRs are only available on referral from a GP. Only one HMR may be conducted per patient per year unless the patient's GP deems otherwise.¹⁶⁶ Furthermore, since March 2014, pharmacists are limited to providing no more than 20 HMRs per month.¹⁶⁷

Unlike HMRs, pharmacists are able to initiate MedsChecks and Diabetes MedsChecks without a referral from a GP.¹⁶⁸ However, the number of MedsChecks and Diabetes MedsChecks is capped: pharmacists may only conduct and claim up to ten MedsChecks (including Diabetes MedsChecks) per month.¹⁶⁹

In evidence to the Committee, Eastern Melbourne Medicare Local stated there are 'various barriers which have plagued the successful and widespread uptake' of the HMR, such as the abovementioned requirement for a GP referral.¹⁷⁰ The National Stroke Foundation advised that the cap on pharmacists providing no more than 20 HMRs per month may have an adverse impact in the future, given that audits show that despite nearly all people who have had strokes leaving hospital with appropriate

¹⁶⁶ The Commonwealth of Australia and the Pharmacy Guild of Australia, *Fifth Community Pharmacy Agreement, 2010*, p. 29; 5th Community Pharmacy Agreement, 'Home Medicines Review', <http://5cpa.com.au/programs/medication-management-initiatives/home-medicines-review/>, accessed 25 June 2014; Australian Department of Health, *Programme Specific Guidelines: Home Medicines Review (HMR)*, 1 March 2014, p. 4.

¹⁶⁷ Australian Department of Health, 'Changes to the Home Medicines Review (HMR), Residential Medication Management Review (RMMR) and MedsCheck Programmes', <http://www.health.gov.au/internet/main/publishing.nsf/Content/MC14-000966-changes-to-home-medicines-review-programme>, accessed 25 June 2014.

¹⁶⁸ 5th Community Pharmacy Agreement, 'MedsCheck & Diabetes MedsCheck', <http://5cpa.com.au/programs/medication-management-initiatives/medscheck-diabetes-medscheck/>, accessed 25 June 2014.

¹⁶⁹ Australian Department of Health, 'Changes to the Home Medicines Review (HMR), Residential Medication Management Review (RMMR) and MedsCheck Programmes', <http://www.health.gov.au/internet/main/publishing.nsf/Content/MC14-000966-changes-to-home-medicines-review-programme>, accessed 25 June 2014.

¹⁷⁰ Eastern Melbourne Medicare Local, *Submission no. 19*, p. 3.

medication, many have gone off their medication when they re-present at hospital with a subsequent stroke.¹⁷¹

The ANMF is supportive of community pharmacy-delivered medication management programs, noting that they play a 'really important role' and that such programs may 'embrace the potential hotspots in health'.¹⁷² Furthermore, the ANMF expressed its support for pharmacy being part of the solution to the problem of medication-related admissions to hospital. The ANMF specifically drew the Committee's attention to the impact of Australia's ageing population and the potential beneficial role of medication reviews. According to the ANMF, the recent changes to the *Aged Care Act 1997* (Cth), which will see more elderly people having the opportunity to receive care in their homes, necessitates a need for home medicine reviews to be further utilised. In short, the ANMF believes 'there are a number of avenues for community pharmacy to further enhance their roles' in respect of medication reviews.¹⁷³

Mr Emad Sidhom, a rural-based community pharmacist, suggested in a submission to the Committee that, in the post-acute care setting, HMR referrals from GPs are often delayed until after the GP receives the hospital report. Mr Sidhom recommended that, in this situation, referrals for HMRs be initiated directly by the hospital at the time of discharge to community pharmacists.¹⁷⁴

FINDING

- 9** *Medicines reviews are valued by health professionals as a tool to help ameliorate the occurrence of medication-related problems and the subsequent cost to the community.*

RECOMMENDATION

- 5** *That community pharmacists be remunerated through the Sixth Community Pharmacy Agreement to provide medicines reviews on a needs basis.*

¹⁷¹ Stroke Foundation, *Submission no. 20*, p. 3. See *National Stroke Audit – Acute Services*, Clinical Audit Report 2013 accessed at http://strokefoundation.com.au/site/media/NSF687.ClinicalServicesAudit2013.Final_.pdf, p. 6, 4 August 2014.

¹⁷² Australian Nursing and Midwifery Federation, *Transcript of Evidence*, 28 July 2014, p. 33.

¹⁷³ Ibid.

¹⁷⁴ Mr E. Sidhom, *Submission no. 9*, p. 2.

Hospital-initiated Home Medicines Review

As outlined in Chapter Three, the Hospital-Initiated Home Medicines Review (HHMR) was intended to be rolled out during the term of the Fifth CPA. However, this has not occurred and is not likely to before the Agreement concludes in June 2015.¹⁷⁵

In submissions to the Inquiry, the Guild and the PSA advised that there is an urgent need for a medication management program targeted at patients leaving hospital, such as the HHMR, to be implemented. In its submission the Guild outlined how medication misadventure frequently occurs when a patient moves from a hospital setting back to their place of residence. The Guild asserted that there is a 'clear need' for improved coordination between the hospital and primary health care systems in terms of managing the medicines aspects of patients transferring out of acute care back into the community setting and that funding must be provided for medication management services at this 'critical juncture.'¹⁷⁶

Similarly, the Heart Foundation stated that only one-quarter of heart attack patients receive optimal secondary prevention, including advice and the appropriate medications, when they are discharged from hospital. Inadequate post-acute care increases the risk of a second heart attack and readmission to hospital.¹⁷⁷ Indeed, according to the Department of Health, Victoria spends \$400m per year treating cardiac-related conditions in hospital.¹⁷⁸ Significantly, it is estimated that 34 percent of hospital admissions in Australia are due to repeat acute coronary syndrome events (encompassing unstable angina and heart attack).¹⁷⁹ The Heart Foundation advised that better medication adherence (including medication reviews) can help to reduce this occurrence.¹⁸⁰

Based on the available evidence, the Committee considers that community pharmacists can play a stronger role in the post-acute setting and that there is a clear need for medicine reviews that target this scenario. On discharge from hospital,

¹⁷⁵ Pharmaceutical Society of Australia, *Submission no. 12*, p. 16.

¹⁷⁶ The Pharmacy Guild of Australia, *Submission no. 13*, pp. 3-4; Cf. Pharmaceutical Society of Australia, *Submission no. 12*, p. 15.

¹⁷⁷ Heart Foundation, *Submission no. 26*, p. 4. Cf. J. Redfern, K. Hyun, D. Chew et al., 'Prescription of secondary prevention medications, lifestyle advice, and referral to rehabilitation among acute coronary syndrome inpatients: results from a large prospective audit in Australia and New Zealand', *Medical Journal of Australia*, 2013.

¹⁷⁸ Department of Health, *Heart Health: improved services and better outcomes for Victorians, Melbourne*, 2014, p. 5.

¹⁷⁹ Deloitte Access Economics, *ACS in Perspective: The importance of secondary prevention*, 2011, p. iii.

¹⁸⁰ Heart Foundation, *Submission no. 26*, p. 4.

patients who are on a minimum of a certain number of medicines should be automatically referred to a community pharmacy for a medicines review.

FINDING

10 *There is currently a gap in the range of medicines reviews available due to the Hospital-initiated Home Medicines Review not being funded.*

RECOMMENDATION

6 *That the Sixth Community Pharmacy Agreement allocates funding for a medicines review program specifically addressing the post-acute care period.*

A new Victorian medication management initiative

On 7 August 2014 the Victorian Government announced a Quality Use of Medicines project that will see pharmacists, GPs and nurses engaged in improving medication self-management by elderly patients taking multiple medications. This will initially be a pilot study, and will involve GPs referring patients to pharmacists for ‘medication reconciliation’, providing consumers with a list of these ‘reconciled’ medicines, and supporting GPs to work with pharmacists and patients to ensure GP and patient medication records are matched. A six to 12 month reassessment will be included in the initiative.¹⁸¹

4.5 Chronic disease screening and management

The Monash University Faculty of Pharmacy, API and the Guild recommended that funding be established for in-pharmacy care in relation to specific chronic diseases such as hypertension, diabetes and asthma.¹⁸² The accessibility and convenience of the community pharmacy are cited as reasons for locating health screening and monitoring services in that space. It is thought that this is particularly pertinent for

¹⁸¹ *Pharmacy News*, ‘Funding for medication management initiative approved’, 7 August 2014.

¹⁸² Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission no. 7*, p. 14-15; API, *Submission no. 15*, p. 2; The Pharmacy Guild of Australia, *Submission no. 13*, p. 12. Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Transcript of Evidence*, 28 July 2014, p. 12.

people who do not often visit GPs and who may otherwise be missed.¹⁸³ The Guild emphasised that any government-funded disease screening or condition management services should only be offered through community pharmacies where there is evidence-based research that has shown an improved outcome for the consumer.¹⁸⁴

Under the Fifth CPA community pharmacies receive a flat-rate incentive payment of \$850 per year if they provide screening/risk assessment and disease management services for certain conditions, under the Primary Health Care program (see Chapter Three).¹⁸⁵ However, the Guild argued that screening and monitoring of chronic disease should be remunerated via a 'well-tailored outcome-based incentive' in order to increase the number of participating pharmacies and also therefore the number of consumers undergoing screening and risk assessment.¹⁸⁶

Similarly, API argued in a submission that not only would a formal program mean adequate funding for pharmacist-delivered chronic disease management, but education and defined processes, competencies and guidelines would ensure that such services are delivered at an 'exceptional level'.¹⁸⁷

According to a submission from the Monash University Faculty of Pharmacy, pharmacists are in an ideal position to monitor the health status of both existing patients and those with undiagnosed conditions or at risk of disease, with initial detection of risks communicated to the patient's GP.¹⁸⁸ The Faculty points to research, such as the Deakin University pilot study, which found a 25 percent decreased risk of cardiovascular disease in 67 participants following an assessment and five follow up sessions with appropriately trained pharmacists, in order to prove the efficacy of pharmacist-delivered chronic health initiatives.¹⁸⁹ The Faculty recommended that the Victorian Department of Health commission further research

¹⁸³ Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission no. 7*, p. 20; The Pharmacy Guild of Australia, *Transcript of Evidence*, p. 15; The Pharmacy Guild of Australia, *Submission no. 13*, p. 11.

¹⁸⁴ The Pharmacy Guild of Australia, 'Disease Screening and Condition Management within Community Pharmacy: Position Statement', p. 1.

¹⁸⁵ The Pharmacy Guild of Australia, Correspondence to Committee, 19 August 2014. Nb.: Participating pharmacies can claim \$850 per year if they offer three or more Primary Health Care services.

¹⁸⁶ The Pharmacy Guild of Australia, *Submission no. 13*, p. 12.

¹⁸⁷ API, *Submission no. 15*, p. 2.

¹⁸⁸ Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission no. 7*, p. 20.

¹⁸⁹ K.P. McNamara et al., 'A pilot study evaluating multiple risk factor interventions by community pharmacists to prevent cardiovascular disease: the PAART CVD pilot project', *The annals of pharmacotherapy*, <http://www.ncbi.nlm.nih.gov/pubmed/22318928>, accessed 5 August 2014.

into coordinated care models under which pharmacists provide monitoring of risk factors in patients with chronic disease and provide early advice to GPs.¹⁹⁰

Both the Stroke Foundation and the Heart Foundation expressed support for chronic disease screening in the community pharmacy location. The Heart Foundation recommends that Victoria introduce a community-based early detection and screening program to detect and manage the risk of heart attack, with community pharmacy part of an integrated approach. This could be particularly useful for Victorians living in rural and remote locations, who are at higher risk of heart disease and can experience difficulty accessing medical services.¹⁹¹ Under the model the Heart Foundation envisages, there would be a strengthened referral pathway from community pharmacy to general practice and Aboriginal health services.¹⁹² The Stroke Foundation is supportive of pharmacies as a setting for preventative care, in particular for raising individual awareness of risk and for increasing the number of people who present to GPs for full assessments.¹⁹³

Concerns about pharmacist-delivered chronic health disease screening and management

In evidence to the Committee, AMA (Vic.) President Dr Tony Bartone expressed his concern that there is no clear pathway between an independent health check and follow-up treatment:

There are a lot of things that can happen between that finger prick that might occur in a community setting and then finally going to see your GP and doing something about it.¹⁹⁴

The vital step, Dr Bartone advised, is that the information from that health check goes into that patient's record.¹⁹⁵ Furthermore, Dr Bartone noted that there is a lack of evidence supporting the benefits of health checks performed outside of general practice and that health checks undertaken in general practice are far preferable:

¹⁹⁰ Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission no. 7*, p. 20.
¹⁹¹ Heart Foundation, 'Media Release: Not so lucky country: snapshot shows hearts at far greater risk in the bush', 14 August 2014. People living in regional areas have a greater risk of heart disease, as they are more likely to be physically inactive, daily smokers and overweight or obese, than those living in major cities.
¹⁹² Heart Foundation, *Submission no. 26*, p. 1.
¹⁹³ Stroke Foundation, *Submission no. 20*, p. 1.
¹⁹⁴ Australian Medical Association (Vic), *Transcript of Evidence*, 28 July 2014, p. 9.
¹⁹⁵ Ibid.

[W]hen preventive checks and health assessments are done in a general practice setting they by far lead to outcomes that are desirable in the reduction of risk factors and the reduction of morbidity and mortality.¹⁹⁶

The Committee notes that pharmacists already provide a range of screening and health check-type services, often in an ad hoc manner and either without cost to the patient or on a fee-for-service basis. These services are evidently popular, particularly in rural areas, and this is due in large part to the convenience of accessing community pharmacies.¹⁹⁷ Early detection is critical for many chronic health conditions and can prevent additional costs to the health system. However, on the evidence provided there is a risk that some pharmacy programs may not be delivered to the highest standards, and the Committee notes the AMA (Vic.)'s concerns about follow-up from the pharmacist to the GP. In addition to the appropriate training of pharmacists, any government-funded chronic disease screening and management program should be contingent upon formal collaboration between the pharmacy and the patient's GP. The Committee notes that expansion of the personally controlled electronic health record system may facilitate such communication (see 4.6.5 below).

FINDING

- 11** *While community pharmacists do provide some chronic disease screening and management services, there is no formalised, government-funded service offered.*

RECOMMENDATION

- 7** *That the Victorian Government consider piloting an evidence-based chronic disease screening and management program in selected community pharmacies, including a formal requirement for communication between pharmacists and the patients' general practitioners.*

¹⁹⁶ Ibid., p. 8. See S. Si, J.R. Moss, T.R. Sullivan, S.S. Newton, & N.P. Stocks, 'Effectiveness of general practice-based health checks: a systematic review and meta-analysis', *British Journal of General Practice*, 1 January 2014, vol. 64, no. 618, pp. 47-53.

¹⁹⁷ See, for example, API, *Submission no. 15*, p. 5.

4.6 Pharmacotherapy

Evidence received by the Committee on pharmacotherapy (opioid dependence treatment) focused mainly on two related issues: service availability and remuneration.

As noted in Chapter Three, around 37 percent of pharmacies in Victoria provide pharmacotherapy. The Committee heard that while Victoria had made significant gains in recent years and was considered a world leader in the field in some regards, there remains a need for more pharmacies to offer the service.¹⁹⁸ Mr Irvine Newton, a community pharmacist and provider of pharmacotherapy, informed the Committee that there are ‘some roaring gaps across the state’ in terms of availability.¹⁹⁹

You can do an overall view and say, ‘We have X amount of pharmacies providing services’, but it may disguise the fact that in many areas we do not have services that are sufficient for people’s needs. If people cannot access a service somewhere near where they live or work or operate, then the service is not going to be taken up. People will not have the facility, will not have the desire and will not want to travel long distances to avail themselves of services.²⁰⁰

Community pharmacies receive funding from the Commonwealth (via the PBS) for the dispensing of pharmacotherapy medicines and currently and up until at least June 2015, pharmacies are provided an annual incentive flat payment of \$850 for offering an opioid substitution program (as long as they also offer two other of the services specified in the Community Services Support program, as detailed in the Fifth CPA – see 3.4.5).²⁰¹

However, the Committee received evidence that the remuneration does not cover the cost of service provision. Mr Newton advised that when he first started providing pharmacotherapy services in 1988 he was charging \$35 per week per patient (or \$5 per day) and in 2014 he still charges \$35 per week per patient. He advised that some

¹⁹⁸ Mr I. Newton, *Transcript of Evidence*, 28 July 2014, pp. 68-9.

¹⁹⁹ *Ibid.*

²⁰⁰ *Ibid.*, p. 69.

²⁰¹ 5th Community Pharmacy Agreement, ‘Community Services Support’, <http://5cpa.com.au/programs/pharmacy-practice-incentives/community-services-support/>, accessed 17 August 2014; The Pharmacy Guild of Australia, Correspondence to Committee, 19 August 2014.

of the bigger chain pharmacies are pulling out of providing opioid dependence treatment as it is not considered sufficiently profitable.²⁰²

The Guild recommended that the pharmacists' fee for dispensing pharmacotherapy medicines be reviewed, as it is not currently 'reflective of the level of service required.'²⁰³ It further recommended a new Medicare Benefits Schedule item number be allocated to pharmacists who provide opioid dependence treatment specifically for conferring with medical practitioners and other relevant treatment providers when involved in a patient's treatment. According to the Guild, this payment would increase the participation rate of pharmacies providing opioid dependence treatment, as well as improving coordination of services.²⁰⁴ Mr Newton is also supportive of incentives being paid to pharmacies to increase availability. He pointed out that Victoria is one of the few states that does not provide financial support.²⁰⁵ The Guild advised that an incentive payment would assist in the initial setting-up phase. This payment could cover the costs of purchasing a pump and a larger safe in which to store methadone, for example.²⁰⁶

An incentive-based model has been operating in NSW since 2000 and has resulted in the recruitment and retention of 680 pharmacies servicing over 10,000 patients. The NSW program is managed by the Guild and the estimated Government contribution is approximately \$1.4m per annum. The Guild recommended that a similar model be adopted in Victoria in order to significantly increase the number of participating pharmacies.²⁰⁷

The Committee received evidence from Victorian Alcohol & Drug Association (VAADA) that the approximate dispensing fee of \$35 per week currently paid by the patient is for many 'particularly burdensome.' VAADA suggests that, due to the obvious cost benefits achieved by pharmacotherapy through reducing risky behaviours related to opioid use, this dispensing fee should be met by government.²⁰⁸

²⁰² Mr Irvine Newton, *Transcript of Evidence*, 28 July 2014, p. 41.

²⁰³ The Pharmacy Guild of Australia, 'Position Statement: Opioid Dependence', pp. 1, 2.

²⁰⁴ *Ibid.*, p. 2.

²⁰⁵ Mr Irvine Newton, *Transcript of Evidence*, 28 July 2014, p. 41.

²⁰⁶ The Pharmacy Guild of Australia, *Transcript of Evidence*, 25 June 2014, pp. 17-18.

²⁰⁷ The Pharmacy Guild of Australia, *Submission no. 13*, p. 14.

²⁰⁸ VAADA, *Submission no. 29*, p. 2.

FINDING

- 12** *In some areas of Victoria there remains a need for more community pharmacies to offer opioid dependence treatment and this is related in part to the cost to pharmacies of providing the service and the minimal remuneration available (other than Pharmaceutical Benefits Scheme payments for the actual medicines dispensed).*

In order to address the abuse/misuse of pharmacotherapy medicines, the Guild recommended that a real-time monitoring system for opioid medicines be implemented.²⁰⁹ VAADA stated that the ‘development and implementation of a comprehensive real time prescription monitoring system is an enduring and lifesaving need for the health sector’.²¹⁰ The Department of Health advised the Committee that a national real-time monitoring system is currently being considered after a limited pilot in Tasmania.²¹¹

On the broader issue of harm reduction, the Monash University Faculty of Pharmacy warned that a growing public health issue in Victoria is the increasing dependency on over-the-counter analgesics containing codeine as well as the growing use of prescription narcotics. The Faculty urged that community pharmacies need support to provide assistance for people with such dependence. This support could include training, access to support programs and public health messages disseminated from pharmacies.²¹²

RECOMMENDATIONS

- 8** *That the Victorian and Commonwealth Governments consider a funding model, such as the allocation of a Medicare provider number to pharmacists, to adequately recompense pharmacists for providing a standardised, evidence-based opioid dependence treatment.*
- 9** *That the Victorian Government and pharmacy peak bodies jointly develop a program which helps community pharmacies support people with a dependence on over-the-counter analgesics*

²⁰⁹ The Pharmacy Guild of Australia, ‘Position Statement: Opioid Dependence’, p. 3.

²¹⁰ VAADA, *Submission no. 29*, p. 3.

²¹¹ Department of Health, *Transcript of Evidence*, 11 June 2014, p. 5.

²¹² Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission no. 7*, p. 19.

containing codeine and/or prescription narcotics.

4.7 Needle and syringe programs

As detailed in Chapter Three, pharmacies receive no direct funding for their delivery of the Needle and Syringe Program (NSP).²¹³

It has been estimated that for every one dollar invested in needle and syringe programs, more than four dollars is returned in health care cost savings in addition to the investment. Across Australia, it is estimated that needle and syringe programs have saved \$1.28bn in downstream health care costs between 2000 and 2009.²¹⁴ In 2010 there were 321 community pharmacies registered in the Victorian NSP (roughly one in four of all community pharmacies in the State).²¹⁵ Over 10 million syringes are exchanged in Victoria per annum, of which around 580,000 are exchanged through pharmacies.²¹⁶

The Guild is strongly supportive of the continuing availability of sterile needles and syringes and its contribution to harm reduction across the community, as well as encouraging more community pharmacies to offer the NSP.²¹⁷ The Guild claimed that an increased number of community pharmacies participating in the NSP would benefit the community by a reduction in the transmission of blood-borne viruses and via safe needle disposal.²¹⁸ It recommends that community pharmacies implementing the program receive an initial allowance as a means of encouraging pharmacists to participate, which would off-set the costs associated with staff training and alteration to premises layout which may be necessary to accommodate the NSP.²¹⁹

²¹³ Department of Health, 'Needle and Syringe Program (NSP)', <http://www.health.vic.gov.au/aod/about/needle.htm>, accessed 22 July 2014. Nb. For the purposes of this program, community pharmacies are classified as secondary NSP outlets and, as such, receive no direct funding.

²¹⁴ The Pharmacy Guild of Australia, *Submission no. 13*, p. 14.

²¹⁵ Department of Health and the Pharmacy Guild of Australia, *Final Report - Community Pharmacy NSP Recruitment Project*, October 2010, p. 13. Note that not all pharmacies registered for the NSP are actively providing NSP services.

²¹⁶ Department of Health, Needle and Syringe Program data collection (NSPDistAll) as at 10 September 2014.

²¹⁷ The Pharmacy Guild of Australia, 'Needle and Syringe Program: Position Statement', p. 1; The Pharmacy Guild of Australia, *Transcript of Evidence*, 25 June 2014, p. 15.

²¹⁸ The Pharmacy Guild of Australia, *Submission no. 13*, p. 15.

²¹⁹ The Pharmacy Guild of Australia, 'Needle and Syringe Program: Position Statement', p. 3.

Since 1986, the NSW Government has been investing \$1,426,700 per annum to the NSP in that State and there are currently 472 pharmacies providing NSP services. The Guild recommended that a similar model be adopted in Victoria in order to significantly increase the number of participating pharmacies.²²⁰

RECOMMENDATION

- 10** *That the Victorian Government investigate real cost incentives to encourage community pharmacies to offer the Needle and Syringe Program.*

4.8 Integrating pharmacy

The Committee received evidence that community pharmacists need to be further integrated into the broader health system. The AMA (Vic.) advised that it would like to see an ‘increased collaboration’ between pharmacists and GPs. The AMA (Vic.) believes that this would produce benefits such as better patient education on medication, improved use of medicines, a reduction in adverse drug events and, ultimately, better coordination of patient care.²²¹ Monash Health considers establishing mechanisms to achieve improved communication between pharmacists, medical practitioners and nurses in the community a ‘high priority’, just as close relationships between these different health professions have been ‘critical’ in the development of clinical roles in the hospital setting.²²²

4.8.1 Interface with acute care

As previously discussed, medication-related issues are common during a patient’s transition into and out of acute care settings. The Committee received evidence that further integrating community pharmacists into the pre- and post-acute care settings would decrease the incidence and severity of these issues.

The Guild sees the lack of integration and communication between hospitals, GPs and pharmacists in the post-acute care setting as problematic:

What can happen at the moment is that a patient might be discharged from hospital. Mrs Jones comes into my pharmacy and

²²⁰ The Pharmacy Guild of Australia, *Submission no. 13*, p. 15.

²²¹ AMA (Vic.), *Transcript of Evidence*, 28 July 2014, p. 2.

²²² Monash Health, *Submission no. 14*, p. 5.

gives me her medications and I try and sort them out. I ring the doctor and say, 'Dr Smith, Mrs Jones is in my pharmacy'. I go to work through the medications with Dr Smith, and Dr Smith says, 'I did not know Mrs Jones was even in hospital. What are you talking about?'. This can lead to a lot of inefficiencies in the system, and it can decrease patient outcomes.²²³

Monash University Faculty of Pharmacy views community pharmacies as well placed to help manage medication issues in the transition of care scenario due to the ease of access and frequency with which patients can access community pharmacies. Both the Faculty and Guild are in favour of implementing post-discharge medication assessments.²²⁴ The Faculty recommended that a model be established whereby patients are referred to their local community pharmacy for both a pre-admission and post-discharge medication management assessment. These assessments would include coordination of medication supply and counselling patients on the use of their medicines, and the management of basic surgical wound dressings (by those pharmacists credentialed in wound care).²²⁵ The assessments would take the place of the current model of the pre-admission clinic, which is currently offered on-site at the hospital and requires the patient to go to the hospital on an occasion prior to their admission.²²⁶ The Committee notes that for patients, particularly those in a rural or remote location, accessing their local community pharmacy would be more convenient than attending a hospital which is potentially at a considerable distance from their place of residence.

Eastern Melbourne Medicare Local recommended establishing a post-acute service focussed on the elderly living at home with a home-visiting pharmacist service triggered by those patients at high risk of a medicines-related problem, especially those recently discharged from hospital. According to EMMML, liaison between the GP, hospital and community pharmacy to conduct medication reconciliation services has the potential to decrease the risk of unplanned hospital readmission.²²⁷ The Committee notes that the service recommended by EMMML would be similar to the Hospital-initiated Home Medicines Review (discussed above), set out under the Fifth CPA but not yet initiated.

²²³ The Pharmacy Guild of Australia, *Transcript of Evidence*, 25 June 2014, p. 16.

²²⁴ *Ibid.*; Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission no. 7*, p. 13.

²²⁵ Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission no. 7*, p. 13.

²²⁶ Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Transcript of Evidence*, 28 July 2014, p. 13.

²²⁷ Eastern Melbourne Medicare Local, *Submission no. 19*, p. 4.

RECOMMENDATION

- 11 That the Victorian Government investigate pre- and post-acute medication assessment models delivered by community pharmacists, with a view to implementation of a pilot program.**

4.8.2 Aged care

According to the Guild, over the next two decades, the number of people aged 65 or over is projected to rise by 91 percent and the number of people aged 85 and over will more than double.²²⁸ As many as 30 percent of hospital admissions for the elderly are due to adverse medicine events, costing the public health system \$380m per year. Fifty percent of these admissions are considered potentially avoidable.²²⁹ The Committee received evidence proposing an increased role for community pharmacists in supporting both aged care in the home and aged care in residential aged care facilities.

Aged care in the home

The Commonwealth Government currently funds health and support services to the elderly in order to allow them to remain in their own homes rather than be transferred to a residential aged care facility. The Home and Community Care Program (HACC), described as a 'basic' home help program and aimed at people who only need a small amount of support, delivers services to more than 500,000 older people nationwide.²³⁰ Home Care Packages are similar to the HACC Program but are able to be tailored to meet more specific needs. In 2012 approximately 60,000 Home Care Packages were delivered and the Government estimates that this will increase to 100,000 by 2016-17.²³¹ Health services provided via the HACC Program and the Home Care Packages include the provision of physiotherapy, podiatry, speech pathology, occupational therapy and diet consultations.²³² Currently, pharmacy is not included in the range of services offered through these programs.

²²⁸ The Pharmacy Guild of Australia, *Submission no. 13*, pp. 4-5.

²²⁹ Ibid.

²³⁰ Myagedcare, 'Help at home: how services are delivered', <http://www.myagedcare.gov.au/help-home/help-home-how-services-are-delivered>, accessed 29 August 2014.

²³¹ Ibid.

²³² Myagedcare, 'Home and community care', <http://www.myagedcare.gov.au/home-and-community-care>, accessed 29 August 2014; Myagedcare, 'Home care packages', <http://www.myagedcare.gov.au/home-care-packages>, accessed 29 August 2014.

The Guild proposed that an ‘aged care in the home’ initiative involving pharmacists be implemented which could include:

- Development of agreed action plans with other health care professionals
- Provision of DAAs
- Home delivery of medicines where required (and possible)
- Medicine reviews undertaken in the patient’s home
- Regular monitoring of blood pressure and other health indicators
- Management and monitoring of any devices that are used by the patient.²³³

In evidence to the Committee, the Guild explained that this kind of aged care in the home is emerging in the US and the concept is known as the ‘medical home’. The purpose of the ‘medical home’ is to keep people in their homes for longer by giving them home-delivered medication services.²³⁴

Aged care in residential aged care facilities

The Committee received evidence that an expanded role for community pharmacists in the health care of residents of residential aged care facilities could ameliorate medication-related adverse events occurring in that setting. Studies show that: 20 percent of patients experience ‘significant’ delays in being administered their medicine upon arrival at a residential aged care facility; an average of four medication-related problems have been identified during medicine reviews in aged care facilities;²³⁵ between 40-50 percent of aged care residents are prescribed potentially inappropriate medicines; and one in four residents are in need of additional medication than that already prescribed.²³⁶

A submission from Eastern Melbourne Medicare Local recommended an expansion of the pharmacist’s role in residential aged care facilities, given that up to 96 percent of residents have been found to have at least one medication-related problem. The submission suggested that this could involve:

²³³ The Pharmacy Guild of Australia, *Submission no. 13*, pp. 4-5.

²³⁴ The Pharmacy Guild of Australia, *Transcript of Evidence*, 25 June 2014, p. 15.

²³⁵ Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission no. 7*, pp. 7-8.

²³⁶ Eastern Melbourne Medicare Local, *Submission no. 19*, p. 3.

- Ensuring that dosage is appropriate relative to renal function (given that a study has found that 45 percent of doses prescribed for patients with renal impairment were inappropriately high)
- Ensuring appropriate medication monitoring is undertaken
- Identifying medicines that may be causing side effects
- Ensuring the most appropriate medicine is selected
- Detecting a need for medication
- Conducting medication reconciliation at the point of entry to the facility and on hospital admission out of the facility
- Reviewing medicines that may be contributing to the behavioural and psychological symptoms of dementia.²³⁷

RECOMMENDATION

12 That the Victorian Department of Health work with its Commonwealth counterpart to:

- *conduct further research into the beneficial role of pharmacists in supporting the provision of aged care in the home*
- *investigate the costs and benefits of providing community pharmacists with provider numbers so that they can deliver specialised care services for residents of aged care facilities.*

4.8.3 Shared care plans

The Committee received evidence that community pharmacists should be able to take part in shared health care plans. Currently GPs are able to recommend a shared health care plan for eligible patients, which involves up to five allied health services being involved in the care team. All the services delivered via the shared care plan are covered by a Medicare rebate for the patient. Community pharmacists are not currently able to be part of these shared care plans.²³⁸ The Pharmaceutical Society of

²³⁷ Ibid.

²³⁸ Australian Department of Health, 'Chronic Disease Management - Individual Allied Health Services under Medicare - Patient Information', <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-medicare-allied-health-brochure.htm>, accessed 20 August 2014.

Australia and the Grattan Institute are supportive of including community pharmacists in shared care teams, in order to better tackle chronic health problems in the community.²³⁹ These care plans would be shared by a patient, their GP and pharmacist, and any other relevant health professionals. Within this formalised shared care team, pharmacists could undertake the following:

- Review a patient's medication, check for adverse drug interactions and ensure patients are informed about their medications
- Adjust doses and discontinue or alter medication
- Give patients their medications in DAAs
- Inform GPs and other health practitioners of any relevant information
- Issue repeat prescriptions.²⁴⁰

The Committee received evidence that in order for pharmacists to be recognised as members of the shared health care plan team, they must have a provider number and a new funding model to support that integration.²⁴¹

The Grattan Institute stated that the introduction of shared health care plans involving pharmacists might need to be limited to those patients with electronic health records, which would facilitate better communication between the participants of the health care team as well as enabling an audit of pharmacist decisions.²⁴² Others were supportive of joint GP/pharmacy care plans to encourage enhanced collaboration between pharmacists and GPs.²⁴³

The Committee believes that including community pharmacists in shared care plans where needed has the potential to enhance communication between the health professions and therefore also the quality of health care provided.

²³⁹ Pharmaceutical Society of Australia, *Submission no. 12*, p. 17; Grattan Institute, *Submission no. 21*, p. 11.

²⁴⁰ Grattan Institute, *Submission no. 21*, p. 11.

²⁴¹ Pharmaceutical Society of Australia, *Submission no. 12*, p. 17; Dr S. Wilson, *Submission no. 24*, p. 3.

²⁴² Grattan Institute, *Submission no. 21*, p. 13.

²⁴³ Ms P.H. Smith, *Submission no. 1*, p. 2, Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission no. 7*, pp. 3, 16; Department of Health, *Transcript of Evidence*, 11 June 2014, p. 4.

FINDING

- 13** *Community pharmacists are currently unable to take part in shared care plans.*

RECOMMENDATION

- 13** *That the Victorian Minister for Health advocate to the Commonwealth Government to consider including community pharmacists in shared care teams.*

4.8.4 Co-location of pharmacists within GP clinics

The Committee notes that in many medical centres around Victoria, community pharmacies and general practices are brought together as separate businesses within the one building. There is no publically available recent data on how common this is, however a 1999 AIHW survey estimated that around seven percent of community pharmacies were located within a medical centre of some kind.²⁴⁴ An example is 'The Well' community hub in Smythesdale, which allows convenient access to a GP, pharmacy and a range of allied health services.

The Committee heard support for the concept of locating non-dispensing pharmacists within a GP clinic. The AMA (Vic.) suggested that, in this model, pharmacists would work under the supervision of GPs and assist with prescribing and improving a patient's medication management and adherence.²⁴⁵ The concept was also supported in evidence from the Pharmaceutical Society of Australia and the Monash University Faculty of Pharmacy.²⁴⁶ Some studies have suggested that medicines-related problems in patients presenting at GP clinics could be significantly reduced by the intervention of a co-located pharmacist.²⁴⁷

Eastern Melbourne Medicare Local stated that locating pharmacists within general practice 'warranted serious consideration':

GPs recognise their limitations in relation to medicines review as being time limitations, heavy workloads and limited knowledge of

²⁴⁴ AIHW, *Pharmacy Labour Force to 2001, 2003*, p. 14.

²⁴⁵ Australian Medical Association (Vic.), *Submission no. 18*, p. 1.

²⁴⁶ Pharmaceutical Society of Australia, *Submission no. 12*, p. 1; Monash University Faculty of Pharmacy and Pharmaceutical Sciences, *Submission no. 7*, pp. 18-19.

²⁴⁷ Eastern Melbourne Medicare Local, *Submission no. 19*, p. 4.

pharmacology and drug interactions. Given the tendency for the elderly to be on complex medicines regimens which would benefit from medicines review and collaborative prescribing decision making, there is a clear role for pharmacists in GP settings. Having the pharmacist onsite in the practice would allow them greater access to more patient information (such as disease states and pathology results) than they would normally have access to. This would allow for collaborative decision making processes, checking for drug-drug and drug-disease state interactions, ensuring appropriate monitoring is being conducted, rationalising complex regimens and the provision of in-depth medicines information to the patient to improve patient adherence etc... A co-located pharmacist could also deal with the complex and time consuming task of reconciling medicines lists – particularly of hospital discharge patients.²⁴⁸

Similarly, Mr Stephen Marty, Chair of the Pharmacy Board of Australia, observed that there was emerging demand from the medical profession for greater involvement of pharmacists in their work:

I think there is a greater future in looking at being co-located with other health services, and that is happening right now. I have medical practitioners ring and say, 'I am wanting to start a new multidisciplinary clinic. I'd like a pharmacy in there. I'd like a pharmacist to be managing our records and providing advice to the practitioners about what drugs are appropriate, et cetera'. That is an ideal world. It will not happen everywhere, but it would be a start.²⁴⁹

The submission from Eastern Melbourne Medicare Local suggested that such a model could be reimbursed by providing pharmacists with an MBS item number for case conferences or involvement in GP management plans and team care arrangements.²⁵⁰ The Committee notes that this is an uncommon model in Australia and there are few examples of it in practice from which to draw conclusions.²⁵¹

²⁴⁸ Ibid.

²⁴⁹ Pharmacy Board of Australia and Victorian Pharmacy Authority, *Transcript of Evidence*, 28 July 2014, p. 52.

²⁵⁰ Eastern Melbourne Medicare Local, *Submission no. 19*, p. 4.

²⁵¹ Freeman et al., 'Integrating a pharmacist into the general practice environment: opinions of pharmacists, general practitioners, health care consumers, and practice managers', *BMC Health Services Research*, 12, 2012, accessed at <http://www.biomedcentral.com/1472-6963/12/229#B6> on 5 August 2014; Cf. E.C.K. Tan et al., 'Stakeholder experiences with general practice pharmacist services: a qualitative study', *BMJ Open*, 3(9), 2013 accessed at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3773653/#R5> on 5 August 2014.

However, given the support from across the medical and pharmacy professions and the demonstrated need to reduce medicine-related presentations at GPs and hospitals, the Committee believes that further research and development of the model would be worthwhile.

FINDING

14 *There is support across the primary health system for the concept of locating non-dispensing pharmacists within general practice.*

RECOMMENDATION

14 *That the Department of Health commission research into the costs and benefits of locating non-dispensing pharmacists in general practice, with a view to establishing a pilot program.*

4.8.5 E-health

In considering the evidence around expanding the role of pharmacists, the Committee has been cognisant of the need to avoid further fragmentation of patient care across the health system. As the AMA (Vic.) pointed out, doctors require robust medical records with as much information as possible to ensure that they can manage their patients as effectively as possible.²⁵² Where health services are provided outside the GP's rooms, as already occurs when patients receive immunisations or health checks at their workplace, for example, the continuity of a GP's patient records can be compromised.

Deficiencies in communication are the most common contributing factor to the occurrence of medication errors, including shortcomings in communication between GPs and pharmacists.²⁵³ Where pharmacists are aware of a patient's medical history, they 'play an important role in detecting and alerting prescribers to potential problems.'²⁵⁴ However, without this knowledge 'it is frequently difficult to determine whether there are contra-indications and/or interactions between prescribed medicines and also with medicines purchased over-the-counter.'²⁵⁵

²⁵² Australian Medical Association (Vic.), *Transcript of Evidence*, 28 July 2014, p. 2.

²⁵³ Pharmaceutical Society of Australia, *Submission no. 12*, p. 15.

²⁵⁴ Victorian Pharmacy Authority, *Submission no. 25*, p. 3.

²⁵⁵ Ibid.

The Committee is therefore interested in the potential of personally controlled electronic health records (PCEHRs) to help pharmacists link in with other health care providers. The PCEHR is an online summary allowing health care providers and hospitals to view and share an individual's health information. A Commonwealth Government initiative, the PCEHR has been slow to develop although it currently has over 1 million registered users.²⁵⁶

The federal Health Minister recently released the *Review of the Personally Controlled Electronic Health Record* (December 2013) report. One of its main recommendations was that the system shift from an opt-in to an opt-out arrangement (Australians would need to actively decide not to have their health records included).²⁵⁷ The Committee notes that, subject to the resolution of the privacy and security concerns identified in the report, opt-out would enhance the usefulness of the PCEHR for patients, pharmacists and medical practitioners.

The involvement of pharmacy in the system may help to overcome the fragmentation of health information and reduce adverse medical events and duplication of treatment. An example of this would be a patient presenting to a pharmacy after discharge from a hospital in order to get a prescription filled: the pharmacist would view the discharge summary in the patient's electronic record in order to confirm the change in a dosage of existing medicines and the introduction of new medicines.²⁵⁸ Pharmacists should also be able to include data in the PCEHR from medication management services and primary health care services that they provide to patients.²⁵⁹ The Department of Health advised that the system would be the appropriate place for pharmacist-delivered immunisations to be recorded.²⁶⁰

In a submission to the Inquiry, the Commonwealth Department of Health noted that the broader e-health agenda includes investment in other initiatives of benefit to pharmacists, such as online PBS claiming and electronic transfer of prescriptions between prescribing and dispensing software.²⁶¹

²⁵⁶ *News.com.au*, 'Aussies to be automatically enrolled for e-Health records under changes', <http://www.news.com.au/national/aussies-to-be-automatically-enrolled-for-ehealth-records-under-changes/story-fncynjr2-1226781862899>, accessed 6 August 2014.

²⁵⁷ National Electronic Health Transition Authority, *Review of the Personally Controlled Electronic Health Record*, December 2013, p. 28.

²⁵⁸ Pharmaceutical Society of Australia, *National eHealth record system: Guidelines for Pharmacy*, December 2013, pp. 10, 13.

²⁵⁹ National Electronic Health Transition Authority, *Review of the Personally Controlled Electronic Health Record*, December 2013, p. 68.

²⁶⁰ Department of Health, *Transcript of Evidence*, 11 June 2014, pp. 6, 8.

²⁶¹ Commonwealth Department of Health, *Submission no. 23*, p. 1.

RECOMMENDATION

- 15 That the Victorian Minister for Health encourage the Commonwealth Government to expedite the development and take-up of electronic health records and ensure that pharmacists are able to participate in the system to improve patient care.**

4.9 Other issues raised in the Inquiry

4.9.1 Return of Unwanted Medicines

The National Return and Disposal of Unwanted Medicines Ltd, known as the RUM program, enables consumers to return unwanted or out-of-date medicines to any pharmacy at no cost to themselves.²⁶² The program aims to avoid accidental childhood poisoning, medication misuse and toxic releases into the environment. The collected medicines are then destroyed in an environmentally-friendly manner using high-temperature incineration. To support this program, Commonwealth funding is provided to National Return and Disposal of Unwanted Medicines Ltd.²⁶³

The Guild is supportive of the RUM project and encourages its members to participate in it.²⁶⁴ The Victorian Pharmacy Authority advised the Committee that the majority of pharmacies do participate in the program, despite not being paid for undertaking the service. The Authority urged that '[o]ngoing funding for the scheme is necessary for the scheme to continue.'²⁶⁵

Due to increased utilisation of the service, the Commonwealth Government has recently provided a further \$800,000 to maintain the project until June 2015 when the funding agreement concludes.²⁶⁶ In evidence to the Committee, Dr Stephen

²⁶² This program is run by a national not-for-profit company. Australian Department of Health, 'National Return and Disposal of Unwanted Medicines', <http://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-prescribers-return.htm>, accessed 7 August 2014.

²⁶³ Ibid.

²⁶⁴ The Pharmacy Guild of Australia, 'Position Statement: Return of Unwanted Medicines to Community Pharmacies', 2012, p. 1.

²⁶⁵ Victorian Pharmacy Authority, *Submission no. 25*, p. 3; Note, community pharmacies receive an incentive payment of \$850 per annum to offer the RUM program as part of the Community Services Support initiative – see 3.4.5.

²⁶⁶ *Pharmacy Daily*, 'Managing your RUM', 27 August 2014, p. 1.

Marty advised that this extra funding ‘will not be enough; it will not last all of the financial year’.²⁶⁷

FINDING

15 *The Return of Unwanted Medicines program forms a valuable part of community pharmacy’s contribution to preventative health care in Victoria and requires adequate funding to ensure its ongoing existence.*

4.9.2 Emergency contraception provision

Since 2004 the emergency contraceptive pill has been available from pharmacies without a prescription from a medical practitioner. Women’s Health Victoria (WHV) stated that it is important that community pharmacies support women’s health by providing the full range of contraceptive options, and particularly emergency contraception.²⁶⁸ However, evidence suggests that women are often unaware of the emergency contraceptive pill’s availability.²⁶⁹ Additionally, a recent study found that Victorian pharmacists’ actual knowledge and practices towards the emergency contraceptive pill were not always evidence-based, requiring further training.²⁷⁰ For example, some pharmacists refused to supply the emergency contraceptive pill outside a 72-hour time frame.

WHV made a number of points regarding emergency contraception in their submission to the Inquiry, including:

- There needs to be clarification regarding the dispensing of emergency contraception to a third party: the Therapeutic Goods Administration does not require that it only be dispensed to the intended user but the PSA’s protocol requires that it not be dispensed to a third party
- Refusal to supply a woman with emergency contraception on the basis of the pharmacist’s personal beliefs impedes on a woman’s right to make decisions regarding her own health, and whether or not to have children

²⁶⁷ Pharmacy Board of Australia and Victorian Pharmacy Authority, *Transcript of Evidence*, 28 July 2014, p. 48.

²⁶⁸ Women’s Health Victoria, *Submission no. 10*, p. 1.

²⁶⁹ Ibid.

²⁷⁰ S. Hussainy, K. Stewart & M-P. Pham, ‘A mystery caller evaluation of emergency contraception supply practices in community pharmacies in Victoria, Australia’, *Australian Journal of Primary Health*, CSIRO online publishing, 13 June 2014.

- There is a need for a standardised protocol and compulsory training to be developed (to expand on the existing PSA protocol) which includes how to respond in different situations, such as dispensing to a third party or to women under 16 years of age, advice on where consultations should take place in the pharmacy, rights and responsibilities of pharmacists who refuse to dispense emergency contraceptives on the grounds of personal beliefs, counselling on future contraceptive use and sexually transmitted infections, and timeframes within which emergency contraceptives can be supplied and used.²⁷¹

The Pharmacy Board of Australia believes that pharmacists should supply emergency contraceptives, being in the patients' interest, or else refer someone to the next available pharmacy. In the hypothetical circumstance where a pharmacist is in a country setting a long way from another pharmacy but refuses to provide emergency contraception, Dr Marty postulated that it will take a test case to determine the question definitively, but reiterated that:

At the moment the board certainly believes that it should be supplied in all circumstances unless there is an alternative available within a timely manner.²⁷²

FINDING

- 16** *Many women are unaware that community pharmacies are able to provide emergency contraceptives without a prescription and pharmacists may not have a clear understanding of the guidelines around dispensing.*

RECOMMENDATION

- 16** *That the Pharmaceutical Society of Australia work with pharmacists to improve understanding of the guidelines on the provision of emergency contraception.*

²⁷¹ Women's Health Victoria, *Submission no. 10*, pp. 2-5.

²⁷² Pharmacy Board of Australia and Victorian Pharmacy Authority, *Transcript of Evidence*, 28 July 2014, p. 49.

4.9.3 Telemedicine

'Telemedicine' refers to a health service delivered over the phone or internet. An example is the Victorian Stroke Telemedicine project, recently launched by the Florey Institute of Neuroscience and Mental Health. The project will link neurologists in Melbourne with rural emergency departments via video-link to provide treatment advice about patients with stroke symptoms and in particular to assess whether patients should receive thrombolysis, a medication which, when given soon after a stroke, results in a better chance of good recovery.²⁷³

'Telehealth' is a telemedicine program run by the Commonwealth Government which provides financial incentives to eligible health professionals and aged care services that help patients have a video consultation with a specialist, consultant physician or consultant psychiatrist. The program aims to 'remove some of the barriers to accessing medical services for Australians who have difficulty getting to a specialist or live in rural and remote areas.'²⁷⁴ Specialists, consultant physicians and psychiatrists, medical practitioners, nurse practitioners, midwives, practice nurses and Aboriginal health workers are all currently eligible to be involved in the Telehealth program.²⁷⁵ Both the specialists consulted by video-link and the health practitioners providing the hosting service face-to-face with the patient are paid through the MBS, and therefore must have a Medicare provider number (or must provide services on behalf of a medical practitioner using their provider number).²⁷⁶ Currently pharmacists are ineligible to be involved in the Telehealth program.²⁷⁷

²⁷³ The Florey, 'Stroke', <http://www.florey.edu.au/research/epidemiology-public-health/the-victorian-stroke-telemedicine-program>, accessed 26 August 2014; *Pharmacy Daily*, '\$9m telemedicine launch', 22 August 2014, p. 1.

²⁷⁴ Australian Department of Human Services, 'Telehealth', <http://www.medicareaustralia.gov.au/provider/incentives/telehealth/>, accessed 26 August 2014.

²⁷⁵ Ibid.

²⁷⁶ Australian Department of Human Services, 'Program Guidelines: Financial Incentives for Telehealth', p. 1, at [http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/OCA5AF3D82AB2CDDCA2578A30006DA42/\\$File/Telehealth%20Program%20Guidelines%20effective%201%20January%202013.pdf](http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/OCA5AF3D82AB2CDDCA2578A30006DA42/$File/Telehealth%20Program%20Guidelines%20effective%201%20January%202013.pdf), accessed 28 August 2014; Australian Department of Human Services, 'Telehealth for health professionals', <http://www.medicareaustralia.gov.au/provider/incentives/telehealth/information-for-health-professionals.jsp>, accessed 28 August 2014.

²⁷⁷ Australian Department of Human Services, 'Telehealth for health professionals', <http://www.medicareaustralia.gov.au/provider/incentives/telehealth/information-for-health-professionals.jsp>, accessed 28 August 2014.

The Committee received evidence from the Department of Health and others that community pharmacies should be involved in telemedicine.²⁷⁸ The Guild argued that community pharmacy in regional and remote Australia, due to its accessibility and convenience, 'may be the only available or most appropriate health service for conducting Telehealth consultations.'²⁷⁹ Pharmacies could then facilitate consultations between specialists located in cities and residents in rural and regional settings.²⁸⁰ The PSA recommended that pharmacists involved in telemedicine consultations be remunerated similarly to the other health professions involved.²⁸¹

RECOMMENDATION

- 17** *That the Victorian Government advocate to the Commonwealth Government to consider the inclusion of community pharmacy within the Telehealth program.*

Committee Room

17 September 2014

²⁷⁸ Department of Health, *Transcript of Evidence*, 11 June 2014, p. 4.

²⁷⁹ The Pharmacy Guild of Australia, *Submission no. 13*, p. 8.

²⁸⁰ *Ibid.*; Pharmaceutical Society of Australia, *Submission no. 12*, p. 18.

²⁸¹ Pharmaceutical Society of Australia, *Submission no. 12*, p. 18.

APPENDIX A: SUBMISSIONS

- 1 Mrs P Smith
- 2 Dr C Hirst
- 3 Slade Pharmacy
- 4 National Pharmacies
- 5 Pharmacy Board of Australia
- 6 Professor Emeritus C Chapman
- 7 Faculty of Pharmacy and Pharmaceutical Sciences, Monash University
- 8 Consumers Health Forum of Australia
- 9 Wedderburn Pharmacy
- 10 Women's Health Victoria
- 11 Health Services Commissioner
- 12 Pharmaceutical Society of Australia
- 13 The Pharmacy Guild of Australia
- 14 Monash Health
- 15 Australian Pharmaceutical Industries Ltd
- 16 Gippsland Women's Health Service Inc.
- 17 Australian Nursing and Midwifery Federation
- 18 Australian Medical Association Victoria
- 19 Eastern Melbourne Medicare Local
- 20 Stroke Foundation
- 21 Grattan Institute
- 22 Rural Doctors Association of Victoria
- 23 Australian Government Department of Health
- 24 Dr S Wilson
- 25 Victorian Pharmacy Authority

- 26 Heart Foundation Victoria
- 27 Professionals Australia
- 28 Therapeutic Goods Administration, Department of Health
- 29 Victorian Alcohol & Drug Association

APPENDIX B: WITNESSES

11 June 2014

Mr Peter Fitzgerald	Deputy Secretary, Health Strategy Productivity and Analytics
Mr Matthew McCrone	Chief Officer, Drugs and Poisons Regulation
Mr Dan Jefferson	Director, Health Workforce

Department of Health

25 June 2014

Mr Stan Goma	Professional Services Manager
Mr Anthony Tassone	Victorian President

The Pharmacy Guild of Australia

Ms Michelle Lynch	Victorian Branch President
Mr Bill Suen	Victorian Branch Director
Dr Alison Roberts	Director of Policy and Practice

Pharmaceutical Society of Australia

28 July 2014

Dr Tony Bartone	Victorian President
Ms Katherine Walsh	Senior Policy Officer

Australian Medical Association (Vic.)

Professor Carl Kirkpatrick	Director, Centre for Medicine Use and Safety
Mr John Jackson	Director, Project Pharmacist

**Faculty of Pharmacy and Pharmaceutical
Science, Monash University**

Dr Stephen Duckett	Director, Health Program
Mr Peter Breadon	Health Fellow

The Grattan Institute

Dr Christine Hirst

Ms Catherine Hutchings
Ms Trish O'Hara

Professional Officer
Professional Officer
**Australian Nursing and Midwifery
Federation**

Mr Irvine Newton

Mr Stephen Marty

Chair (Registrar, Victorian Pharmacy
Authority)

Mr Joe Brizzi

Executive Officer
Pharmacy Board of Australia

APPENDIX C: ELIGIBILITY CRITERIA FOR THE QUEENSLAND PHARMACIST IMMUNISATION PILOT (QPIP)

For pharmacies:

- Have not hosted an in-pharmacy immunisation service previously.
- Authorised pharmacy premise which is Quality Care Pharmacy Program accredited.²⁸²
- Access to Guildcare²⁸³ software (including Vaccination Module).
- Appropriate indemnity cover for the business for immunisation scope of practice.
- Have at least two generally registered pharmacists on duty when immunisation is being provided.
- Appropriate facilities to host immunisation (e.g. private counselling area).

For individual pharmacists to immunise:

- General registered pharmacist with Pharmacy Board of Australia (not intern).
- Complete immunisation training (only provided through PSA Queensland for the QPIP trial).
- Current First Aid Certificate and CPR certification.
- Appropriate professional indemnity cover for immunisation scope of practice.

²⁸² The QCPP is a quality assurance/accreditation program run the Pharmacy Guild.

²⁸³ Guildcare is pharmacy software owned by the Pharmacy Guild.

APPENDIX D: QPIP FAST FACTS

30th June 2014 > 10,000 vaccinations completed

Snapshot of >7,000 patient evaluations below

Sex	Male: 38%		Female: 62%	
Age	18-30	31-45	46-65	>65
	18%	24%	52%	6%

Previous vaccination?	<ol style="list-style-type: none"> 1. Yes yearly : 48% 2. Not every year: 38% 3. No never: 14%
Why haven't you had a 'Flu' vaccination? (Ever, or every year)	<ol style="list-style-type: none"> 1. Didn't think it was necessary 2. Inconvenient to attend clinic/GP 3. Too busy
If the vaccination service was not available?	<ol style="list-style-type: none"> 1. GP clinic/surgery: 74% 2. I would not have had a vaccination: 17.5% 3. At work: 7%

What's the main reason for having your 'Flu' vaccination here today?	<ol style="list-style-type: none"> 1. Convenient location 2. Easy to get appointment 3. Friendly and relaxed environment 4. Health professional I trust
Were other aspects of your health discussed? (YES)	<ol style="list-style-type: none"> 1. Concerns I have about my health: 60% 2. Other medications I usually take: 58% 3. My general health: 38%

About the Service	
Were the details of the vaccination process explained adequately?	Completely satisfied: 96%
Was the vaccination provided in a professional manner?	Completely satisfied: 97%
Did you feel comfortable with the skills of the professional providing the immunisation?	Completely satisfied: 97%
Overall, how satisfied are you with your vaccination experience?	Completely satisfied: 96%
Were the facilities adequate?	Yes: 97%
Were you comfortable while you waited?	Yes: 97%
Overall satisfaction with the QPIP service	
Would you be happy to receive your flu vaccination in a pharmacy in the future?	Yes: 97%
Would you recommend this service to others?	Yes: 97%

