Submission by

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27 February 2009
**Contents**

INTRODUCTION .........................................................................................................................3

FORMAT SUMMARY .....................................................................................................................4

EDITORIAL SUMMARY OF KEY POINTS ..................................................................................6

1. HEALTH CARE COSTS AND SAVINGS .................................................................................9

2. APPLICATION OF PHARMACIST SKILLS ..........................................................................12

3. PAYMENT FOR PROFESSIONAL SERVICES .......................................................................22

4. RECOMMENDATIONS AND INNOVATIONS .......................................................................29

5. ISSUES OF CONCERN ..........................................................................................................34

6. AUSPHARM POLL RESULTS ..............................................................................................40

References ................................................................................................................................42
INTRODUCTION

AusPharmList is an internet based pharmacy discussion group which provides a forum for discussion and debate of a variety of pharmacy practice and drug therapy related issues. It is one of the largest professional interactive internet forums in Australia, with 6,500 registered members. There are over 90 weekly "posts" on a variety of topics, many of which generate spirited and robust exchanges, expressing a wide spectrum of differing viewpoints, reflecting the individual experiences of the subscribers.

Importantly, as an interactive website forum, AusPharmList touches base with, and also provides a unique collegiate function for, pharmacists at the "coalface" as they share with colleagues their day-to-day experiences and concerns involving questions of legality, work stresses, ethics and accepted best practice, at a very personal level. AusPharmList therefore serves as a powerful vehicle for cross-pollination of pharmacists' issues and concerns.

Since 2002, there have been over 300 AusPharmList Polls, canvassing pharmacists' views on a diverse range of issues. It is clear that many of the issues of concern to individual pharmacists revolve around the need for sufficient resources to enable more effective utilisation of the expertise of pharmacists, as the experts in medication use, within the community, so as to assist in producing some of the Primary Health Care outcomes identified by the Discussion Paper.

In this submission, we have distilled and collated some of the relevant views and concerns of our subscribers as they relate to the plans to improve the delivery of Primary Health Care in this country.

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AusPharm would like to thank John Gibson, Ron Batagol and Debbie Rigby in particular for their help in preparing this submission.

Mark Dunn
Publisher/Editor
AusPharm.net.au

Feb 27 2009
FORMAT SUMMARY

This Submission has been prepared from posts made to AusPharmList in the period December 2008 to February 2009 and from the results of a series of polls conducted during the period June 2008 to February 2009.

It is comprised primarily of posts that relate to primary health care issues that affect pharmacy and, in particular, community pharmacy. It also includes posts relating to issues that impinge on community pharmacies ability to provide the range and standard of professional services it would wish.

Apart from brief explanatory notes in a few places, the presentation is in the words of the AusPharm subscribers themselves, leaving the posts to ‘do the talking’.

To ensure authenticity, no attempt has been made to make grammatical or other corrections to posts to improve the presentation. They are as they have been recorded by subscribers on what is an interactive forum where open debate and free flowing communication is encouraged.

All posts have been identified by the initials of the subscriber who made the post and the date on which the post was made. A title has been given to each post or group of related posts to facilitate easy identification of the subject matter of the post for readers. In many cases, full posts have been presented. In other cases extracts from posts have been included (but quoted verbatim) to convey the message of the subscriber.

Where references to original publications have been included by subscribers, these can be found in the References section.

The Submission has been presented in six sections.

Health Care Costs and Savings includes relevant information that has been posted on the cost and incidence of chronic disease in the community, strategies to reduce medication incidents (and therefore the associated cost) and estimated savings made as a result of intervention with S2 and S3 medication in community pharmacies.

Application of Pharmacist Skills describes a wide range of situations where pharmacists believe their skills can be applied to the advantage of the public. This section demonstrates the belief by pharmacists that they have the potential to expand their professional services much more widely, both in community pharmacies and in the wider community.

Payment for Professional Services describes a number of alternatives through which pharmacists believe they could or should be paid for the provision of these services. This section includes frequent comment by pharmacists on their frustration that current remuneration systems in many cases prevent them being able to fully and effectively apply the skills that they possess for the benefit of their clients or patients.

Recommendations and Innovations includes posts that describe situations where pharmacists have used their initiative to develop innovative and, in some cases, new professional services that will benefit the community. It also includes posts that make
recommendations for action that they believe could improve professional services provided by pharmacists.

Issues of Concern describes situations where pharmacists feel frustrated, disappointed and sometimes angry about situations that impinge on their ability to provide the standards of service that they would like. Posts are also included that demonstrate the frustration that pharmacists feel when they find some of their colleagues not performing to expected standards. Other posts describe what some pharmacists see as barriers to change that they believe, if removed, would be advantageous to the profession and improve quality use of medication. Also included are posts that demonstrate the sometimes heavy demands on a pharmacist’s time (unpaid) needed to meet their professional obligations in relation to the management and control of restricted substances. Together these posts indicate something of the frustrations that some pharmacists feel that their profession is not functioning more effectively and that their professional services are not more widely available.

The results of 10 polls held between June 2008 and February 2009 are presented. Whilst they have obvious statistical limitations, they nevertheless provide a picture that demonstrates reason for concern at the difficult environment in which pharmacy proprietors and their staff work and possible effects on their ability to provide professional and other services.
EDITORIAL SUMMARY OF KEY POINTS

In this section the key points raised by AusPharmlisters in their posts are summarised. Summaries are based on the Sections in the Submission.

Health Care Costs and Savings

- The safety and quality use of medicines in chronic disease should be a high priority in the development of the National Primary Health Care Strategy
- This has seemingly been overlooked in the past
- Data is presented on the cost of chronic disease, medication use and medication misadventure in Australia and some other countries
- Data is presented on the incidence of chronic disease and associated risk factors and the annual cost to the economy of chronic disease in Australia
- Innovative, evidence based programs for pharmacists are needed to ensure safety and quality use of medication on every step along the medication management pathway
- Strategies that have been shown to reduce medication incidents are described
- The results of a study describing savings from interventions in Australian pharmacies in the use of S2 and S3 medication are presented, including high significance interventions that avert emergency medical attention or serious harm or that are potentially life saving

Application of Pharmacist Skills

- Pharmacists and Pharmacy have received little consideration in the recently released National Health and Hospitals Reform Commission report. Development of the National Primary Health Care Strategy provides an opportunity to redress this situation
- Pharmacists need to be positioned where their cognitive skills can be recognised and used to contribute to optimum Quality Use of Medicine
- Pharmacists need to be able to apply their skills in environments outside community pharmacies
- Roles for pharmacists in stop smoking and weight loss management programs are proposed. Pharmacists could be funded to administer incentive programs to support patients
- Greater input by pharmacists into medication adherence is needed.
- The National Primary Health Care Strategy provides an opportunity to identify strategies where pharmacists can participate as members of health care teams in providing preventive care in areas such as weight loss, smoking cessation and community follow up of patients discharged from hospitals
- The creation of a Private Practitioner Pharmacist role is proposed where pharmacists can work independently in the community alongside medical, nursing and other allied health professionals
- A proposal is made were pharmacists could work in General Practitioner surgeries where patients are referred to the pharmacist for a consideration of medication related problems.
- Enabling pharmacists to work in health care environments outside community pharmacies would create a new career pathway for pharmacists
As health professionals, pharmacists should be able to access direct payment for services from Medicare.

Forward Dispensing is described as a model where community pharmacists can counsel every patient and improve medication use in a sustainable and economically viable manner.

Payment for Professional Services

- Models are needed where some first contact primary care services (management of minor ailments) provided in community pharmacies are paid for rather than all being provided free.
- Medicare payment to pharmacists for triaging, health advice and referrals to medical practitioners in community pharmacies are recommended.
- Medicare Provider Numbers are recommended for pharmacists providing professional services either in community pharmacies or in the wider community.
- Two categories of pharmacist are proposed; one where an appointment is made for a consultation and a fee charged; the other to check to ensure the correct medication is supplied.
- Lack of time and non-availability to the public because of cost considerations are identified as barriers to pharmacists expanding their professional activities.
- Payment to pharmacists for professional services is described as having been given a very low priority in the past.
- A model in which a pharmacist is paid directly by the public for a professional service is described.
- Advice from pharmacists is described as invaluable but, because of a lack of recognition and remuneration, services cannot be provided.
- It is proposed that allowing pharmacists to bulk bill preventive services would reduce total cost to government and improve health outcomes.

Recommendations and Innovations

- A wide range of professional services are described that would facilitate the full utilisation of pharmacist skills and lead to improvements in quality use of medicine in primary care settings.
- The inclusion of pharmacists as members of GP Boards of Divisions of General Practice is recommended as being a beneficial health care initiative.
- A new online software program that would enable the systematised implementation of medication related programs in community pharmacies is recommended.
- An extensive range of professional services being delivered by a pharmacist to remote indigenous communities is described and recommended for expansion.

Issues of Concern

- A range of issues that impinge on the ability of community pharmacists’ to provide appropriate professional services are described.
• The failure of the community pharmacy sector to adequately document the range and value of its professional services in the past
• The lack of support from representative pharmacy organisations for the expansion of pharmacy services outside community pharmacies
• The difficulties encountered by pharmacists in seeking to control multiple purchases of S2 and S3 medication intended for illicit use
• Difficulty in monitoring the purchase of medication where its use could be deleterious to the patient
• Poor standards of practice by some community pharmacists that reflects badly on the profession
• The non-funding by government agencies of close-control distribution of prescription medication.

Auspharm Poll Results

• The results of 10 polls taken on the Auspharm website between June 2008 and February 2009 that looked at various aspects of community pharmacy practice are described.
• Results indicate that community pharmacists are experiencing significant difficulties in maintaining professional standards in their difficult work environment
• Some pharmacists are not satisfied with the status quo in relation to the provision of professional services and have serious concerns about the future direction of the profession
1. HEALTH CARE COSTS AND SAVINGS

1.1 CHRONIC DISEASE AND INAPPROPRIATE MEDICATION USE

D.R. (18.2.09)

Consider these points - they are a timely reminder of the cost of chronic disease and inappropriate medication use to both the community and economy. The safety and quality use of medicines should be a high priority in these discussions - but has seemingly been overlooked or is the problem too hard to fix?

- in 2005–06, total expenditure on medications in Australia was $11,501 million
- medication-related adverse events are associated with about 10% of hospital separations
- in 1999 it was estimated that at least 80,000 medication-related hospital admission occur, with between 32 and 69% of these hospitalisations considered avoidable
- in 2002 it was estimated that around 140,000 hospital admissions each year were associated with problems with the use of medicines
- ADRs are acknowledged as a major health problem - in older people medication side effects are main cause of disability in 2% of older people
- A substantial proportion of the ADRs leading to hospitalisation are considered preventable as they are caused by inappropriately prescribed medications
- inappropriate use of medicines in Australia costing approximately $380 million per year in the public hospital system alone
- over 21% of the Australian veterans are dispensed at least one potentially inappropriate medicine
- Over 80% of GP visits result in a prescription for a medicine - the 30 most often prescribed accounted for 44.3% of the total
- Chronic problems account for more than a third (34.6%) of all problems managed by GPs
- Comorbid congestive cardiac failure, peripheral vascular, chronic pulmonary, rheumatological, hepatic, renal, and malignant diseases, and diabetes are the comorbid conditions most likely to predict readmission to hospital for ADRs
- 41% of Australian children have a long-term health condition, most commonly asthma (12%), hayfever and allergic rhinitis (8%)
- Diabetes is becoming more common—prevalence at least doubling in the past two decades
- In 2006–07, about one in nine of all prescriptions under the PBS/RPBS were for a mental health-related medication

We need innovative, evidence-based programs for pharmacists to ensure safety and quality in every step of the medication management pathway - from prescribing, dispensing, medication review, reconciliation, continuum of care, disease state management, chronic condition self-management, disease prevention and health promotion.
1.2 CHRONIC DISEASE AND ASSOCIATED RISK FACTORS

D.R. (18.2.09)

The 2006 AIHW report on Chronic Disease and Associated Risk Factors in Australia showed:

- Chronic diseases are common: in 2004–05, 77% of Australians had at least one long-term condition; common were asthma (10.0% of the total population), osteoarthritis (7.9%), depression (5.3%) and diabetes (3.5%).

- Chronic diseases can be a problem at all ages: almost 10% of children 0–14 years had three or more long-term conditions; this figure increased to more than 80% for those aged 65 years and over.

- Many people are at risk of developing chronic diseases: for example, 54% of adult Australians are either overweight or obese.

- Chronic diseases are a drain on the health system: in 2000–01 they accounted for nearly 70% of the total health expenditure that can be allocated to diseases.

A recent AIHW report provided a conservative estimate of the annual cost to the Australian economy of chronic disease in terms of decreased participation in full-time and part-time employment, and lost participation due to absenteeism for persons (aged 25-64 years) who reported having a chronic disease, and loss to the labour force due to death from chronic disease:

- people with chronic disease were 60% more likely to not participate in the labour force, were less likely to be employed full-time, and more likely to be unemployed, than those without chronic disease

- Of the total loss in full-time employment, 40% was associated with arthritis, approximately 25% with depression, and around 10% each with asthma and chronic obstructive pulmonary disease

- overall loss to the workforce associated with the chronic diseases assessed here, amounts to around half a million person-years

- Older people were more likely to have chronic disease than younger people (54% of 55-64 year olds compared with 21% of 25-34 year olds)

- about 33% of approximately 10.5 million Australians aged 25-64 years reported at least one of the following chronic diseases in 2004-05: arthritis, asthma, coronary heart disease, chronic obstructive pulmonary disease, depression, diabetes, osteoporosis or cerebrovascular disease (stroke). The most commonly reported chronic diseases were arthritis, asthma and depression

- Arthritis, asthma and depression were associated with 76% of the total loss due to days away from work (29% associated with depression, 24% with arthritis and 23% with asthma)
1.3 STRATEGIES TO REDUCE MEDICATION INCIDENTS

D.R. (18.2.09)

Strategies that have been shown to reduce medication incidents include:\(^4\)

- use of computerised prescribing with clinical decision-support systems by doctors — information about medicines for health care providers on-line or in prescribing/dispensing software.
- Computerised adverse drug event alerts — these hold information about the patient’s medical record and medication record, and automatically signal the presence or possibility of an adverse drug event when a medicine is prescribed.
- Individual patient medication supply in hospitals — medicines are labeled, supplied and stored for each individual patient, reducing the risk of wrong medicine or wrong dose.
- Clinical pharmacy services — pharmacists in hospitals can support systems to reduce medication incidents, through patient and staff education, monitoring and medication review.
- Transfer of information between hospital and community settings — complete list of current medications held by the patient and better transfer of information between hospital and community health professionals.
- Community based medication management services and case conferencing — assisting patients considered at high risk of medication-related problems through review of their prescribed, over-the-counter and complementary medicines, and discussion of their overall health care.
- Discharge medication management services — range of services for people at risk of medication incidents, including discharge and medication summaries to patients and health care providers.

1.4 SAVINGS OF $2.61B PER ANNUM WITH S2 & S3 INTERVENTIONS

A.R (23.2.09)

Given these discussions, 'listers may be interested to know of a study that was conducted as part of the 3rd Agreement R&D Program, which evaluated both the clinical and economic benefits of pharmacy interventions for non-prescription medicines. The report (from 2005) is entitled: A Cost-Benefit Analysis of Pharmacist Only (S3) and Pharmacy Medicines (S2) and Risk-Based Evaluation of the Standards

The study estimated that Australian pharmacies perform 485,912 interventions per annum in the process of dealing with non-prescription medicines, with 101,324 of these being high significance interventions (averting emergency medical attention, serious harm or potentially life-saving), and an estimate of the net benefit of these interventions being $2.61B per annum.

The full report is available here:
2. APPLICATION OF PHARMACIST SKILLS

2.1 AN OPPORTUNITY FOR PHARMACISTS

D.R. (18.2.09)
The National Health and Hospitals Reform Commission details a long-term health reform plan. Pharmacists and pharmacy receive little mention in this report. The current discussion on the National Primary Health Care Strategy discussion paper provides an opportunity to redress this.

It provides an opportunity for pharmacists, regardless of models of care, to put their hand up to prevent medication-related problems and hospital admissions and help people better manage chronic disease, including programs to assist patient self-management and improve adherence.

2.2 RECOGNITION OF COGNITIVE SKILLS

R.M. (18.2.09)

Lets not argue about supply - a machine can do that - but let’s push for the cognitive skills to be recognised.

We should be trying to find ways pharmacists can be in it - not reasons to keep them out where they are now - away from the real action.

My thesis is that pharmacists be positioned where they can contribute to optimum QUM - that has to be in the PHC (Primary Health Care) team in a super clinic.

The money is there to improve QUM - it is just distributed the wrong way.

$1 billion a year goes to pharmacies in dispensing fees - and yet what are we getting apart from a supply system that DHL/Ipec or TNT could do.

2.3 PROVIDING SKILLS OUTSIDE PHARMACIES

A.R. (18.2.09)

The Pharmacy e-News titled their article with “Profession split on Clinics”. No it’s not, it is the body representing pharmacy owners having a different view to the body representing the professional interests of pharmacists and of pharmacy. And if we all have the one view (i.e. that of the guild) we would forever be seen only ever as a supplier and paid on number of medications supplied no matter what other little programs were developed. It is the plurality of views of professionals that will forward the profession, not locking away pharmacy in a building with supply as the mainstay. The retail pharmacy system offers value to the Australian public. So much so that a private company thinks they can package up a lot of what we do, have it provided by nurses and have it paid for. Unfortunately I believe that for pharmacists to be recognised as having these skills we need to be able to perform them outside of pharmacies. In numbers. To do this we need
to ensure the Pharmacy Guild is not representing the profession to government by default.

Recent comments from the PSA implied to me they would follow the Guild line so I welcome Shane Jackson’s comments that “PSA believes that enhanced pharmacy services should ideally be accessible to the public from within the proposed Comprehensive Primary Health Care Centres”.

2.4 PHARMACISTS AND SMOKING CESSATION PROGRAMS

D.R. (11.2.09)

A number of articles were published in Archives of Internal Medicine this week on smoking and weight loss management that highlight roles for pharmacists in these areas.

See [http://archinte.ama-assn.org/cgi/content/full/169/3/230](http://archinte.ama-assn.org/cgi/content/full/169/3/230)

Obesity and smoking are the 2 leading preventable causes of death. Evidence based treatments for smoking cessation and weight loss have been well established and validated. Despite this, motivation and support is often lacking in primary health care. The recent debate about pharmacy weight loss programs has highlighted the need for greater training, education and credentialing for these services.

With limited health care dollars, better targeting of strategies is needed. The Archives papers suggest a window of opportunity for secondary prevention is when patients are diagnosed with stroke, lung disease, heart disease, or diabetes - patients are more likely to quit smoking after receiving these diagnoses.

Another paper provides evidence that trained GPs plus cost-free NRT or bupropion is effective in smoking cessation. Perhaps the role of assessing, advising, agreeing on set goals, assisting the patient with support and arranging follow-up could be done by trained community pharmacists.

Another paper in the Annals of Pharmacotherapy ([http://www.theannals.com/cgi/content/abstract/aph.1L556v1](http://www.theannals.com/cgi/content/abstract/aph.1L556v1)) this week provided evidence for pharmacist-delivered smoking cessation programs. The rate of abstinence after 6 months was more than double in the pharmacist intervention group compared with standard 5-10 minute telephone support.

2.5 PHARMACISTS AND SMOKING CESSATION PROGRAMS

D.R. (16.2.09)

An article in the New Engl J Med ([http://content.nejm.org/cgi/content/short/360/7/699](http://content.nejm.org/cgi/content/short/360/7/699)) this week showed significantly higher abstinence rates at six months for smokers who received financial incentives at progressive stages compared with those who received information on cessation programs only. Rewards were paid for reaching certain goals (consistent with health behaviour change principles) - $100 for completion of smoking
cessation program, $250 for confirmed abstinence 6 months after quit date and $400 for confirmed abstinence after one year. People who completed the cessation program were more than twice as likely to quit smoking if they received the cash rewards (46.3% vs 20.8%).

This research provides ideas for feedback to the NPHC discussion paper. The management of these incentives could be done through community pharmacy, in conjunction with our professional support. Pharmacists could be funded to administer the program as well as provide funded programs to support patients. I like the idea of progressive payments - keeps people coming back to the pharmacy for discussions on goal setting and outcomes.

Hence the need for generic trained and credentialed pharmacists as opposed to product-based training and ad hoc support. Evidence for financial incentives for weight loss is limited, but an article in JAMA in 2008 http://jama.ama-assn.org/cgi/content/short/300/22/2631 demonstrated that significant weight loss over a 16 weeks intervention was not sustained - most likely due to the short follow-up and insufficient rewards.

2.6 IMPROVING MEDICATION ADHERENCE

D.R. (16.2.09)

The other area relevant to this element of the discussion paper is in medication adherence or persistence. Literature suggests 30 to 50% of medications are not taken as intended. This is especially true with long-term medications for chronic diseases. Pharmacists need to take greater responsibility in improving this situation.

Until the recent introduction of the Guild's MedsIndex, community pharmacy has not been focussed on influencing adherence. MedsIndex and the new Mirixa programs are only tools or prompts; therefore we need greater input by pharmacists, again with further training and skills development in this area.

The UK organisation NICE has just released a paper (http://www.nice.org.uk/Guidance/CG76) which is worth considering for ideas on how to improve medication adherence and the vital role pharmacists can and should play.

2.7 PREVENTIVE CARE OPPORTUNITIES

R.B. (18.2.09)

It seems to me that herein [The National Primary Health Care Strategy] lies the perfect opportunity to identify services and needs that pharmacists are already assisting patients with, (usually for free!), and to suggest ways in which the pharmacist input could be improved, carried out in conjunction with others members of the Health Care Team, and thereby incorporated (and resourced!) within the Primary Health Care Strategy.

Two or three examples immediately come to mind.

1. Low carb diet products for weight loss, and the (currently very contentious) role that
pharmacists play in selling and advocating these products and the programmes and "add-ons" that go with these sales. Now, as is well known, these diets were originally designed for short-term use in the inpatient hospital setting, with close monitoring of important patient parameters, under medical supervision, since the experts in the field say that these patients, by definition at in the at-risk group, with respect to metabolic and medical complications.

Given that there is concern at the National level at the overall increase in obesity, with all its potential health risks, why not suggest that these products be given under a Nationally-funded preventive medicine Obesity Program, with strictly-defined entry criteria, co-ordinated by GPs under such a Program, who would be responsible for monitoring the patients, again under strictly-defined criteria, with specific roles assigned to pharmacists. These could include a consultative and GP referral role for patients meeting the entry criteria, supply of food products, counselling and assisting patients to self-monitor their progress.

2. Smoking Cessation Programs. In principle, similar to above, with pharmacist playing a well-defined consultative and referral role and a supply and (funded!) counselling role to enrolled patients.

3. Pharmacist involvement in community follow-up of patients discharged from hospital following a cardiovascular event, again, as part of a GP co-ordinated and funded preventive medicine program.

One would think that most of these types of initiatives could be covered under one or another of the Preventive Medicine Initiatives that, at least philosophically, Governments and Ministers have paid lip-service to wanting to set up and run.

2.8 TRANSFERRING TO A SERVICE-ORIENTED ROLE

D.R. (11.2.09)

As the pharmacy profession transforms from a supply of medicines culture centred on dispensing to a service-orientated role as part of the primary health care team delivering patient-centred care, it is important that significant input is provided to Govt discussion papers such as this [National Primary Health Care Discussion Paper] Pharmacists are critical to optimal medication management through our roles along the medication management pathway - from the decision to prescribe, dispense, distribute, administer, and monitor. This initiative represents a challenge and an opportunity for pharmacists to expand their traditional roles in hospitals and community pharmacies to integrated health care delivery.

In my opinion, the focus of the profession's response to this whole discussion paper should be on what pharmacists can contribute to the safety and quality use of medicines. We need to highlight the role we currently play in primary health care, mainly through community pharmacy. But also look to emerging models such as Robbo's remote pharmacy service as well as suggesting roles for pharmacists in chronic condition self-management, health education, preventive health and so on.

Question: What can pharmacists do to improve this situation?
Quality use of medicines is best achieved at the point of decision-making ie in consultation with the patient and prescribers.

Some dot point strategies that others may like to comment on include:

- expand existing pharmacist services such as HMRs and RMMRs to enable access in remote, aboriginal and CALD populations (including greater use of technology e.g. telepharmacy) through greater flexibility of rules, better targeting of high-risk patients with evidence-based triggers, direct payment to pharmacists conducting the service, pragmatic referral process (eg AHW, community nurse, medical specialist referral)

- non-medical prescribing in remote areas

- expand recent availability of Aust Gov Translating and Interpreting Service (TIS) to all pharmacists - not just community pharmacies.

- active role in educating and empowering patients in chronic condition self-management
- allowing patients to take greater responsibility in their health management will alleviate to some degree workforce shortage issues (especially GPs).

I’m sure there are many other ways pharmacists can contribute to equitable access to primary health care.

2.9 A ONCE IN A GENERATION OPPORTUNITY

R.B. (28.1.09)

JGs Feature Article The Private Practitioner Pharmacist - A Third Career Path (27/1/09) was an excellent summary of the absolutely unique window of opportunity for our profession that has become available through the forthcoming National Primary Health Care Strategy, and he hits the nail on the head when he describes this Government initiative as a "once in a generation opportunity to move pharmacy forward to a new level of professionalism ."

It is important to raise issue such as this via Auspharmlist, because, in recent years, the internet forum of Auspharmlist, due to its ease of on-line access and participation, has become a unique, easily-accessible and very powerful and effective focus of regular exchange of opinion and information amongst a large number of Australian pharmacists. Furthermore, "movers and shakers" at all levels, seem to be acutely aware when a "hot topic" is put out for discussion on Auspharmlist, and often respond surprisingly quickly by way of explanation or clarification of various issues!

JGs draft list of professional services, as well as some of the other services in his expanded list of "potential roles", cover a large proportion of the professional services that pharmacists could provide, if a viable and sustainable mechanism of funding recognition and reimbursement were to be established.
2.10 THE PRIVATE PRACTITIONER PHARMACIST – A THIRD CAREER PATH
(Feature Article)

J.G. (27.1.09)

The [National Primary Health Care Strategy](#) currently being developed by the Federal Government offers an unequalled opportunity for pharmacists to be recognised as key primary health care providers, along with doctors, nurses, physiotherapists, occupational therapists and other allied health practitioners, and to receive payment for same.

The creation of a Private Practitioner Pharmacist role offers the prospect of the establishment of a third career path for pharmacists.

This would entail pharmacists working independently in the community, providing specified professional (non-dispensing) services directly to GP surgeries, medical clinics, care facilities and the like.

I have developed a draft list of services that could potentially be provided by Private Practitioner Pharmacists.

- medication reconciliation
- compliance assessment and counselling
- patient education
- drug information services
- adverse drug reaction management
- Chronic Disease Management Team member (activities to be defined)
- collaborative medication management (pharmacist prescribing)
- Hospital in the Home service support
- Home Medicines Reviews
- Residential Medication Management Reviews
- rural and remote services (activities to be defined)
- specialist medication services
- medication use research

Private Practitioner Pharmacists could also provide specified professional services to community pharmacies on a contract basis, thus increasing the likelihood of individual pharmacies providing professional services that they might not otherwise be able to provide.

2.11 A PHARMACY RENAISSANCE

A.V. (28.1.09)

With the seemingly inevitable entry of supermarkets and pressure to decrease margins from the government, I do believe that such a concept [Private Practitioner Pharmacist] may very well save pharmacy in Australia IF and only if implemented well. Maybe we could see a new renaissance for the world of pharmacy?
I will be looking forward to seeing any new developments arising from this.

2.12 EMBRACING CHANGE - WORKING IN GP SURGERIES

D.R. (2.2.09)

Pharmacists are gradually embracing changing professional roles. The services such as HMRs, RMMRs, DMAS, PAMS, DAAs etc funding under the Community Pharmacy Agreements are driving the change to transform the pharmacy profession from a product-oriented to a patient-oriented profession involved in multidisciplinary care.

However many factors impair the adoption of new roles, including the lack of consensus regarding the profession's goals, resistance to broadening responsibilities beyond dispensing roles and lack of confidence/competence.

Your list (J.G.) of professional services is broad and I'm sure others can add to it.

But I also envisage a role for pharmacists in primary healthcare doing what we are qualified to do i.e. medication management experts - using existing knowledge and skills, rather than defined services which require further education, skills development and credentialing.

Imagine having a room in a GP surgery, equipped with drug information and patient care resources and access the patient's medical history. A GP refers a patient, suspected or known to have drug-related problems, perhaps requires some education or brief intervention to change behaviour or improve medication adherence - whatever issue is identified by the GP or patient. The "service" is not defined or limited by business rules - it is whatever the patient needs to achieve optimal benefit from their medicines.

There would be a greater emphasis on improving patient outcomes, reaching clinical targets and goals, solving medication-related problems, improving medication and lifestyle adherence and quality of life. It would occur as part of a team (including the patient's community pharmacy) and collaboration actively provided.

This can be compared to the successful integration of nurses into GP practices.

If pharmacists are to be considered part of a health care team in primary healthcare, they will need to adopt the essential attitudes required - responsibility, accessibility, confidentiality and most importantly patient orientation.

We need a well-articulated vision and voice to fully integrate pharmacists in the health care team.

2.13 AN OPPORTUNITY FOR CHANGE

J.G. (3.2.09)

When ward pharmacy started in the 1970s, pharmacists first went to the wards as 'drug housekeepers'. It involved checking medication charts (or drug charts as they were
called at the time), to see what medications were needed. There was no thought at that
time of providing the extensive clinical services that we know of today. They hadn’t even
been thought of.

It was being there, on the ward, that opened our eyes to what the possibilities were. By
our being on site, doctors, nurses and others had immediate access to us and started
asking all sorts of medication related questions, some which we could answer and some
which we couldn’t. This led to us going to the pharmacy schools and asking for the
courses that could give us the knowledge that we needed. So post graduate education
was born.

The same thing would happen if pharmacists went into GP surgeries now. Once there, it
is certain that doctor, nurses and others would start using the resource and we would
see the service develop and expand as it did on the wards in hospitals. It would create a
new career path for pharmacists.

2.14 FORGING A NEW PATHWAY – AND THE NEED FOR PAYMENT

C.W. (28.1.09)

It is heartening to hear another with similar views to my own [see Private Practitioner
Pharmacist – a Third Career Path]. As an independent pharmacist it can be a struggle
when excluded from access to Medicare direct payment. The RMMR process is so much
better for payment than invoicing & waiting for a third party to pass on the payment.

Unfortunately many of our profession see us as an ‘elitist' group, but we are forging a
new pathway & opening up the way for our upcoming graduates to have more choice in
career. Pharmacy is such a great career and will only continue to be a great career if we
can move with the times to meet the community needs.

We are all pharmacists, but choose to practice in different areas. Really no different to
any other profession and why should we be the only ‘other health professional' not able
to access direct payment for service from Medicare? It is not about them & us, but simply
allowing access to our expertise in the most efficient & effective manor.

2.15 FORWARD DISPENSING AND QUALITY USE OF MEDICINES

Posts by PH (30.1.09), PB (2.2.09) and PA (9.2.09) demonstrate the value and viability
of forward dispensing as a model for providing quality use of medicines.

P.H. (30.1.09)

There has been a lot of discussion of late on the subject of expanding professional
services and it set me wondering how many pharmacies will be able to properly and
professionally handle patient/disease state management. I suppose the answer is “some
will and some won’t. Those which won’t include the discounters, those who stack
specials baskets by the front door, and those whose pharmacies look more like toy
shops or gift shops. The first requisite is to provide an atmosphere which screams the
message “this is a medicines and advice shop”.
The next thing is to install a system which allows the pharmacist to counsel EVERY patient, not those who the pharmacist thinks needs counselling; and not to wait for the patient to ask for advice (they rarely do). One such system is “forward dispensing” – and for those of you who are ideologically opposed to this idea please read on to the bottom line.

After attending the 5-day seminar given in 1998 by 3 American pharmacists (Hepner et al?) I set up “forward dispensing” and it really was quite simple. I removed the back counter and replaced it with a desk which had a chair on each side. When I told some colleagues what I was planning they all told me it would never work. “Customers are not used to sitting down in pharmacies, they just won’t do it”. Well, I took stats on that and 98 out of every 100 did sit down! The top of the desk simply had the computer terminal, PP Guide, notebook and phone. Staff were instructed that all prescriptions had to be handed in by the patient at the desk, I invited them to sit down, and I then entered the script details into the computer which was connected by cable to the printers in the dispensary, where my Dispensary Assistant assembled the script. This gave me the opportunity to check dosages, compliance etc and counsel the patient.

As the desk was angled across the back corner of the shop it provided a very private area and it enabled me to build a greater rapport with my customers than I had ever had before.

Under this system we dispensed up to 150 scripts per day, sometimes reaching 200, and I still had time to monitor all sales of S2 and S3 items, take and record blood pressures, check diabetics feet etc.

And the bottom line is – turnover increased by an average 17% per year, and the only advertising was word-of-mouth! However, the professional satisfaction far outweighed the financial gain. So give it a go – the greatest mistake in life is to continually fear making one.

P.B. (2.2.09)

Congratulations, Peter H. You have said it all and proved we can be professional and be seen to be professional. My own situation was a compromise but the satisfaction similar in a pharmacy which was profitable with 90% of turnover in prescriptions. Good to hear there is hope for us, including the proper handling of scheduled medicines.

P.A. (9.2.09)

‘COMMUNITY PHARMACY IS PROFESSIONALLY UNSATISFYING’

Well it needn’t be, many of us ‘dispensers’ have got it right, and the magic word is ‘FORWARD DISPENSING.’

Case in point today: Rae's husband presents shopping note from wife, Somac repeat, Gaviscon OTC. History shows anti-hypertensives. Husband knows nothing. Playing a hunch, (high Na in antacid) he agrees to my suggestion to phone her. SIX nights a week of bad reflux. Big meals. Late. Coffee late. The full catastrophe.
'OK I'll send home some Gaviscon, but you could ask your doctor about upping your acid
blockers. Also Rae, change your eating habits [detailed] and here's the zinger -- a glass
of water beside the bed. Sip it when the volcano erupts, it flushes down the acid from
where it isn't meant to be. Guess what? It works for me.'

D.S. wrote: "Personally, I had to wait for "retirement" before I could consider
accreditation, as I had no spare time at all with my busy pharmacy. Now I am enjoying a
feeling of professional satisfaction that has taken me from the pressure of supply
service, to feeling accepted for what I do better - working with the patient."

......... which is what we Forwardies do already. It may not be rocket surgery, but the
health information we impart certainly changes lives. It's not only high-powered
Accrediteds who have The Information. We used to be anxious that in putting ourselves
out there, they would ask us the difficult questions that would show us up as frauds, not
the drug experts we claim to be. Well, it doesn't happen, we never say 'I give up.' With
our resources, never have I been stumped. OK the occasional flick pass of a zinger to
TAIS, but really, most questions that come up, any pharmacist who reads The List could
answer.
3. PAYMENT FOR PROFESSIONAL SERVICES

3.1 PAYMENT FOR CURRENTLY FREE PHARMACY SERVICES

J.G. (19.2.09)

For as long as any of us can remember and for a long time before that, pharmacists (Chemists in earlier days) have provided ‘first contact’ primary care / management of minor ailments (that are not always minor) free.

Some will feel that this is the way to go in the future. Using this as some sort of ‘loss leader’ to draw customers into the pharmacy where they can be prevailed on to hopefully have their prescriptions dispensed and spend money. Not an unreasonable approach at face value.

But it is unsustainable.

Whilst there will always be a place for pharmacists to provide some free services there is a great need for models to be developed where some categories of this type of care are paid for.

This ideally should be done by our representative national organisations such as the Pharmacy Guild and PSA, but there is no reason why pharmacy franchise groups, who wish to develop their professional services, and even individual pharmacists, cannot do this.

3.2 MEDICARE PAYMENT FOR PHARMACIST TRIAGING AND ADVICE

R.B. (18.2.09)

Finally, of course, the one that I have been advocating recently on Auspharmlist—probably the most important one of all, namely Medicare recognition of already-existing pharmacist triaging, health advice and referral to medical practitioners when required. Medicare funding of the triaging and advice components is analogous to Medicare Funding of optometrist consultations, psychologist consultations under a variety of State and Federal programs. Within that concept there could be an extension to include Medicare recognition of “detailed counselling” in conjunction with dispensing and supply of script items, requiring that additional professional service. (Obviously in such cases, pharmacist would have to complete pro-forma to identify these items and appropriate code (eg. designated Medicare code for "detailed pharmacist counselling of dispensed item", which would have inbuilt criteria to identify appropriate cases).

The barrier to all this being done is, of course, the funding required to support it. There are, however, at least in overseas literature, data to demonstrate that pharmacists interventions of this sort produce health and financial benefits that outweighs the financial cost.
3.3 MEDICARE PROVIDER NUMBERS FOR PHARMACISTS

R.B. (20.2.09)

Therefore, if we therefore assume that it is cost-effective to the community to have pharmacists continue their triage role, their advisory role on non-prescription medicines, referral role to medical practitioners, and their therapeutic advisory role on prescribed medications, it seems logical to extend Medicare Benefits recognition for allied health professionals (Medicare items 10950 to 10970) to pharmacists performing these functions and various extended consultative roles that may develop in the future.

As is currently the case for allied health professionals who have Medicare Provider numbers, I have suggested that each individual pharmacist be issued with a Medicare Provider number. An appropriate fee could be charged for this service, for which the patient would receive a Medicare reimbursement, and if desired, direct bulk-billing arrangements could be made. Now, clearly under such an arrangement, as with an employee doctor or optometrist, the billing and administrative functions would normally be carried out under the umbrella of the Pharmacy Practice. The pharmacy practice owner and each employee pharmacist could negotiate an agreement regarding the split-up of fees collected.\&/ or Medicare reimbursements, again in the same way as do employee medical practitioners and their employers, and presumably optometrists, working within a medical or optometry practice.

With this model, we could accommodate the concept raised by J.G. in his recent Feature Article "The Private Practitioner Pharmacist- A Third Career Path", 27/1/09, by having pharmacists operating independently and providing services to medical clinics, care facilities etc.

3.4 TWO TYPES OF PHARMACISTS

T.I. (19.2.09)

(Includes R.B. quote from 18/2) It seems to me that herein lies the perfect opportunity to identify services and needs that pharmacists are already assisting patients with, (usually for free!), and to suggest ways in which the pharmacist input could be improved, carried out in conjunction with others members of the Health Care Team, and thereby incorporated (and resourced!) within the Primary Health Care Strategy."

I believe the “usually for free!” [above] part of this post is the important part, for too long the patients and governments have been used to getting information on medicines from pharmacies for nothing.

There seems to be parallels in other industries. On Sunday when in Melbourne, I spoke briefly to one of the editors of the Age who predicts print newspapers will disappear in 5 years. Her reason is the diminishing income from classified advertising. So the reason why some of us still buy newspapers: to read the news and opinions produced by the journalists, is in fact subsidized by income from the classifieds that we do not read, although on the other hand people who buy to read the classifieds may not read the rest of the paper. Apparently the classifieds income is decreasing because of online advertisements that are being placed at less cost – sometimes free.
So pharmacy has been able to continue by utilizing technology to speed up the supply function for which we get paid, and to make ourselves feel good we provide information for which we do not get paid. It may be difficult to make comparisons with other healthcare professionals all of whom perform in places where an appointment is the first step in having an interaction between the consumer and the practitioner. Perhaps the public’s perception is similar to an interaction that happens in a hardware store where stand-up advice is often given on their products (although they are NORMAL items of commerce). Maybe when a consumer must make an appointment to have a consultation with a pharmacist a fee can be charged and everyone will be happy. Maybe we will then have two levels of pharmacists, those who check to ensure the correct medication is SUPPLIED – and those who have a consultation in room after an appointment has been made to speak with them, and a fee charged. Perhaps a logical first step is for more forward dispensing where at least

the consumer is sitting down while talking with the pharmacist, because what other health professional has standing discussions with consumers?

3.5 PHARMACISTS NEED TO BE COMPENSATED FOR THEIR TIME

P.S. (12.2.09)

The question of barriers would always (nearly) have to be time and money? Currently we are paid to supply medications. This needs to change to move pharmacist out of the dispensary.

Recently I have had the same elderly gentleman come in 4 times in 48 hours to get help with his blood glucose monitor. I spent over that time around 40-50 minutes with him. The initial sale going through the contents and process, 2nd visit things "missing", 3rd visit "things found" how does it work and 4th visit how does it work again. Now other than the fact we had a low mark-up on the product (will look at increasing and spending more than 10mins on initial sale) financially it would of been better for me to dispense/check 20-40 scripts in that time. I could of spent more time with him talking diets etc as his reading was 33 mmol/l (3rd visit) and 28 mmol/l (4th visit) but by this time scripts were calling and I had to refer him to the doctors and he is to see the diabetes educator in 2-3 weeks time.

Now I don’t call myself a diabetes educator, but I could of sat down for 10-15 minutes and gone through a few things, but again would of have been paid for this (paying for the service/my time was not an option for this pensioner and yes I had scripts to do).

But at the end of the day l/we are much more accessible than most health professionals, and have the knowledge to help people, but we need to be compensated

for our time. And would also allow for another pharmacist even part time to be put on to dispense or spread the work load for pharmacies that aren’t spitting out 100’s of scripts and hour.

I do wonder why the government would start paying us for service we currently provide for free, so as Debbie mentions we need to find new areas to practice in.
3.6 DOES GOVERNMENT SEE PHARMACISTS AS WORTHWHILE?

D.S. (3.2.09)

While I see purpose-trained pharmacists in GP clinics, much as Debby describes [2.12. DB 2.2.09], it will need to be a well paid position. Practice nurses, are almost always part-time, and are paid far less than hospital nurses. No matter how much professional satisfaction there is for a Clinic Pharmacist, the bottom line will most likely be that remuneration will need be adequate and reflect their importance in the system. Pharmacy must be a profession, not just another "allied health" addition to the clinic. I think the Division Facilitators and accredited pharmacists have got GPs accepting pharmacist’s abilities as greater than they realised, but will they be willing to show that with adequate recompense? Maybe, government will have to start by subsidising their salary. But does government see the future role of pharmacists as worthwhile in this new context? On the other hand I believe most pharmacists already have those essentials - responsibility, accessibility, confidentiality and most of us are learning about patient orientation.

3.7 PAYMENT FOR PROFESSIONAL SERVICES GIVEN LOW PRIORITY

M.S. (3.2.09)

I agree with everything you and many others have stated on this subject [provision of professional services to the community outside pharmacies].

But to use well known public service jargon, I ask "at the end of the day who pays?"

Of course as you rightly state "we also need a well-articulated vision and voice to fully integrate pharmacists in the health care team".

But this must include financials. However, I am sorry to say that this regularly seems to be given a very low priority by the academics and proponents of this type of pharmacy service.

3.8 PATIENTS WILL PAY FOR ADVICE

G.M. (29.1.09)

I have conducted private consultations from a medical centre connected to our pharmacy. The patients all paid for the consult and I was booked out for one day each week. I have extra qualifications in nutrition, herbal medicine and also a consultant pharmacist. The patients were all very happy to pay for my advice which was basically holistic health care starting from the diet and then looking at drugs and supplements.

We are in a unique situation to give this type of service. I now lecture these principles at Griffith University school of pharmacy and find most students very interested in the model.
3.9 PHARMACIST ADVICE INVALUABLE – IF IT IS AVAILABLE

A.S. (30.1.09)

I have been waiting for this topic to start for quite some time now.[Private Practitioner Pharmacist - A Third Pathway]

I remember having a heated discussion during tutorial at Sydney Uni about the future of pharmacy in the context of what was happening to Sydney and Australia as a whole and saying the worst case scenario would be if we continue heading towards the US system. where pharmacies sell everything; medication, medicines, hot food, and alcohol without proper structure ignoring rules and regulations as to how pharmacy and the profession should uphold the sacred image of pharmacy as a primary healthcare focal point. One student that had the chance to see first hand what it was like in the US shared her experience through fascinated story telling of how pharmacy was in America and I remember thinking and later telling her thank god i stayed in Australia. However after getting more experience in community pharmacy in oz, it became apparent the recognition and remuneration awarded to pharmacists by the government is much less than even what the patients expects for a pharmacist. this is indeed unfortunate as some patients view pharmacist advice as invaluable, and sadly some cases the pharmacist cant provide the same level of care and attention because of the lack of recognition, remuneration and incentive.

One thing is for certain I’m proud that some heads are finally turning and a model that finally recognises the pharmacist practitioner as part of a healthcare provider network is on the chopping block.

3.10 ALLOW PHARMACISTS TO BULK BILL

J.D. (23.2.09)

I agree that free pharmacist advice as a hook to sell product is unsustainable.

The preventative health model and professional advice ought to be supported by medicare service numbers.

Pharmacists can do many things well and cost effectively but patients would rather incur a $35 doctor consultation with medicare rebate than pay $10 to a pharmacist without rebate.

Allow pharmacists to bulk bill minor preventative procedures and the total cost to government of primary healthcare delivery would fall and preventative health outcomes improve.

3.11 A NEED FOR CHANGE

C.W. (26.2.09)
CB wrote:

"I believe that payments for professional services should be made through the community pharmacy for a number of reasons including: 1. Pharmacy owners have risked their capital in establishing, maintaining and developing the community pharmacy infrastructure and are entitled to a return for their investment. 2. The community pharmacy network, critical for the health care of the community, must be maintained and therefore should be financially supported. 3. The service, and service opportunity, is and must be linked to product supply."

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For many of us these are not good enough reasons for keeping things as is.

As an independent consultant pharmacist I should be allowed the freedom of true independence. I always include the community pharmacy where that is possible, but not all patients are loyal to just one pharmacy anymore. I appreciate that pharmacy owners have made huge investments, however, many choose to contract for professional services because in reality they cannot do everything themselves. Independent pharmacists work together with GPs, community pharmacists & the patient for better health outcomes, but our services should not be mandated to be forever linked to product supply.

Things must change for the continued viability of our profession.

3.12 SERVICE OUTSIDE PHARMACIES NOT TO BE LINKED TO SUPPLY

J.G. (26.2.09)

CB wrote: "The second argument I put forward at the lecture, which has not been widely reported, is about financial arrangements. I believe that payments for professional services should be made through the community pharmacy for a number of reasons including: 1. Pharmacy owners have risked their capital in establishing, maintaining and developing the community pharmacy infrastructure and are entitled to a return for their investment. 2. The community pharmacy network, critical for the health care of the community, must be maintained and therefore should be financially supported. 3. The service, and service opportunity, is and must be linked to product supply."

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Doctors also risk their capital in establishing, maintaining and developing the medical infrastructure of the community, as do dentists, physiotherapists, opticians and others. But that does not automatically guarantee that they will be entitled to a return on their investment.

Much as I want to see all community pharmacies successful and profitable, just being there as a pharmacy should not automatically entitle them to a financial return. What should guarantee them a financial return on their investment, as for any other health professional, is being good at what they have been trained to do, as a pharmacist – and being paid adequately for that service. Which is definitely not the case now.
To seek to artificially prop up pharmacies by ensuring that they have no outside competition from other pharmacists is wrong. It has the appearance of a defacto restraint on trade

It denies other pharmacists the opportunity to expand their professional horizons by practising in areas in the wider community and, by seeking to stand in the way of expanding professional services, it is limiting the ability of the profession to develop and grow in a natural way.

On CB’s other two points; Yes, the community pharmacy network is critical for the health care of the community, must be maintained and therefore should be financially supported – by ensuring adequate remuneration for professional services provided.

Yes, the service opportunity should be linked to supply, but only in the pharmacy.
4. RECOMMENDATIONS AND INNOVATIONS

4.1 RECOMMENDATIONS FOR THE FUTURE

D.R. (18.2.09)

1. Continue HMRs with greater flexibility to the model for high-risk patients, more frequent reviews where appropriate, referral by health providers other than GPs where appropriate (e.g. AHW, hospital LMOs, nurses in rural and remote areas) and direct referral to accredited pharmacists and community pharmacies

2. Continue RMMRs, again with better targeting and increased funding for QUM services

3. Continue DMAS and PAMS programs, as diabetes and asthma have high rates of medication use (and misuse) with significant morbidity and mortality
4. Fund credentialed programs for smoking cessation through community pharmacy and primary care settings with funded NRT for selected persons

5. Fund credentialed programs for weight loss through community pharmacy and primary care settings

6. Credentialed programs to address poor medication compliance and health behaviour change through community pharmacy and primary care settings

7. Pharmacist prescribing for appropriately trained and credentialed pharmacists through primary care settings

8. Programs for post-marketing surveillance through community pharmacies

9. Warfarin management programs through community pharmacy and primary care settings

10. Generic primary care service covering all aspects of medication management through community pharmacy and primary care settings

4.2 PHARMACISTS AS MEMBERS OF GP DIVISION BOARDS

D.S. (18.2.09)

As a GP Division Facilitator, I find we are moving to a much more team-based approach.

Most Divisions would have a Program Advisory Group, and ours has just evolved to a wider base for that group, which includes pharmacists, GPs, Community health Nurse, Community representative and Division Officers. It covers a variety of Practice Capacity services such as CPD, Practice Nurse education, NPS and Medication Management. Their suggestions are then passed on to the Board.

However, I do think it would be helpful for a pharmacist to be a Board Member so that another side of argument could be represented, especially seeing the overlaps of all health related issues. There has never been a better time for that to be acceptable to the GP population.
A.R. (18.2.09)

Some GP divisions have renamed themselves eg Central Australian Division of Primary Care (now changed to an NT wide body?). Mt Isa also has a more encompassing name as well. Unfortunately some are encompassing only in their name. I think it is essential for pharmacists (and an allied health rep) to be on the board to ensure that other health professions are recognised. Anywhere where pharmacists are mixing with other health professionals away from their dispensing counter of security, working together for a common aim can only be beneficial.

J.G. (18.2.09)

It would be a big step forward for a pharmacist to be on every Division Board. I do not know of any where this is current - but recently a practice manager has been appointed to the Board and in Northern Division outside experts eg lawyers and accountants are being sought.

A number of Divisions have associate membership for pharmacists and an increasing number of joint CPD events are being conducted. The advantages of closer integration results in improved communication and a team approach to patient management. Many of the barriers to good professional relationships can be identified and solutions sought eg owing prescriptions, generics and concerns about chronic disease state management programs being developed by GPs and also now pharmacy organisations. Medication Management Review programs are at last being accepted by more and more GPs as a useful tool - especially in identifying adherence issues. Initially these programs were seen as a check on prescribing and bureaucratic paperwork. An informed pharmacy board member can often dispel GP concerns about the increasing number of cognitive services being offered by pharmacies . It is essential that GPs are involved in these programs as the case manager and each member of the health care team understands their role and the roles of other team members

4.3 NEW PROFESSIONAL PHARMACY PROGRAMS

P.A. (12.2.09)

Last night, in Brisbane, I attended the first Road Show for the roll out of Mirixa.

"Mirixa is an online software platform which will enable the systemised implementation of medication related care programs, and will allow every community pharmacy to implement professional pharmacy programs and open new streams of revenue to your business."

After the presentation I asked many of the pharmacists what they thought and there was an excitement in the air. All felt that this program will not only enhance the pharmacist’s role but also improve our standing within the community as Pharmacy Professionals.

I wish to congratulate the Guild for this Pro-active initiative and urge all pharmacists and staff to attend the Road Shows when they are presented in your cities.
4.4 PHARMACIST SERVICES IN REMOTE COMMUNITIES

A.R. (9.2.09)

I have spent an evening catching up on Auspharm and have been delighted to see JGs Article [2.10 The Private Practitioner Pharmacist 27.1.09]. I was also disappointed as John puts remote health only as a facet of a private pharmacist practitioners work when all the draft list of services (in both his short and long form) and more a remote pharmacist can perform in a normal day at work.

But first: For those who search for “Ngaanyatjarra Health Funding Pharmacist” and variations and hit my site let me tell you how I am funded. I contract to the health service and others and am funded by Ngaanyatjarra Health out of money saved in other areas and put towards my cost as I show I provide value to the health service.

We have another position open – the first pharmacist position in remote health funded by the Office of Aboriginal and Torres Strait Islander Health (contact me urgently if you want to be different). If I fill this the doctor in charge of chronic disease for the Northern Territory wants to sit down and work out how to fund pharmacists as part of the chronic disease team. Speaking with the consultants who performed the DoHA review of HMRs I was informed several Aboriginal Health Services would love to have a pharmacist working seeing patients all day.

I intend to continue to pay as I am so I can look those in the Guild, SHPA and PSA in the eye and say there is a position for pharmacists out bush, and not the visiting service the Guild and SHPA believe all should be offered to remote indigenous Australians. I have written earlier about their woeful submissions to the National Health and Hospital Reform Commission. As to the PSA - Their submission cover sheet did not tick the Indigenous Health box. So despite pharmacists already providing a bare bones pharmacist service they decided pharmacists could provide no input into indigenous health. They should all move to Antarctica wearing nothing but their underwear and stop hindering pharmacist roles.

Lets look at J's list:

Medication Reconciliation: Hospitals are getting a swag of money to implement this. Guess how many times our health service has been called in 3 months regarding a patients medications from a hospital pharmacy department after an RFDS evacuation. ONCE. I want a pharmacist to track our patients into hospital and force feed information to pharmacists, and if they choose not to listen, straight to the consultants. I receive the renal physicians letters not for just our patients, but all the Western Desert area (about 25% of WA). I would like to track our patients into specialist appointments so we can then ensure we can obtain the medications required. Medication reconciliation is required as a highly mobile population may visit several health services before returning home.

Compliance assessment and counselling: So instead of in a case conference I hear words like they take them sometimes an exact figure and history can be provided. Despite having a much higher incidence of disease the amount of PBS medications used under the S100 scheme is abysmal compared to the world of the whitefella.
Another pharmacist would spend up to 30% of their time bush performing this service. There is no one else who performs this as it needs to be done.

**Drug information services:** Specific enquiries and general information both from an office environment and when working closely with doctors and nurses. This also spills over to other health services and also into hospital as you advise doctors on resources and options out bush. How do you monitor warfarin?

**Adverse Drug Reaction Management:** I am the first point of call from RANS and Docs alike in reviewing a reaction to determine if allergy or reaction, or determining which drug it may have been. This also includes incidents with vaccines. Yesterday that included reviewing a procaine reaction where a child fitted and a spike in temp to 40C after a Hep B injection (high temps 1% with this item)

**Chronic Disease management Team Member:** I am involved from when the physician sees the patient following up on certain information. At a patient level I work closely with our chronic disease nurse. With the chronic disease programs I have seen around the country the nurse programs offer information sessions and also ensure the testing/follow up is done. I assist with this, but also speak with patients about their medications, using aids from 3D models to pictures to show the disease and the benefits of medications. We are exploring how to work further together. A nurse can claim for a case conference. Why can’t a pharmacist? Oh, I’d need a Provider number for Medicare and assign the money to the Health service.

**Collaborative medication management (pharmacist prescribing):** Out bush with different stock at different health services there are patients who come across with a different medication to those on imprests (eg ACE Inhibitor). A pharmacist after reconciliation could then prescribe a different ACE inhibitor so the patient can continue to be treated. As discharges come out of hospital and with a lack of doctors in remote areas a pharmacist could write up a script, again after the reconciliation process. I have further ideas in this area

**Hospital in the Home service support:** I am the sole pharmacist for 11 “hospitals” each with hospital in the home with patients coming to the clinic for IVs or perhaps a dialysis patient. Many patients have my number and ring me for assistance/advice. Palliative Care out bush is becoming a bigger issue out bush and I play a role there as well.

**Home Medicines Reviews** are only useful if they can be ongoing and sustained, increasing the amount of knowledge each time. I have spoken with various people and my aim is to have a trial of a suitable method up in 12 months. And why should my referrals go to a pharmacy 1100kms away where the patients have never been? Why cannot I identify them and commence and bill Medicare?

**Residential Medication Management Reviews** cannot be done in indigenous facilities as they are not accredited and are not funded to a level to be able to be accredited. A senior Guild employee was advised of that in 2005 on a visit to the lands and AACP was advised by email about that time. I was advised it went to the Board. Who seemingly did nothing. However there is a role to play as a remote practitioner in working with the Indigenous Programs, Office of Finance and Audit to ensure this occurs. Yes I have been asked.
Rural and Remote Services: covers all I have mentioned, plus logistics, emergency drugs, disaster planning, patient transfers and much more.

Medication use research: We were the first aboriginal health service to sign up to the Kanyini Collaboration looking at raft of things for indigenous cardiac patients such as the benefit of Care Plans. There is also a polypill trial component, one of the first in the world which is how I got involved. There is also the more mundane such as continuing QA and Drug Usage evaluations on an ongoing basis.

And don’t forget Vaccinations. My role here has led to us being granted an exemption to the WA schedule due to our isolation and logistics and population. The pharmacist was the best person to argue this at a department level. A vaccine is still a drug. And I want to be able to vaccinate. All clinical enquiries, cold chain, incidents, catch ups come to me to be handled.
5. ISSUES OF CONCERN

5.1 MEDICINES AREN’T NORMAL ARTICLES OF COMMERCE

P.C. (20.2.09)

In my post (prompted by Gerald's eloquence) that op ened this thread, I called "medicines are not normal articles of commerce" a 'dead horse' argument and suggested that we stop flogging it. What I meant was that ANY argument that focuses on the allegedly 'special' nature of 'our' goods rather than of our professional services, has - historically speaking - proved impossible for pharmacy to win.

So in my opinion we need to get away from arguing about pharmaceutical goods which (truly) are in some respects almost ‘commodity like’ and which the modern consumer thinks they have a ‘right’ to have (both of which are reasons why we struggle with the "not normal articles of commerce" argument) and talk instead about the THINGS WE DO that are unique, valuable and inimitable, and hence the source of our SUSTAINABLE competitive advantage, and therefore with which it is difficult for our detractors to argue.

When we have firmly established the argument, and our professional focus, in the realm of service provision, rather than goods, we have a fighting chance. Unless we do, we don’t.

M.S. (20.2.09)

I am not advocating that medicines be stored hidden from view, under the counter or locked in dark cupboards, but pharmacists should be vigilant and pay due diligence to the misuse potential of all medicines, scheduled or unscheduled.

Medicines should not be treated as a commodity to be bought from wholesalers under an assortment of creative deals and be then heavily promoted and on sold to consumers at such low prices so as to encourage their purchase and perhaps misuse.

G.M. (20.2.09)

How does selling Panamax at 95c per packet generate HARM? Is a non-concessional card holder with osteo-arthritis who buys three packets for about $3 more likely to abuse or misuse them than a concessional holder with the same complaint who gets 3 packets on the PBS for $5.30. Come on! Unreasonable bulk selling is another matter and if proven should result in a complaint to the pharmacy board. The firewall required between Joe public and the misuse of medicines is present in the scheduling and its implicit requirements.

Let me be clear that I regard the sale of pharmacy only (S2) and pharmacist only (S3) medicines as being serious business and would expect that such sales would be carried out responsibly.
P.A. (18.2.09)

…… Numerous events showed how pharmacy / pharmacist intervention gave quality advice and health outcomes that simply could not happen with a self-service model. Gastro. Likely giardia. See a Dr. Wart on foot -- best treatment chosen... and a dozen others every day.

R.B. (20.2.09)

…… even if we don't have extensive specifically Australian data at the community pharmacy level, there is already ample data from various studies which demonstrate the overall concept of pharmacist input and interventions saving both health dollars, and even more importantly, preventing severe adverse health outcomes. It has been an established principle in major teaching hospitals worldwide and in this country, for decades. Also, the American College of Clinical Pharmacy has been documenting and evaluating the cost versus benefit of clinical pharmacy services since 1988, with positive study results throughout this period.

All we are talking about here is extending this principle to the primary health care programs within the community, in line with the overall philosophy of managing patients who don't require hospital care, by fully-utilising the readily-available pool of health care professionals, including community pharmacists. Once again, there is ample documentary evidence, albeit mostly overseas, to attest to the economic and health benefits of such a primary health care model. Obviously funding resources are required to sustain this model of care. [see also 3. Payments for Professional Services]

5.2 THE EFFECT OF PRICE COMPETITION

P.A. (20.2.09)

At a meeting with pharmacists today, one told of being presented with a bag of the patient's new prescriptions.

'I got them at the discount pharmacy, but they didn't tell me anything about them. Will you please.'

Options?

1) Sure I'll give you 10 minutes free, explaining that time has value -- and next time you will come back to me. 5% probability?
2) For $10 I'll give you 10 minutes, and next time you will come back to me. 70% probability that she says you are a rude man and leaves. 30% she sees the light.
3) She reports the Bad Chemist to the Pharmacy Board. 0%
4) She keeps going there and goes on with Un-Quality Use of Medicines. 80% I reckon

what would you do?
5.3 OUR FAILURE TO DOCUMENT WHAT WE DO

R.B. (9.2.09)

As I’ve written many times, I am one of the few who, over 20-30 years, week in and week out, concurrently managed in community pharmacy on weekends and in the evenings, whilst having clinical and later, senior management roles, in hospital pharmacy. Like John, whilst working in community pharmacy then, as well as managing full-time at various other periods of my career, what always struck me as a tragic missed golden opportunity, was the fact that community pharmacy groups had never bothered to set up the relatively simple exercise of systematically documenting the health outcome data, including serious health events prevented, or triaged to medical care, for urgent attention, which directly arose from an, albeit free and informal, consultation with the pharmacist in a community pharmacy setting. We all saw it each and every day—a veritable gold mine of referrals to doctors, many quite urgent, advice given on preventive medicine, advice to patients on how to use their medicines, awareness of side-effects and adverse reactions etc. etc. So, why, oh why, did no one think of collecting, following up, and "number-crunching" this mass of available data, and presenting it to the appropriate Health Authorities, to work towards Medicare recognition or similar for pharmacists carrying out these valuable primary care activities!

5.4 A BARRIER TO CHANGE

J.G. (10.2.09)

Your post [AR 9.2.09 above] goes to the crux of our problem in expanding professional pharmacy services - all over Australia. Until the Guild and PSA recognise the massive benefits that would flow to the public (and to pharmacists) if pharmacists were 'deregulated' from Guild control and the Guild and PSA throw their considerable weights behind attempts such as yours to build an exciting future for the profession, nothing much is going to change.

5.5 CONTROLLING THE PURCHASE OF ILLICIT MEDICATION

In a series of 16 posts beginning with DH (1.12.08) titled ‘A new Twist’ community pharmacists have described the considerable difficulty they have controlling the purchase of S3 and S2 products that are open to abuse or that may be purchased inadvertently by a customer and predispose them to serious medical risk.

Examples are given below of some of the ruses (‘Twists’) that drug abusers resort to when seeking to obtain illicit medications.

D.H. (1.12.08)

I thought I'd heard every excuse reason deception and twist of the truth till yesterday. Busted a poor dependent soul who thought the same twisted pharmacist wouldn't pull two 15 hr days in a row.... wrong! Mersyndol and Unisom please ..... avenging pharmacist angel swoops ... hang on .. you were in buying these yesterday ( with a good story ) Nope .. weren't me .... that was my twin sister!
C.M. (8.12.08)
But unless you are requesting photo id there's nothing stopping them coming in and using a different name every time. We had one example recently who we eventually discovered was using about 12 different names. It's even easier when you have an "exotic" name and you end up with them entered 4 times each with different spellings.

Asking for photo id does have merit... but there are also drawbacks. Customers are often resistant to the idea and in busy pharmacies where resources are already pushed to the limit the extra time spent can be used on more constructive tasks. Smaller pharmacies might have the time but often don't have the problem in the first place.

D.H. (8.12.08)

Why should QLD SA and Vic have different rules to NSW. Why can't we have consistent countrywide rules for the sales of medicines? Operation Stop does not work in Sydney because nobody consistently uses it. I know. I work in the pharmacies.

5.6 PHARMACIST RESPONSIBILITIES

P.B. (12.12.08)

On page 28 of the same AJP is a feature on S3 Somac. Professor Leon Piterman of Monash Uni shares my concern that some of the 1% of GORD cases which progress to pre-cancerous Barrett’s Oesophagus may be missed because of the easy availability of a drug which a few years ago was available only on an authority prescription issued following endoscopy.

He is quoted as saying: "What we are talking about here is a shared care arrangement between the GP and the pharmacist. If this is not done then I believe pharmacy is at risk of litigation..... Only one course should be sold without medical assessment ....."

I suggest that the only way to monitor that supply is with an accessible written record.

5.7 POOR STANDARDS OF PRACTICE

P.B. (5.1.09)

I eventually received the item in a bag sealed with the sticker missing from the duplicate, an alternative to that ordered without offer or any indication on the label or prescription that a substitution was made. The directions read “Take one tablet daily as directed by your doctor” when a layperson could clearly see those ordered were “i daily before XRT” (one hour before treatment having been stated by the prescriber). The repeat form was missing but was waiting in an envelope for posting to my home address although it was obvious I was an in-patient. The Medicare card number shows the wrong expiry date. There was CMI in the pack but no explanation was offered. Other products supplied earlier came without CMI.

K.C. (13.1.09)
I totally agree with [PB] after my experience whilst holidaying on the North Coast of NSW. I presented prescriptions for Somac 40mg (1 d) second repeat and an authority for Epipen (I have developed a severe allergic reaction to green ants) to person who
was the pharmacist no name badge no smile just "hello". It was nine thirty in the morning no other customers and two staff leaning on the dispensary bench chatting one giving a yawn or two as she listened to the others story. The pharmacist brought out the dispensed scripts and requested signatures and dates. As i was doing so the tablets and epipen were put in a bag and sealed "$65.80 please" and that was that. I was so annoyed at the total lack of professionalism that lucky for the pharmacist I was gobsmacked. Could have been a first timer with epipen, no conversation no questions no demo with dummy epipen. If you don't care get out of the profession and leave to those who are really genuine. For goodness sake stop the pathetic apology of " as directed by your doctor" put on both labels and take responsibility for being a pharmacist

**G.M. (14.1.09)**

Failure by a pharmacist to advise a client on the correct procedure for Epipen use, if it was the first time the client had received the prescription, would certainly result in a "please explain" if a complaint was made to the NSW Board, with the potential for a finding of unsatisfactory professional conduct. The first question should obviously be: "Have you had this preparation before?"

**5.8 PRESCRIPTION FORGERIES DEMAND MUCH PHARMACIST TIME**

Pharmacists spend considerable time dealing with suspected and actual prescription forgeries. A post by GT (23/1/09) demonstrates that this can require several hours of time completing paper work and attending court. A series of 27 posts made in January 2009 made clear the significant amount of time that is required and the disruption to normal work that can be caused for pharmacists by forged prescriptions. An example is given below

**G.T. (23.1.09)**

A local pharmacist dispensed a DD but after patient left could not find the prescription. Suspecting the patient may have intentionally pocketed it, the pharmacist rang around other pharmacies to be alert if it was presented to be dispensed again. It showed up at my pharmacy, the Police were called, patient took off and we all had lots of paperwork to fill in. Long story, short version....patient was eventually hauled in to court where over several hours with 2 pharmacists waiting to give evidence but never did, they plea bargained down to being guilty of the theft of a piece of paper! nothing about fraudulent attempt to access S8- seemed to be a huge waste of police, judicial and pharmacists' time....not sure about the moral to the story.

**5.9 PRESCRIPTIONS FOR MULTIPLE DISPENSING IN SMALL PACKS NOT FUNDED**

The post by TL (21/1/09) demonstrates that pharmacists are increasingly unwilling to continue to provide unfunded services.

**T.L. (21.1.09)**

So, to summarise, if a prescription contains an instruction to supply dribs and drabs of a quantity of medicine, it is my very firm view that a pharmacist should plan to comply with that instruction. As I am aware that a fee can be legally charged for the extra service, I invoke my right to charge it, and give the consumer the right to accept it or seek
someone whose bottom line is deep enough to give the service away for less or for free. Until QUM measures such as this type of close-control, or Methadone/Subutex daily dosing, are remunerated by a government agency, I personally believe the only financially viable policy for pharmacies to adopt is one in which the user pays a fee as I have described.
6. AUSPHARM POLL RESULTS

JUNE 2008 to FEBRUARY 2009

The results of a number of polls taken between June 2008 and February 2009 on the Auspharm Website are described below.

Future of Pharmacy
In response to the question posed on 11/6/08 ‘How do you see pharmacy in 5 years?’ 38% of 159 respondents answered ‘Price check on aisle 17’ and 31% answered ‘much the same as now’. Only 30% (less than one third) saw the future as ‘Even better than now’. This indicates that many pharmacists are not optimistic about our professional future.

Threat levels for pharmacy staff
On 2/7/08 Auspharm subscribers were asked to respond to the statement ‘In the last 12 months I, or the staff where I work, have been threatened and/or intimidated and/or assaulted and/or held-up by a customer’. Twenty four percent of 189 respondents replied that there had been a high level threat and 43% knew of a low level threat. Only 33% answered ‘no’, there had been no threats, intimidation, assaults or hold-ups. This indicates a high level of exposure of community pharmacy staff to serious hazards in the course of their normal work.

Availability of locums
In response to the 3/9/08 question ‘Where I work there are enough locum pharmacists to cover days off, holidays and emergencies’ only 35% of 98 respondents were able to answer ‘yes, there’s always someone available’. Forty two percent said they struggled but usually found someone, while 20% said ‘no, they’re rare as hen’s teeth’.

Clear lunch breaks
In the 24/9/08 poll that asked whether pharmacists got a clear lunch break of at least 30 minutes in the pharmacy in which they worked, a high 78% of the 269 respondents answered ‘no’, they did not get a clear 30 minute break. Ninety three percent of respondents were either community pharmacy employees or pharmacy owners. This has implications for the safety of work conditions in community pharmacies.

Enough staff to deliver new professional programs
In the 16/9/08 poll that asked pharmacists whether, in the pharmacy in which they worked, they had sufficient pharmacists to deliver the new professional practice programs, 75% (three quarters) of the 91 respondents answered ‘No’ they did not, including 20% (18) who said they were not delivering the new professional programs at all. These are smaller numbers than in other polls and the question needs to be asked whether this may indicate a general lack of enthusiasm for answering this question. That is, is it irrelevant to many? Are the non supporters of the program even higher?

Direction of pharmacy
In response to the statement in the 12/11/08 poll that ‘The profession of pharmacy is heading in the right direction in Australia. Pharmacists will soon be universally considered as important and essential members of the healthcare team’, only 4% (6) of the 158 respondents answered ‘yes absolutely’. A further 43% answered ‘mostly’, but
they said that either some change in focus or more effort was needed. Over half (54%) answered either ‘no way, big change is needed to more firmly establish our place in the health system’ (43, 27%), or ‘not really, quite a bit needs to change’ (43, 27%). Indicating that some pharmacists are not satisfied that the profession is heading in the right direction.

**Charging for taking blood pressure measurements**
A surprising 78% of 160 respondents to the 19/11/08 poll advised that ‘In the pharmacy where I work we perform blood pressure checks free’ while a further 8% said that they never took blood pressure measurements. Only 15% provided blood pressure measurement as a paid service. It is at least 30 years since pharmacists began taking BP measurements. This is an indictment of the ability of the community pharmacy sector to develop paid professional services.

**Workload impact**
In the 24/11/poll that asked ‘How often do you feel that workload impacts on your professional responsibility as a pharmacist’ 50% of 162 respondents answered ‘Often’. A further 39% replied ‘occasionally’. Only 12% were able to answer ‘Rarely’. This raises a concern whether pharmacists can confidently expect to meet professional standards under current workload conditions.

**Dispensing errors**
In the 5/1/09, poll where pharmacists were asked to say how long since they last made a dispensing error, 21% of 191 respondents admitted to making an error in the last week, 22% to an error in the last month and 26% to an error in the last 3 months. The significance of the errors was not investigated however, the number of pharmacists admitting to errors was high. Only 17% reported that they had not made an error in the last 12 months.

**Pharmacists role in health care**
In response to the 28/1/09 question ‘What do think a pharmacist’s role in primary health care should be?’, 128 of 169 respondents (76%) answered in favour of models that allowed pharmacists to work independently, (inside pharmacies or in community health care settings - outside pharmacies). Only 18% favoured a model that restricted the delivery of professional services to being through community pharmacies only. Five percent said that the pharmacist’s role should be the sale of products and dispensing only.

**Discussion of poll results**
There are probably as many interpretations possible of these results as there are people who read through them but, despite the obvious statistical limitations, some things seem clear;

- Pharmacists working in community pharmacy are struggling to maintain professional standards in a difficult work environment.
- Pharmacists work in a high pressure and potentially dangerous environment
- They are not satisfied with the status quo in relation to the provisional of professional services to the community
• Many have serious concerns about the future direction of the profession.

• Pharmacists are open to the idea of expanding their professional services

• They continue to provide services free that most people in Australia in the 21st century would expect to pay for (eg blood pressure measurement), despite struggling to provide expected standards of care.

If this situation can be extrapolated to the wider community pharmacy workforce, it indicates that community pharmacists are experiencing significant difficulties in maintaining an acceptable standard of care in the difficult environment in which they work and have important concerns about the future of the profession.

References


10 National Health Survey 2004–05. ABS cat. no. 4364.0. Canberra: ABS.