~ Submission ~

THE PARLIAMENT OF VICTORIA’S INQUIRY INTO COMMUNITY PHARMACY
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Dear Committee members,

**Discount pharmacy is destroying community pharmacy**

On behalf of Professional Pharmacists Australia members, we thank you for the opportunity to provide this submission in response to the Terms of Reference for the Inquiry into Community Pharmacy.

Professional Pharmacists Australia (PPA) is the industry representative for non-owner pharmacists who work in community pharmacies across Australia.

PPA is part of the Professionals Australia network with more than 25,000 members across Australia including non-owner community pharmacists, private hospital pharmacists and independent contractor pharmacists.

PPA offers access to the highly regarded Society of Hospital Pharmacists of Australia CPD (SHPA CPD) program, as well member support and advocacy.

PPA is run by community pharmacists, for community pharmacists.

Please note, in the submission we refer to “pharmacists” rather than “pharmacies” as described in the Terms of Reference. The reason being that we believe pharmacists are the single most integral component of the community pharmacy industry, and therefore the interests of pharmacists, not pharmacies or their owners should be the paramount focus for this inquiry.

Recent financial and professional difficulties highlight the fact that the current business model is failing consumers, the government, and the health care sector.

PPA has been advocating for many years that the current community pharmacy model of supply and dispensing must change. As far back as November 2009, when PPA surveyed community pharmacists about their preferred model of practice, a majority of respondents preferred a mixed model, which focused on the provision of primary health care services in addition to patient-outcomes-orientated dispensing services.

Through this submission, we hope to provide substantial evidence supporting our claim that current model is broken, and to demonstrate the potential benefits of a mixed model approach to community pharmacy.
Furthermore, we wish to address a number of inaccuracies put forth by the Pharmacy Guild of Australia at a public hearing held on June 25, 2014. While the following comments do not explicitly relate to the Terms of Reference for this inquiry, we believe for the Committee to make accurate recommendations, its understanding of community pharmacy must also be accurate.

Firstly, the Guild stated:

“Community pharmacies are located all across Australia and Victoria. There are approximately 1300 in Victoria and over 5000 across Australia. They are the traditional chemist shops that you may see in retail strips or in shopping centres, both large and small, or co-located in medical centres. Each and every community pharmacy is supervised by a registered pharmacist by law.”

While Professional Pharmacists Australia would like the picture painted by the Pharmacy Guild to be accurate, unfortunately the rise of discount pharmacies has significantly warped the pharmacy landscape.

The most common form of pharmacy located in retail strips and shopping centres is no longer community pharmacy, rather discount pharmacy chains.

The rise of discount pharmacy banner groups that operate as chains in all but name is changing the industry. The largest of these groups is Chemist Warehouse (CW) which now makes up over 20% of the industry and is growing rapidly. Operating through what can be described as interesting corporate arrangements to work within ownership rules, and seemingly relying on a large number of owners being members of one of either two families.

This does not favour community pharmacy, and demonstrates the inaccuracies with the Pharmacy Guild’s statement.

The second statement made by the Pharmacy Guild we wish to address is:

“Part of the guidelines for the licensing of community pharmacies is that they all have a private and confidential counselling area, and some pharmacies actually expand this to even be a formal consulting room. This is a really important point for the public to be aware of in terms of pharmacies’ capacity to take on these professional services or an expanded role that might need that extra care and confidentiality.”

While we agree with importance of having private counselling rooms available, we assert that counselling rooms are not actually present at many community pharmacies, despite what the Pharmacy Guild alludes to in the statement. We ask committee members to reflect for a moment on their recent pharmacy experiences. This is part of a rosy view of community pharmacy that the Pharmacy Guild likes to promulgate as it is in the interests of the pharmacy owners they represent to advocate for no change in one of Australia’s last vanguards of protected industry.

Emblematic of the broken nature of community pharmacy and the final, crucial point Professional Pharmacists Australia hopes to make to the Committee is that community pharmacists wages have stagnated at a parlous level. A recent remuneration survey of our members revealed that ages for community pharmacists have only risen by 48 cents in the last three years, from $34.38 to $34.86. That’s approximately $69,000 per annum.

The survey also found that 1 in 5 community pharmacists reported not receiving a pay rise in more than four years and that pharmacists working at Chemist Warehouse seem to be earning on average $5.61 an hour less than the average rate of pay in community pharmacy across pay classifications.
Graduate Careers Australia’s (GCA) 2013 annual Australian Graduate Survey shows that pharmacists’ starting average salary, at $39,000 per annum, is the worst of all university graduates.

It’s no wonder pharmacy owners believe the current system needs little change.

Professional Pharmacists Australia would welcome the opportunity to discuss the points raise above and within this submissions further.

Sincerely,

Chris Walton, CEO
Professionals Australia
Terms of Reference and recommendations

The following pages detail Professionals Pharmacists Australia’s response to the Terms of Reference for this Inquiry.

We understand that the Legal and Social Issues Legislation Committee is required to report by the role and opportunities for community pharmacy in primary and preventative care in Victoria, and in doing so, will put forth a series of recommendations for consideration. As we address each Term of Reference, where PPA believes there is an opportunity to improve the current situation, we have presented our own recommendations, and we appreciate the Committee’s consideration of.

The role of pharmacies in post-acute health care, aged care, personalised medication management, and vaccinations

The National Medicines Policy provides a framework for developing services that are designed to improve the health outcomes of all Australians. The framework is defined as;

“... a cooperative endeavour to bring about better health outcomes for all Australians, focusing especially on people’s access to, and wise use of, medicines. The term "medicine" includes prescription and non-prescription medicines, including complementary healthcare products. The Policy has four central objectives: timely access to the medicines that Australians need, at a cost individuals and the community can afford; medicines meeting appropriate standards of quality, safety and efficacy; quality use of medicines; and maintaining a responsible and viable medicines industry.”

Pharmacists, no matter where they are located, have the capacity and capability, if given the resources and appropriate practice environment, to contribute to these aims as part of the healthcare team.

As such, PPA supports the current federally funded programs which provide positive health outcomes for patients when properly conducted. The programs PPA supports include:

- Home medicines review,
- Residential medication management reviews for residents of aged care facilities,
- MedsChecks and Diabetes MedsChecks that provide in-pharmacy reviews of medications, education and self-management,
- Filling of dose administration aids for community patients,
- Recording of clinical interventions by pharmacists,
- Staged Supply services to help patients overcome potential medication abuse, by issuing supplies every few days to the patient,
- Primary Health Care programs which include screening and risk assessment activities for patients not yet diagnosed with respiratory, cardiovascular, diabetes, or mental health diseases,

• Disease State management activities for patients who have been diagnosed with aforementioned diseases,
• Opioid substitution programs to assist people coming off heroin and other drugs of addiction,
• Needle & Syringe Exchanges where used syringes and needles can be collected and disposed of in a safe manner, and
• The Return of Unwanted Medicines (RUM) program, which allows the safe collection and destruction of expired or unused dispensed medicines

Enhanced role of pharmacies in other jurisdictions such as Queensland and the Northern Territory with respect to influenza immunisation services

PPA supports the changing of legislation in the Northern Territory and the trials in Queensland of vaccinations performed in pharmacies by pharmacists. We regard vaccination as a critically important public health intervention, and believe that, considering the accessibility of community pharmacies, that the involvement of pharmacists in this service will assist in the maintenance of immunisation levels. PPA would also support establishing the necessary standards of care that will evolve from these trials.

**Recommendation 1.**

PPA recommends that the Victorian Government change existing legislation to allow pharmacists to provide vaccinations, upon completion of an appropriate training program.

Role of pharmacies in making referrals to other health care professionals

Pharmacists have traditionally had the role of being a primary health gatekeeper. Pharmacists are trained to recognise and refer complex cases of patient symptoms to other health practitioners, whether it is to a medical practitioner for antibiotics or high blood pressure, or to a physiotherapist for muscular pain.

This already occurs frequently in current practice, but is rarely acknowledged, partly because pharmacists—unlike other health professionals—do not use a formal written referral document.

**Recommendation 2.**

PPA recommends that the Victorian Government continue to allow pharmacists to administer referrals to other health care practitioners.
Role of community pharmacies in rural and remote Victoria

With the scarcity of medical practitioners and allied health professionals in rural and remote areas, there is a significant opportunity for community pharmacists to provide expanded services to their community in support of and in collaboration with other local health professionals. This was recognised by Professor Stephen Duckett in the Grattan Institute report “Access all areas: new solutions for GP shortages in rural Australia”\(^2\).

However, there are a number of structural barriers inhibiting this collaborative opportunity.

The Senate Community Affairs References Committee reported on “the effectiveness of special arrangements for the supply of Pharmaceutical Benefits Scheme (PBS) medicines to remote area Aboriginal Health,” and found that when compared with other countries, community pharmacists have a very limited role in delivering primary care. They found that (p22) “with additional training, pharmacists could help to reduce GP workloads in under-served areas” and “when a patient agrees, GPs could authorise pharmacists to give repeat prescriptions and help manage chronic care.”

The Committee made the following recommendation:

Recommendation 4

“2.70 The committee agrees with submitters and recommends that program flexibility be implemented to give remote area [Aboriginal Health Services (AHS)] increased and direct access to the services of a pharmacist. This could be done by AHSs engaging a pharmacist directly or in collaboration with other stakeholders or service providers. Options for funding and operating these services could include cashing-out existing program funding, access to alternative funding measures, expansion of the Practice Nurse Incentive Program to include pharmacists, remunerating remote pharmacists for services though the Medicare Benefits Schedule, and removal of legislative barriers that prevent the operation of pharmacy businesses in remote areas.”\(^3\)

Additionally, the Queensland Aboriginal and Islander Health Council highlighted the challenges faced by primary health providers with the unconnected and unintegrated nature of a range of programs. Its solution was to recommend that payment for services be directed to the Aboriginal Community Controlled Health Services, which would then allow negotiations directly with community pharmacists or academic pharmacists to provide services.

In response to this, the Senate Committee recommended the following:

“5.9 While pharmacists may be able to provide extended clinical programs such as medicine use reviews, dose administration aids, disease state management for conditions like diabetes and asthma, and health promotion, it appears that funding for the exclusive provision of these services


\(^3\) The Senate: Community Affairs References Committee. The effectiveness of special arrangements for the supply of Pharmaceutical Benefits Scheme (PBS) medicines to remote area Aboriginal Health Services October 11, Commonwealth of Australia, 2011
is limited to members of the Pharmacy Guild of Australia. The committee considers that where AHSs wish to, and have capacity to do so, provision should be made for these services to be provided by the AHS directly by using the funding to place a pharmacist within an AHS.”

The Committee then made the following recommendation:

“Recommendation 9

5.11 The committee would like to see greater integration of existing programs to provide complementary services to patients of AHSs. The evidence the committee received during the course of this inquiry supports this. Therefore the committee recommends that DOHA develop a process for integrating existing programs, and that a clear policy and program logic is published to show how these programs will work together.”

The Committee also concluded that a significant problem remains in that there is little evidence that pharmacists are available to provide ongoing support.

“2.38 The committee has formed the view that significant work has been done to establish relevant guidelines and tools to assist pharmacists in the provision of services funded under the section 100 pharmacy support allowance and that other supporting initiatives such as OPRAH and Good Medicines Better Health programs (discussed earlier) provided by the NPS are offering opportunities for up-skilling pharmacists to work with staff of AHSs. However, it appears that there are few examples of pharmacists being able to provide direct support and continuing advice to patients when it is required.”

Recommendation 3.

PPA recommends that the Victorian Government consider the recommendations made by the Senate Community Affairs References Committee listed above.

Remuneration, workforce, and financial issues with respect to any expansion of the role of community pharmacies

In order for pharmacists to contribute fully to patient care in collaboration with other health professionals, demonstrated patient outcomes—separate from PBS funding—should form the basis for the remuneration of services offered by pharmacists.

The current business model constrains innovative approaches to healthcare. Pharmacists should be able to work as employees or independent practitioners in both pharmacies and non-pharmacy settings (e.g. in a medical practitioner’s rooms, or with other health practitioners; community health services; or in the aged care setting).
Currently, pharmacy practitioners seeking recognition as independent health practitioners face barriers in the health system. As such, pharmacists struggle to achieve the same regard as medical practitioners, nurses, other allied health practitioners, or other pharmacists who wish to work collaboratively with the aforementioned professionals in patient care.

Many pharmacists want to shake off the discounting retail model’s shackles and shift their practice’s focus onto caring for their patients. They wish to be able to practice in the way they were trained: to assess and provide both clinical advice and information to both patients and the other members of their health team, to assist in achieving optimal health outcomes.

The aforementioned Grattan Report (p.22) also states, “These reforms would require changes to the way pharmacists are paid. Community pharmacy is a heavily regulated industry. Pharmacists are essentially paid for selling medicines rather than for providing care and advice.”

In New Zealand⁴, the focus has shifted from remunerating the pharmacist for dispensing to remunerating for proving patient care, as a member of the healthcare team. Pharmacists are reimbursed for dealing with patients who have long-term conditions (complex cases), specific services (e.g. INR monitoring, servicing patients in aged care facilities), and the core services of both episodic dispensing for patients and monitoring of their medication use.

Furthermore, the growth of discount pharmacies exacerbates the issues of a dispensing focused model, by making it increasingly difficult for community pharmacies located in close proximity to discount pharmacies to compete.

If we look at the strip shopping centre precinct on Carlisle St, in the suburb of Balaclava in Melbourne as an example, we see that within a 5-minute walk, there are six pharmacies: two discount model pharmacies, two banner group pharmacies and two single owner pharmacies.

Having visited the location on numerous occasions, PPA can make informed assumptions as to their operations. The large discount chains would most likely be very high turnover stores with solid profit levels, while the Terry White pharmacy and it’s fellow midsize banner group neighbour appear to be medium volume locations that seek to differentiate themselves from the discounters with improved levels of service. However, the last two are clearly low traffic and low prescription level stores that would struggle financially when compared to the other four. If one, or both of them, did not exist then the people of Balaclava would still have ready access to prescription drugs through any of the remaining four pharmacies.

**Recommendation 4.**

PPA recommends that the Victorian Government change the remuneration systems for community pharmacists to take the impetus off number of units dispensed, to patient outcomes.

Other issues relevant to the role and opportunities for community pharmacies in primary and preventative care

The overseas trend is to recognise a pharmacists’ clinical role in the community.

a) Refer to the Scottish Government’s “Prescription for Excellence” A summary is provided at Appendix One.

In this model a system will be established to accredit clinical pharmacists who can act - for example - as independent prescribers. Patients register with one pharmacy and the focus of care changes from dispensing to a patient-centred care model. The multidisciplinary healthcare team expands to include pharmacists, training and accepting the latter as an important element of the patient’s care. This team develops patient plans that include health and social issues for the patient.

b) In the United Kingdom, a number of programs have been identified where pharmacists can contribute to the improvement of patient health outcomes (refer to Appendix Two):

- Weight programs: providing outreach, education, and weight management plans
- Smoking cessation: develop plans and allow supplementary prescribing by the pharmacist
- Sexual health: provide test kits, chlamydia screening, oral contraceptive advice, and education
- Alcohol use: provide lifestyle advice, screening, and assessment of alcohol use by patients
- Ageing population: provide education and medication reviews
- Long term conditions: pharmacist screening and ongoing Disease State Management of the patient can assist these complex cases
- Mental health: promote good mental health and screen for depression
- Medication harm: follow Therapeutic Guidelines to monitor safe and rational prescribing
- Drug misuse: provide needle exchanges, wound management and immunisation services

c) In Canada, the role of the pharmacist has expanded dramatically, but continues to vary from province to province. Refer to the Table in Appendix Two.

- The pharmacist has more scope to amend a prescription (e.g. formulation, dose)
- Pharmacists can prescribe medications in an emergency situation
- Pharmacists are trained to administer injections
- Pharmacists conduct medication reviews and they keep medication records rather than just, dispensing records for patients
- Pharmacists are trained to interpret and order laboratory tests
- Pharmacists develop care plans in collaboration with other health practitioners for patients with chronic diseases

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7 [http://www.pharmacists.ca/cpha-ca/assets/File/cpha-on-the-issues/CanadianPharmacyServicesFramework.pdf](http://www.pharmacists.ca/cpha-ca/assets/File/cpha-on-the-issues/CanadianPharmacyServicesFramework.pdf)
Conclusion

PPA would encourage the consideration of fundamental discussions within the State and with the Federal Government around a practice model that shifts the focus of care provided by pharmacists from the supply of medications to one that is patient focussed, collaborative, holistic, and caters for the needs of the members of the public as its mission. This will require significant structural and philosophical changes from within the profession, but more importantly, from governments and consumers as well.
Appendix One -
Prescription for Excellence – The Scottish Experience

The Scottish Government released a vision and action plan for pharmaceutical care in September 2013. This is another example of a Government that recognises the valuable role pharmacists can play in managing and monitoring the health of the community by releasing pharmacists from their traditional dispensing role.

Many of the phrases will be familiar...“facilitate the professional independence of pharmacists, working in collaborative partnerships with other health and social care professionals.......all patients will receive high quality pharmaceutical care using the clinical skills of the pharmacist to their full potential.”

The Chief Pharmaceutical Officer defines “Professionalism” which could be a useful definition to apply to certain pharmacies in Australia that have been over-servicing patients and putting their financial interests before those of the patients who genuinely need those services.

“Professionalism can be defined by a set of values, behaviours and relationships. It encompasses aspects such as commitment, integrity, honesty, a sense of service, accountability, independent judgement and individual responsibility and is underpinned by a culture of continuous improvement.

It is therefore fundamentally important that pharmacists, regardless of employer or environment, are able to make professional decisions for their patients at all times. New and innovative models to facilitate the professional independence of pharmacists will be explored as a priority in this Action Plan.”

Major Points Raised in the Plan:

- There will be a move from focusing on services provided in a pharmacy to the clinical capability of pharmacists working in a variety of environments.
- Pharmacists will be recognised in the NHS as clinicians responsible for providing pharmaceutical care, to encourage and support the patient managing their own conditions.
- The release of pharmacists will require full utilisation of pharmacy technicians, support staff and the use of robotics in dispensing.
- All patients would have access to an NHS accredited clinical pharmacist independent prescriber in all settings to optimise the use of medication to include monitoring and adjusting treatment.
- Introduction of the concept of a named pharmacist and patient registration with NHS Board listed pharmacists, to provide consistency and continuity with a pharmacist for patients who have long term conditions.
- NHS Boards have a direct relationship with individual pharmacists providing services in their areas, regardless of the setting.
• Pharmacists work in groups (clinical pharmacist group practices) to deliver NHS pharmaceutical care, especially for complex or long term conditions, with allocations of caseloads.
• Pharmacists will undertake an enhanced role which will require them to be trained appropriately in multidisciplinary team based practice at the undergraduate and postgraduate levels.
• The plan will promote integration between the hospital, community pharmacist (NOT “community pharmacy”) and medical practitioners for the benefit of the patient.
• The plan requires the sharing of patient information between the pharmacist and other health and social care professionals to maximise case management.
• The plan will tackle the problems of multi-morbidity, non-adherence to prescribed medicines, wasted medicines and prescribing errors.
• The plan will increase the access of pharmacists support to GP practices, so they work in collaboration and caseloads are allocated to the pharmacist to manage patients with LTCs.
• The plan will enhance the role of an NHS accredited clinical pharmacist independent prescriber to work with GPs to deliver medication/polypharmacy reviews.
• The plan will move pharmacists away from a focus purely on the dispensing of medicines to the provision of person-centred care as part of the wider healthcare team.
• Standards and specifications will have to be developed to ensure consistency of service for patients and delivery of outcomes that are person-centred.
• There will be an expansion of pharmacist prescribing skills to review medicines used to treat sexual health, drug and alcohol services and smoking cessation.
• The introduction of biopharmaceuticals and genomic research need to be developed to educate clinical pharmacists in these areas.
• There will be an integration of adult health and social care services.
• Currently in primary care, NHS Boards make arrangements with pharmacy owners for the delivery of pharmaceutical services. The pharmacist delivering these services needs to ensure that their priorities are focused on the patient above all else. Perverse incentives such as targets and bonuses based on commercial retail priorities should not be allowed to adversely affect patient care.
• The plan will introduce a framework to promote and increase mobile technology to support people to manage their medications.
• The plan will support the use of action based research, practice research and clinical research to enable the development and evaluation of pharmaceutical care.
**Patient Journey in 2020**

For me the way I look after my health has changed over the last 5 years. Last year I went into hospital after a heart attack. I had suffered for 3 years previously with angina and also more recently had problems with my breathing which had started a couple of winters ago after a chest infection.

My GP told me I had chronic obstructive airways disease (COPD) which had been caused by my years of smoking and that it could get worse if I didn’t stop smoking. I had been a smoker for over 40 years and at the age of 63 I felt too old to be breaking old habits! My GP had asked me to see the pharmacist who worked closely with my GP for a review of my breathing after a chest infection.

Before this I had only seen my pharmacist for advice for winter ailments as I was on a list of medications. The pharmacist gave me a self-management plan for my breathing and showed me how to monitor my treatment, I felt much more in control and knew I could ask for help when needed. After this one weekend I felt my chest was flaring up and after getting advice from the pharmacist started to take my antibiotics that she had prescribed as a standby. It was wonderful as normally I am ill for weeks afterwards as I normally wait until I am really poorly before I make an appointment to see my GP. After this the pharmacist provided me with support and prescribed treatment to help me stop smoking. It took me a while but she was very supportive and helped talk though all the issues that I had. Its six months since I quit and I am less breathless. My breathlessness score is better and I have not had so many chest infections.

Anyway, when I was admitted to hospital, the pharmacist gave the pharmacist in hospital a list of my tablets that I was taking. Just as well as in the shock of it all, I had forgotten the new one I had been started on. After my heart attack, I was put onto some additional medicines and the dose of others was increased. The pharmacist in the hospital had sent all my medication changes to my pharmacist who reviewed all my medication and then ran through the changes with me. I couldn’t understand why I was taking a higher strength of my cholesterol tablets and also why I needed a new tablet for my heart as my blood pressure was fine. The pharmacist working with my GP sees me every six months to manage my COPD and heart conditions and I see the GP when I need to.

They record everything on one system so the GP and pharmacist both seem to know what’s going on with my care. It seems like a great team effort.
Appendix Two - New Zealand Model

Pharmacist members of Professionals Australia have commented they are very envious of the new model of practice that starts on 1st July 2012 in New Zealand. The new practice model represents a substantial shift to a more patient centred model of care and it provides community pharmacists the opportunity to work as a member of the patient’s multi-disciplinary team.

The new funding mechanism will remove the perverse incentives related to the current model of payment for dispensing medications rather than services and act as a substantial structural incentive for practice change. Community pharmacies will receive more money for the provision of patient care services and less money for dispensing medicines.

The new service model introduces three patient categories:

**Long Term Conditions (LTC) Service** that is designed for people with medicines adherence issues and complex medicines management needs; namely those with chronic health conditions who are both high users of medications and of course at risk of medication related harm. These patients are assessed by a pharmacist for eligibility and register with a pharmacy for the service. A fee of $130 per patient per year will be paid to the pharmacy from early 2013. This capitation fee will be reviewed each year and is anticipated to increase. Pharmacists providing LTC services will be paid monthly a fee that is the sum of the LTC Service fee, a handling fee (i.e. $1.00 dispensing fee) and a transition payment (that will stop after two years).

**Specific Services** are funded separately and relate to an agreed set of additional services provided by pharmacists. These include extemporaneously compounded products, controlled drugs, aseptic and sterile manufacturing, INR monitoring, services to aged-care facilities and community residential services. The current schedule of fees applies, which vary from $5.30 to $10.60 as the dispensing fee per item of service.

**Core Services** are all those services not captured in the LTC and Specific Services schedules. It includes episodic dispensing, LTC patients after hours or away from their registered pharmacy and patients with LTCs who are adherent and do not need additional support. The fee will be $3.40 from early 2013 per patient per pharmacy when dispensing initial items only.

Transitional payments will be made to ensure pharmacies are not disadvantaged by the change to the new system. The transition payment will be calculated and paid to pharmacies as well as the new fees for the first two years of the new scheme. This will allow a reduction in dispensing volumes without a significant impact on income.
As part of the LTC requirements, pharmacists, in collaboration with their patient, the patient’s GP and other members of the multi-disciplinary team as necessary, will develop an individualised Medication Management Plan for their LTC service patients. Pharmacists will also have the responsibility for reviewing the patient’s medicines, synchronising a patient’s repeat prescriptions and provide education to the patient about their medicines.

The LTC funding arrangements give an incentive to provide services according to the patient’s needs. The model is a shift from the flat fee‐dispensing model which encourages volume dispensing and acts as an incentive to maintain the supply model rather than a service model. There has been a shift away from a reliance on the dispensing fee (currently $5.30) to a handling fee of only $1 per prescription item, plus the cost of the drug and a mark-up. A Service fee is paid to pharmacists for professional activities and services provided.

A number of changes will occur as part of this restructuring of pharmacy services. There will be the opportunity for the pharmacists to facilitate the synchronisation of dispensing where a pharmacist could align the patient’s medicine regimen to a common end date, so a patient could visit the pharmacy and prescriber once instead of multiple times. It is expected that synchronising of dispensing prescriptions will reduce medication wastage and it has been estimated this will allow pharmacists to have more time to spend consulting with their patients. Further, some form of case notes will be introduced into NZ pharmacy at a later stage designed to support good patient care.

Another difference between our countries medication supply systems is that in New Zealand, each patient registers with one pharmacy for their medication services and dispensing of medications. This gives pharmacists the motivation to provide a suite of professional services to attract patients to register with them, rather than offering a discount retail model to attract them.

It is encouraging to see pharmacists being recognised for the clinical skills they have to offer to contribute to the health team for the benefit of the patient, and gain remuneration for services rather than volume of items dispensed. This shift from the supply model to the service model should be more professionally satisfying for pharmacists.

New Zealand has embarked on a major overhaul of their pharmacy practice model, rather than maintaining a supply model with some professional services added on as an after‐thought.

What is challenging for the pharmacy sector (and the government) in Australia is how the whole pharmacy profession can best respond to the national health reforms currently under way. There is a demonstrated need for better management and coordination of care for people with chronic and multiple health conditions across all levels of health care. There is the requirement for a flexible well trained workforce that works together to provide best care to patients.

It is obvious that the continuation of the current health system is not a viable approach. The Professional Practice Incentive Program of the SCPA is a limited step in the required shift towards patient services. The financial incentives associated with this program has resulted in some pharmacies embracing some of those services in light of the tightening retail margins, but the focus of remuneration remains based on maximising the dispensing of prescriptions.
## Canadian System

<table>
<thead>
<tr>
<th>Activity</th>
<th>Details</th>
<th>Benefits</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adapting a prescription (identify drug related problem)</td>
<td>For existing prescriptions, may alter the dose, formulation, duration or regimen without prescriber consent but with patient consent and follow up with prescriber update.</td>
<td>Optimise outcomes for patient. Reduce burdens on GPs and other health professionals. Reduce employee absenteeism as result of script resolution? Cost reductions?</td>
<td>May require training for therapeutic substitution. Documentation tools and technology Patient education, monitoring and follow-up Provider notification when required.</td>
</tr>
<tr>
<td>Prescribing in an emergency (create a prescription)</td>
<td>When an immediate risk to patient’s health prescribe minimum amount to safely treat the immediate need until medical care is sought. NOT narcotics or controlled medications.</td>
<td>Immediate healthcare available to optimise therapeutic outcome. Encourage interprofessional collaboration. Reduce employee absenteeism.</td>
<td>Training. Assessment guide. Technology and documentation.</td>
</tr>
<tr>
<td>Medication by injection/imunisation</td>
<td>A qualified/authorised pharmacist may administer medication by injection for existing prescription or as needed in an emergency.</td>
<td>Better access to medication and vaccines. Reduce burden on GPs. May reduce absenteeism (vaccinations in the workplace).</td>
<td>Training Location for administer injections. Technology and documentation Educate and observe the patient after injection.</td>
</tr>
<tr>
<td>Comprehensive Medication Reviews</td>
<td>..similar to HMR and RMMRs. BUT create a Care Olan and FOLLOW UP.</td>
<td>Provides prescribers with an accurate medication history. Patient benefits from this process.</td>
<td>Train for new or advanced patient assessment skills. Documentation. Follow up as required. Initial appointment 60 minutes.</td>
</tr>
<tr>
<td>Interpret and order lab tests</td>
<td>Part of the medication management process. Pharmacist must remain competent in interpretation of lab</td>
<td>Optimise outcomes for patient (drugs and doses are appropriate) Reduce burden on</td>
<td>For monitoring drug therapy NOT for diagnostic tests. Training in interpret lab data,</td>
</tr>
<tr>
<td>Minor ailments assessment and management</td>
<td>Pharmacist assesses minor ailment and can prescribe from a defined list of medicines OR can refer to another healthcare provider.</td>
<td>Patients self manage minor ailments, efficient access to healthcare professionals and referral if needed. Allow GPs focus on more seriously ill patients. Assist with reduced employee absenteeism.</td>
<td>Develop a formulary and list of minor ailments. Pharmacist to be competent. Documentation.</td>
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<tr>
<td>Medication reconciliation (MedRec)</td>
<td>Provision and maintenance of accurate medication record for the patient.</td>
<td>Aim to prevent medication errors and adverse events, at transition points in care or with complexity of medications or change of doctors.</td>
<td>Training to take history, documentation, skills in reconciliation of patient’s medications. Document discrepancies and resolve drug related problems.</td>
</tr>
<tr>
<td>Chronic Disease Management</td>
<td>Interprofessional, collaborative approach to manage patients with chronic medical conditions.</td>
<td>Improve health outcomes &amp; optimise drug therapy outcomes, identify patient at risk and may slow disease progression. Utilise pharmacist’s drug therapy expertise. Cost savings by better management of the disease.</td>
<td>Specialised training. File care plans and medication records.</td>
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</table>
## Summary of Pharmacists’ Expanded Scope of Practice Activities across Canada

<table>
<thead>
<tr>
<th>Pharmacist Scope of Practice</th>
<th>BC</th>
<th>AB</th>
<th>SK</th>
<th>MB</th>
<th>ON</th>
<th>QC</th>
<th>NB</th>
<th>NS</th>
<th>PEI</th>
<th>NL</th>
<th>NWT</th>
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<td>Implement in Jurisdiction</td>
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<td>Pending Legislation or Regulation or Policy</td>
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<td>Not Implemented</td>
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### Details

1. QC: not specifically identified in Pharmacy Act; these scope of practice activities are enabled by means of "administrative agreements" between pharmacist & physician regulatory authorities and QC government.
2. MB: as per Continued Care Prescriptions policy.
3. QC: when authorized by a physician by means of a "collective prescription" (i.e., collaborative agreement).
4. QC: As enabled by passage of Bill 41 by the Quebec Order of Pharmacists on December 8, 2011. Regulations have not yet been modified to reflect these scope of practice activities.
5. QC: for demonstration purposes only.

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**UK System**

### Annex 1: Health challenges – how pharmacy can contribute

In addition to the usual services that pharmacies provide, including dispensing and advice on taking medicines, they may provide additional services and support to tackle some of the most pressing health challenges. These, and their likely benefits and outcomes, are set out in the table below.

<table>
<thead>
<tr>
<th>Health challenge</th>
<th>Long term impact if not addressed</th>
<th>How pharmacy can contribute</th>
<th>Likely benefits and outcomes</th>
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</thead>
<tbody>
<tr>
<td><strong>Healthy Weight</strong></td>
<td></td>
<td>• Body Mass Index (BMI) and waist circumference measurements</td>
<td>• A more health-literate population, aware of the effects of diet and physical activity on health</td>
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<tr>
<td><strong>Healthy Lives</strong></td>
<td><em>Healthy Weight</em></td>
<td>• Weight management clinics in the pharmacy or elsewhere</td>
<td>• Increased awareness of the actions that can be taken to improve health</td>
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<td>• Prescribing or patient group directions (PGDs) to enable the supply of weight reduction</td>
<td>• Improved access to a range of services aimed at improving diet and physical activity and</td>
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<td>medicines as part of an overall weight reduction strategy</td>
<td>reducing weight</td>
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<td></td>
<td>• Education, information and advice for all, including families with young children</td>
<td>• Tailored information to help specific patient groups, e.g., children</td>
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<td></td>
<td>• Outreach work in the community</td>
<td>• Contribution to improving BMI scores, with the potential to improve health overall</td>
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<td>• Exercise on prescription</td>
<td>• Reduced risk of undetected complications</td>
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<td></td>
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<td>• Recommending the use of the NHS LifeCheck service and working with users’ results in</td>
<td>• The public value of community pharmacists as local leaders in health matters</td>
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<td></td>
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<td>setting weight management goals</td>
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<td></td>
<td>• Vascular checks</td>
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<tr>
<td>Smoking</td>
<td>Smoking is set to decline and</td>
<td>• Opportunistic and brief advice/interventions for stopping smoking</td>
<td>• Successful quitters</td>
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<tr>
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<td>significant progress has been</td>
<td>• NHS stop smoking clinics, including in schools</td>
<td>• Greater awareness of the range of options to support quitting</td>
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<td>made in reducing how many people smoke. However, it is still the principal avoidable cause</td>
<td>• Availability of over-the-counter products to support quitting</td>
<td>• Potentially better health outcomes for people who quit</td>
</tr>
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<td>of premature death and ill health today.</td>
<td>• Community-based outreach</td>
<td>• Health benefits due to the reduction in secondary smoke inhalation</td>
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<td>• Supplementary prescribing of medicines that help people stop smoking</td>
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<td></td>
<td></td>
<td>• Availability of stop smoking medicines through PGDs</td>
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<tr>
<td><strong>Sexual health</strong></td>
<td>The risk of pelvic inflammatory</td>
<td>• Promotion of condom use and access to free condoms at screening and treatment sites</td>
<td>• Increased awareness of sexual health and safe sexual practices</td>
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<tr>
<td></td>
<td>disease, infertility and ectopic</td>
<td>• Prescribing or PGDs to enable the supply of medicines related to sexual health</td>
<td>• Greater understanding and availability of advice on contraception</td>
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<td></td>
<td>pregnancy will increase</td>
<td>• Availability of advice, EHC and other contraception in a secure and private environment</td>
<td>• A reduction in the rate of young people acquiring chlamydia and gonorrhoea and the number with long standing chlamydia, as reducing the risks of infertility problems</td>
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<td>Untreated infection will damage</td>
<td>• Doing an NHS Teen LifeCheck</td>
<td>• Helping reduce teenage pregnancy rates</td>
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<td></td>
<td>reproductive health.</td>
<td>• Raising awareness of HIV, chlamydia and other sexually transmitted infections, including</td>
<td>• Younger people value pharmacies as a source of trusted advice and help for their sexual health and contraception</td>
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<tr>
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<td>The cost to the NHS will be</td>
<td>HIV and the risks of re-infection</td>
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<tr>
<td></td>
<td>around £100 million a year</td>
<td>• Providing, with the help of the National Chlamydia Screening Programme, an easy-to-use</td>
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<td>(excluding in vitro fertilisation treatment costs)</td>
<td>non-invasive test kit</td>
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<td></td>
<td>The number of unintended</td>
<td>• Supplying the contraceptive pill</td>
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<td></td>
<td>pregnancies will increase</td>
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| Alcohol use            | Alcohol causes major health problems – up to 800,000 hospital admissions and 15,000 to 22,000 deaths in the UK in 2003 – as well as major social problems. Between 1991 and 2005, deaths directly attributed to alcohol almost doubled. More people die from alcohol-related causes than from breast cancer, cervical cancer and methicillin-resistant Staphylococcus aureus (MRSA) infection combined. Excessive alcohol consumption has insidious health complications because it can take a long time for life-threatening and life-lasting problems such as liver cirrhosis to become evident. For every £1 spent in treatment, the public sector saves £5 (UK Alcohol Treatment Trial Research Team 2005 – see Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT). British Medical Journal, September 2005). Further analysis within the Department of Health indicates that for every £1 spent on alcohol interventions, £1.70 is saved by the NHS. | • Healthy lifestyle advice aimed at raising awareness of the harmful effects of excess alcohol  
• Brief interventions (such as screening, assessment, NHS LifeCheck)  
• Prescribing or PGDs to enable the supply of medicines related to reducing alcohol intake  
• Blood tests to detect levels of alcohol consumption and early risks of complications developing  
• Supervised monitoring of medicines to treat alcohol withdrawal | • Enabling people to take the action they need to help themselves reduce risks and maintain healthier lifestyles  
• People manage their condition better  
• Increased awareness and identification of physical consequences and risk factors  
• Helping to reduce the incidence of alcohol-related conditions |

| An ageing population  | The greatest health costs arise in the final years of life. If healthy 75–84-year-olds become unhealthy 85-year-olds, this will increase the burden on the NHS. Around 10% of hospital admissions may result from older people not coping with or taking their medicines as intended. | • Support for staying healthy and healthy lifestyle advice  
• Support for self-care  
• Signposting to social care  
• Aligning health and social care plans  
• Focused medication reviews for the most vulnerable, e.g. to prevent falls  
• Targeted pharmaceutical care through, for example, domiciliary visiting for those on complex medicine regimes, and multidisciplinary care and case management, including closer working with community matrons and case managers  
• A dispensing and delivery service for compliance aids | • Reduced falls for people, helping to reduce secondary admissions  
• Better quality of health and increased independence for people  
• Older people using their medicines to reduce the effects of inappropriate multiple medicines  
• Health and safety aspects of medicines are all |
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<tr>
<td>Long term conditions</td>
<td></td>
<td>• Health campaigns aimed at improving awareness of the risks associated with certain LTCs</td>
<td>• Increased awareness of risks encourages positive changes in behaviour, resulting in a reduced incidence of the condition in the long term</td>
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<td></td>
<td></td>
<td>• Improving medicines-related care for people with LTCs to reduce emergency admissions</td>
<td>• Earlier detection of diseases and better control of conditions can help reduce long term complications</td>
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<td></td>
<td>• Screening services within national guidelines following UK National Screening Committee recommendations to identify those at risk of developing, or who have already developed, a condition but are unaware of it — e.g. blood pressure and diabetes</td>
<td>• Increased access to services and support for self care</td>
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<td>• Medication reviews and adherence programmes to improve medicine taking, tailored for particular conditions, including advice on new medicines, side effects, etc.</td>
<td>• Improved compliance with medicines and hence improved health outcomes</td>
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<td>• Monitoring with dedicated clinics using prescribing or PGDs to help control cholesterol for those on statins and blood pressure for those on antihypertensives</td>
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<td></td>
<td></td>
<td>• Signposting to social care information and aligning care plans</td>
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<td>• Prevention and early detection of some cancers</td>
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<td>The prevalence of LTCs is predicted to increase over the next 20 years by approximately 25% due to the effects of the ageing population. Those living with LTCs will be using services for longer. They will expect their medicines to be available promptly and to have confidence that early advice and support on medication is available before their condition causes more serious problems. Care services will face worsening pressures to support people at home and in the community.</td>
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<tr>
<td>Mental health</td>
<td>Services users and carers will not receive the support they need to benefit from medicines.</td>
<td>• Awareness and promotion of good mental health</td>
<td>• Better quality of life for people with better adherence to their medicines</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Simple mechanisms to help people understand and take their medicines as intended</td>
<td>• People with mental health problems are better able to understand and manage their own condition</td>
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<td>• Liaison with GPs and community health teams</td>
<td>• Readily available support in the community and/or closer to home</td>
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<td>• Instalment dispensing and supervised administration</td>
<td>• Improved access to drug therapy monitoring</td>
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<td>• Training for patients and carers about medicines</td>
<td>• Carers more supported in dealing with people taking medicines</td>
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<td>• Involvement in evidence-based alternatives to medicines, e.g. information about/provision of computepnsed cognitive behavioural therapy and general information about talking therapies</td>
<td>• Medicines policy issues health systems that care for people with mental health problems are discussed and resolved, a senior level</td>
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<td>• Information about local support networks, mental health helplines, etc.</td>
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<td>• Involvement in outreach to minority communities</td>
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<td>• Identification of people who may show signs of depression and referring them on appropriately</td>
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<td>• Senior leadership on medicines issues and governance in mental health trusts and ensuring that appropriate service level agreements are in place with provider organisations</td>
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<td>People with a severe mental health problem or learning disability have markedly poorer health outcomes than the rest of the population — e.g. on average people with schizophrenia die 10 years earlier.</td>
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<td>Long term impact if not addressed</td>
<td>How pharmacy can contribute</td>
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| Healthcare-associated Infections         | There will be a failure to achieve and sustain reductions in infections. | • Senior specialist antimicrobial pharmacists, primary care trust pharmacists and microbiology/infectious diseases/infection control teams lead development, implementation and monitoring of antimicrobial guidelines across the health economy  
  • Pharmacy-led ‘switch’ policies to convert patients from intravenous therapy to oral drug therapy at the earliest appropriate opportunity 
  • Supporting the appropriate use of intravenous antibiotics at home  
  • Community pharmacists and GPs work with hospital teams to align prescribing with agreed policy 
  • Pharmacy in all settings is part of the public advice and campaign network to increase public awareness of antibiotic resistance and the rational approach to infection control matters regarding, for example, MRSA and C.difficile  
  • Training junior doctors and nurses on rational antimicrobial prescribing, administration and use | • A co-ordinated, rational and cost-effective approach to antimicrobial use  
  • Reduced public demand for antibiotics in situations where they are ineffective, e.g. viral infections  
  • Reduced volume of antibiotic prescribing and rational use will help limit the emergence and spread of resistant bacteria and help reduce C.difficile rates  
  • Improved antimicrobial knowledge and skills in medical and nursing teams  
  • Improved knowledge of the rational use of antibiotics by the public |

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| Medication-related harm                  | It is estimated that preventable harm from medicines could cost the NHS more than £750 million each year in England. | • Chief pharmacists lead and promote safer medication practices  
  • Community pharmacists work with GP and nurse prescribers on safe and rational prescribing  
  • Training the whole trainee and qualified healthcare team on safe medicines use  
  • Working with patients to help understanding of medicines  
  • Medicines use reviews, clinical screening of prescriptions and identification of adverse drug events  
  • Use of automation, auto-identification (bar-coding) and IT to provide opportunities for better medicines safety  
  • Working every day with doctors, nurses, etc. to reduce dosage and administration errors  
  • Ensuring that medicines are not omitted unnecessarily  
  • Ensuring that medication allergies are clearly documented  
  • Helping other professionals, e.g. those working with children, to calculate doses, safely administer medicines, etc. | • Right medicine, right patient, right dose, right time  
  • Reductions in pre-medicines-related morbidity and mortality  
  • Fewer hospital admissions directly related to medication problem  
  • Fewer dosage errors and omitted doses, etc  
  • New technologies reduce mis-identification  
  • Reduced length of stay and associated co-hospital inpatients |
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<tr>
<td><strong>Drug misuse-related harm</strong>&lt;br&gt;It is estimated that there are 332,000 problematic drug users (crack and heroin) in England. Among current injecting drug users, 42% are estimated to have contracted hepatitis C. There is an increasing number of crack/cocaine users and steroid misusers.</td>
<td>Drug misuse results in harm to the individual and to the wider community. Rates of blood-borne viruses will rise.</td>
<td>• Needle exchange services&lt;br&gt;• Supervised administration of drug therapies&lt;br&gt;• Wound management&lt;br&gt;• Advice on safer injecting and harm reduction measures&lt;br&gt;• Referral to other healthcare professionals as appropriate&lt;br&gt;• Immunisation for and advice on blood-borne viruses&lt;br&gt;• Information and signposting to treatment services&lt;br&gt;• Support to clients to prevent them falling out of treatment&lt;br&gt;• Use of independent/supplementary prescribing and PGDs, as appropriate&lt;br&gt;• Wider and more flexible access through longer opening hours and weekend availability&lt;br&gt;• Information and support on health issues, other than those that are specifically related to the client's addiction</td>
<td>• Reduced risks to the individual user and wider social network – families, friends and communities&lt;br&gt;• Reduction in health costs associated with wound infections and blood-borne viruses&lt;br&gt;• Increases in the numbers of drug misusers in treatment&lt;br&gt;• Reductions in the numbers in relapse&lt;br&gt;• Support for increased retention in treatment&lt;br&gt;• Improved communications between treatment providers participating in the clients’ care plans</td>
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<td><strong>Health and work</strong>&lt;br&gt;Around 150 million working days were lost to sickness absence in 2006, at an estimated cost to the economy of £11.2 billion. Common mental health problems, musculoskeletal disorders and cardio-respiratory disease account for about two-thirds of sickness absence, long term incapacity and early retirement. There is strong evidence that work is generally good for physical and mental health and wellbeing. While temporary absence from work can be therapeutic, worklessness can be detrimental to health and wellbeing and lead to health inequalities.</td>
<td>The annual economic costs of sickness absence and worklessness associated with working age ill health are estimated to be over £86 billion. If current trends continue, this is expected to rise to over £92 billion by 2025. For many people, short term sickness absence can progress to long term sickness absence and worklessness. Over 250,000 people move from work or a prolonged period of sickness absence to incapacity benefits each year. The prevalence of psychiatric disorders among children whose parents have never worked is almost double that among children with parents in low-skilled posts and five times greater than that among children whose parents are in occupational professions.</td>
<td>• Raising awareness of the general benefits of work on health, e.g. through public health campaigns&lt;br&gt;• Advice when handing out dispensed prescriptions or selling products, e.g. for back pain or depression&lt;br&gt;• Supporting people in better self care, especially for common causes of sickness absence, e.g. back pain and stress&lt;br&gt;• Outreach work with local employers, whose needs might vary depending on the nature of their business&lt;br&gt;• Pharmacies may also wish to consider modelling themselves as healthy workplace, perhaps even as local exemplars</td>
<td>• Early intervention in sickness absence helps to prevent short term sickness absence from progressing to long term sickness absence, worklessness and poverty&lt;br&gt;• Reduction in health costs associated with sickness absence&lt;br&gt;• Reduction in the cost to the economy associated with sickness absence and worklessness&lt;br&gt;• Better health outcomes for working-age people and their families, and improved prospects for children</td>
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