

Transcript

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Item: **NATIONAL PRESS CLUB ADDRESS BY KOS SCLAVOS WHO TALKS ABOUT THE WORK DONE BY THE PHARMACY GUILD OF AUSTRALIA.**
INTERVIEWEES: KOS SCLAVOS, PHARMACY GUILD OF AUSTRALIA

Demographics:	Male 16+	Female 16+	All people	ABs	GBs
	N/A	N/A	N/A	N/A	N/A

ANNOUNCER: Today at the National Press Club, the President of the Pharmacy Guild of Australia Kos Sclavos.

With the cost of Australia's subsidised prescription drug scheme skyrocketing, Mr Sclavos will talk about the role medicines play in modern health care and the benefits of the Pharmaceutical Benefits Scheme.

From the National Press Club in Canberra, Pharmacy Guild President Kos Sclavos.

KEN RANDALL: Ladies and gentlemen, welcome to the National Press Club and today's National Australia Bank address. We're very pleased to welcome Kos Sclavos here today, the - I think it's the first time we've had a President of the Pharmacy Guild of Australia address the club.

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Pharmacists, of course, are in the front line of our health professionals in Australia and he has been an outstanding advocate on their behalf.

In fact, next Monday he will be made an Honorary Doctor at Griffith University in recognition of his distinguished contribution to the pharmacy profession and to innovation in the profession. And he will also be delivering the occasional address for a graduation ceremony at the Griffith University on the Gold Coast and I'm sure he won't miss an opportunity to make a few points there as well.

But there are many current issues involving pharmacists in our health system at the moment and I'm sure he will be addressing most of them today.

Please welcome Kos Sclavos.

[Applause]

KOS SCLAVOS:

Well thank you very much Ken and thanks to National Press Club. Welcome ladies and gentlemen. I'd like to also acknowledge the support of our sponsors, the National Australia Bank.

I would like to start off by thanking all of you who are present here today. To those watching at home. To my pharmacist colleagues, pharmacy assistants, key health industry workers, health consumers. All of these people take a keen interest in and play an

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active role in our health system and our world class Pharmaceutical Benefits Scheme or PBS as I will refer to it today.

Medicines benefit all Australians in our quest to live longer, happier and more productive lives. The Pharmacy Guild of Australia, or Guild as we are referred to, is the peak body that represents community pharmacy. Our members are the owners of Australia's network of 5000 community pharmacies in diverse locations; private hospitals, medical centres, shopping centre, suburbs and pharmacies in the most remote parts of Australia.

Naturally I am a community pharmacy owner and I actually live in the Prime Minister's electorate in Brisbane and being a fellow Queenslanders may I also say I'm here to help.

[Laughter]

Now those who know me know I am passionate about community pharmacy and public health. Through adversity, I know what it's like to be on the patient side of the health system. I think it's made me a better person. It's certainly made me a better pharmacist. In 2003 our beloved son Stanley, at the age of 10, passed away after a three year battle with leukaemia. Leukaemia is one of the many health conditions where the support of a pharmacist is absolutely paramount; support with their

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chemotherapy medicines, the significant side affects and all medicine related issues.

Now sadly our hospital system, with their limited resources, was not there to provide that help. My wife Effie, also a pharmacist and here today, we'd be asked an overwhelming number of pharmacy related issues from other parents of children with leukaemia. A pharmacist, the medicine's expert, should be there for everyone. What drives me today, what I'm passionate about, is to ensure that pharmacy services are expanded, not contracted. The pharmacist is an essential part of the health system.

Now one of the most important things I want to talk to you about today is change. Now while I hope to use this opportunity to speak about the essential role of medicines and pharmacy, in the ongoing lives of all Australians, I hope to use this opportunity to show you how the profession of pharmacy is changing to meet a modern Australia. I want to make sure that pharmacists remain, as they have always been, the most accessible of all health professionals. You don't have to make an appointment to see your pharmacist.

I've discussed pharmacy's direction and plans over many meetings with both Prime Minister Rudd and Health Minister Nicola Roxon. The Pharmacy Guild always works cooperatively with the Government of the day. I need to place on the record our thanks

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for the Government's confidence that they have shown in community pharmacy both in commitments and policy direction. So in terms of change, there is no bigger structural change than what will occur to the PBS in a few days time on the 1 August. It's the biggest change to the scheme in the 60 years it's been in existence.

Now the Guild helped design these changes and they went through the Federal Parliament last year. As custodians of the PBS it will be the role of my pharmacist's colleagues to explain these changes to our patients. And in addition, the Federal Government wants us to explain to patients that generic medicines are safe and effective and they can save you money.

Now most important of all, the changes to the scheme will ensure that the PBS remains effective and efficient and sustainable in the long-term. Now there's three major areas of change.

Firstly, for patients on a mass of 1045 medicines, the price is going to drop between 20 cents and \$4.65 and an average drop of over \$2. Now when you're taking medicines each and every month, even these few cents make a big difference.

Secondly, and probably more significantly from a financial point of view, on 99 drugs, representing hundreds of brands, the price that the Government pays for these medicines will drop by 25 per cent.

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Thirdly, moving forward, the reforms will introduce a high level of transparency for the pharmaceutical industry. Now including a rigorous price disclosure, whereby the Guild's calculation, it will generate savings over the decade of \$6 billion and that's twice the amount originally predicted by the Government in 2006. The Guild's calculated all these off patents - in 2012, 2013 40 per cent of the current volume of the PBS will come off patent and we've made calculations of that impact over the decade.

Now community pharmacy warmly welcomes the increased transparency on PBS. It will put to bed once and for all the misleading and mischievous claims that pharmacists chase generic discounts. The simple fact is Australia has the lowest uptake of generic medicines in the western world. In fact, I repeat, the Federal Government wants us to see an increase in generic medicines use.

The Guild works cooperatively with governments at all levels to create good health policy. You cannot create good health policy, unless you have excellent relationship with all health stakeholders. You cannot create good health policy unless your proposals are costed and for that reason the Guild employs more health economists than any other health group. But ladies and gentlemen, health policy and good health policy is a balance. It's a balance between the hard edge of economics, having compassion for the patients you serve, a

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pragmatic approach towards finding solutions, even when you start negotiations poles apart. And also an ethical approach with consideration of social justice issues, where bottom line profit and shareholders returns does not drive your thinking.

The Guild has some 300 staff working across all states and territories in Australia. We are signatory to scores of agreements with governments at all levels. When you signatory do an agreement with the Government, you can't stand on the sideline and complain about the Government of the day. If there are problems, you need to work out solutions. We deliver those solutions through the network of community pharmacies.

Now ladies and gentlemen, some say that Medicare is the jewel of the health system. I disagree. I think the PBS is the true jewel. The Guild is very proud to have helped shape the PBS from the very beginning in 1948. It was the guild that was in discussions with then Prime Minister Ben Chifley when other groups were saying the PBS Scheme should not be started. The PBS delivers key outcomes that Medicare, quite frankly, can no longer claim it universally achieves. In terms of accessibility and affordability, the PBS is now the only commodity, product or service where you pay the same price, certainly on the overwhelming majority of medicines, no matter where you live in Australia. So if a pensioner's \$5 is a price whether

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you live in the city or the country, for general patients \$31.30.

Now the average price of a medicine now, is \$41.54, so that means that taxpayers subsidise the vast majority of medicines. It's important to have price consistency. When you're sick or you have a child that's sick, the last thing you want to be doing is running around trying to find the cheapest pharmacy. For 84 per cent of medicines on the PBS, the price is the same, no matter which pharmacy you go to.

Now compare that to a basket of shopping centre goods, where for example, even within the same supermarket chain, prices vary by 21 per cent. We've all seen the variation in petrol prices. If that approach was taken in pharmaceuticals, millions of Australians would be disadvantaged, it just wouldn't be fair.

The PBS is shaped by five year agreements between the Pharmacy Guild and the Federal Government. Now our current agreement is worth a massive \$35 billion over five years. I have a saying at the Guild, I say to my colleagues, respect the Ms. The Ms stand for millions, because when you work around Canberra, the words millions and billions get thrown around with gay abandon. It's very important for pharmacists, the point I say to my council, for every one cent in efficiency we add to

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the average price of medicine, just one cent, that saves taxpayers \$2.5 million.

Now the agreements we negotiate is more than just on the price of medicines. It's how the scheme is delivered to patients, including support schemes and professional pharmacy services. We are accountable for all these issues, we are accountable for this spending. By way of example, we ensure that rural and regional pharmacies are viable and remain open.

Now some economic rationalists will tell you oh, this is - that's unfair, it shouldn't be the case. I disagree passionately with that argument. Rural pharmacy services are the only regional health services that actually has grown over the last decade. No other health profession can make that claim.

Now over the last three years, in essence there's been no growth in the number of prescriptions that have been dispensed. Now we've got an ageing population who've got chronic disease, and more medications are needed. We've got new therapies that have been added to the PBS all the time, so you would have expected a significant increase.

It is the Pharmacy Guild, through our members, that adds efficiency to the PBS, both in terms of IT development, and implementing Government policy, that adds these efficiencies. So our

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agreement, we predict with Government on the number of prescriptions that there will be each year. So far, since 2005, there's been 39 million fewer prescriptions dispensed. That means a saving to you, the Australian taxpayer, of \$1.5 billion. The custodian role of the Guild, the key role community pharmacy plays, is essential in ensuring the PBS is run viably.

Now, when patients take their medicines, as they've been prescribed by their doctor, they stay healthy, and they avoid unnecessary and certainly more expensive health costs further down the health channel. Staying healthy means you are productive, when you're productive you work, when you work you pay taxes, and when you pay taxes, well that keeps Treasurer Wayne Swan very happy. That is why we say the PBS should always be seen as an investment, not a cost centre.

When patients keep taking their medicines, we say they are compliant. Now to support compliance, the Pharmacy Guild has come up with a world first index called a MedsIndex Score. Now this score is basically a score that compares a doctor's instructions with how the patient is going, taking those medicines. So it's a score out of 100. So if you missed half your doses, you would have a score of 50. The system was only launched in March this year, but already tens of thousands of Australians are benefiting from this scheme.

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I can report today, and it's the first time I'm releasing this data, that the MedsIndex baseline data, show that on high medication users, the average compliance score was 76. Now ladies and gentlemen, that's a concern, because a score of 76 means a patient is missing nearly one in four doses. The fantastic news I can report today is, by assisting the patient, by explaining the importance of taking their medicines, by referring those patients to pharmacy programs, we've seen just in two months, the same cohort of patients' score increase to an average of 90. That's a fantastic result, and it shows that this system will benefit Australians moving forward, as we try and use medicines efficiently.

Now based on this score, different things can happen. A score of 70 means a patient's got serious compliance issues, and that patient is referred straight back to their GP. But there are other programs that we've developed. We've developed those with our sister organisation, the Pharmaceutical Society of Australia, and also with the support of the Federal Government, through the Department of Health and Ageing.

I've only got time to probably outline two key programs. The first is Dose Administration Aids. Now Dose Administration Aids is where the pharmacist packs medicines into those little blisters that makes it easier for patients to remember to take their medicines, and it certainly increases the quality use of medicines. Now this program is going

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to be increasingly important, because by 2020, three million Australians will need to have their medicines packed into these blisters.

Now the number one reason why a patient ends up in a nursing home, is not because they've had a fall, or some drama's happened, it's when they lose understanding of their medicines. So a Dose Administration Aid Scheme, will not only help reduce nursing home costs, it will also help patients stay well.

Another key program is Home Medicines Review. Now this program, which is triggered by the doctor, the patient then picks the pharmacist, or the pharmacy of their choice to coordinate the process. A pharmacist visits the home, looks at what medicines the patient's on, where they're stored, complementary medicines, over-the-counter medicines, and then an accredited pharmacist create - looks at the overall regimen, creates a report for the doctor, and the pharmacist and doctor working together, come up with solutions to improve the health of the patient.

I can tell you, you pick up a lot of areas for improvement, when you visit a patient's home. Now all our pharmacy programs operate in a process where pharmacies are independently assessed in a quality assurance system. The Quality Care Pharmacy Program, as we call it, which was developed in Australia, put Australia as the first

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pharmacy, community pharmacy system in the world, to be quality assured. We are very proud of that that achievement.

Now the National Primary Healthcare Strategy announced last month by Health Minister Roxon, will no doubt see an enhanced role for pharmacy, and we're ready for that opportunity. But there is currently much discussion about which health professionals can prescribe, and which can broaden their services so they can claim Medicare for their services.

I ask that you consider the following efficiencies, that pharmacy can add with no added cost to Medicare. Now firstly for a mere 20 medicines on the PBS, they account for 45 million prescriptions, or a quarter of all claimed PBS items. Now it's our view that once a doctor has initiated therapy, the pharmacist should be able to continue therapy for 12 months, not changing what the doctor's done, but adding an administration efficiency, and continuing therapy for 12 months.

Currently, when a patient runs out of a prescription, the pharmacist has no other choice but to send the patient back to their doctor, there's another place, a valuable place taken up in the health system, and more importantly, there's another swipe of the Medicare card. So some would call this prescribing, we don't. We call it medication continuance.

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Secondly, we would overlay this program with a number of support programs which we would develop with our sister organisation, the Pharmaceutical Society, to ensure that pharmacists are monitoring these patients, and other triggers. For example, if the compliance in any - at any time in that 12 month period was under 70, we would refer the patient back to their GP.

Now secondly, there's some 380,000 Australians, the majority of them in nursing homes, or high care facilities, that have their medicines packed into those blisters that I was talking about earlier. Now for these patients, it's the view of the Guild, for the medicines that are packed, a pharmacy should -, a pharmacist should be able to continue therapy for six months.

Now currently the system, it's an administrative nightmare for doctors, and every time a pharmacist, before they complete packing the medicine, if they've run out of prescription, they need to go back to the doctor. Again, we call this medication continuance. It's not prescribing.

Now thirdly, there are medicines in our view that should move from the prescription only category to a new sub-category called Pharmacy Only Medicines Notifiable.

Basically how we deal with pseudoephedrine sales right now is under that category.

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Now as, as the name suggests, notifiable means that government agencies would be informed of sales. We would do that to ensure that drugs are not misused or abused.

Now pharmacists already do prescribing under the schedule. We've done it for years. So using technology, existing technology that the Guild has developed, a patient could continue to access these medicines with individual protocols set. So, for example, for some medicines the protocol would be that a doctor must initiate therapy. For others, the medicine could not be accessed within 30 days. All those things are available, not with some future technology, with the system that we're working now with pseudoephedrine.

Now, the above three changes would not see one extra cent in remuneration to pharmacists. It would be a true added efficiency.

This proposal equates to four and a half million fewer prescriptions, fewer visits, Medicare visits - four and a half million fewer Medicare visits. It'll just increase the capacity for doctors to see more patients. So, in, it's the equivalent of adding 450 full-time doctors to the workforce, reducing unnecessary, what we call, administration visits to doctors.

Now back to those MBS prescribing rights for other health professionals and PBS prescribing.

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Now for every health professional who's spoken to the Guild, if they get their way and get PBS prescribing, there's going to be seven professions joining the current three - doctors, optometrists, and dentists - who prescribe on the PBS.

Now the role of the pharmacist is going to be even more important if in fact that goes ahead, because the pharmacist as the medications coordinator will want to make sure that what one prescriber has written, doesn't interact with what another has written. The role of the pharmacist is going to become even more important.

But ladies and gentlemen, Medicare is an uncapped scheme. And I can see Treasury and Finance wanting a lot of controls. So this is going to be a long debate, because all professions have to be accountable for their spending. The Pharmacy Guild is accountable for all spending in our agreement; as it should be. So this issue, therefore, will not be sorted out overnight, but the suggestions I have made can be implemented very quickly.

Moving on to another key issue. The Guild is proud to support a number of programs to improve Indigenous health and bridge the health gap. Let me explain just three quickly.

The Q-max(*) Program, as we know it, aims to improve health outcomes for Aboriginal and Torres Strait Islander people as they visit Aboriginal

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community control health services. Now these are both in rural and regional locations. Now this is going to be really important, because one of the key focuses is medication compliance, and within Indigenous health for example, diabetes and compliance with medicines is a really key issue. That's number one.

Let me explain another key scheme. Through the Section 100 scheme, remote area Aboriginal medical services order medicines from their local community pharmacy, enabling PBS medicines to be provided to Aboriginal people as they present to these centres. Now, and these are remote control - remote control - remote pharmacists actually go out to these communities as well, and visit, and make, and provide other services in addition.

This has been a massive improvement in health outcomes for Australians. Previously this scheme, which was run by State hospitals - State and Territory hospitals - we've seen a 350 per cent increase in the amount of PBS medicines that are used by the Indigenous Australians. A true breakthrough in health.

Thirdly, in terms of Indigenous health, we are proud to support a key scholarship scheme which aims to increase the number of Indigenous Australians who become both pharmacists and pharmacy assistants.

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Now, one such recipient is the 2008 Northern Territory Young Australian of the Year Simone Liddy. Now Simone's a bit of a star, because not only is she working part-time in a pharmacy, she's completing her last year at Charles Darwin University in obviously Darwin. And the fantastic thing is, as if she's not busy enough, she plays in the national hockey league for the Northern Territory Pearls. And we're really proud to support people like Simone, and we look forward to her joining our profession.

Now all our pharmacy programs would be even more successful if the Australian health system adopted an e-health model, where we use technology to connect health professions together; where we use it connect State systems with Federal systems; where we use it to connect private systems with public systems. No other, in no other health group has invested more money than the Guild and community pharmacy in terms of seeing e-health programs get up and running.

The Guild, Medicare Australia, and software vendors, in one program the PBS online, a program which in real times checks your entitlement, whether you should be on a concession card or a pension card; real time now 98 per cent of prescriptions run through this system. Three years ago, only three per cent of prescriptions went through. It shows the value of community pharmacy and how efficiently we can implement IT. More

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importantly, this system alone saves the PBS tens of millions of dollars each year.

Our major challenge that we've set in our next five year agreement with the government is to move our health system to an electronic prescriptions, or e-prescribing model. Now that means largely - that the paper prescription you're used to today will largely disappear by the end of that agreement. Now that's going to be real important. We need to know how many scripts are written. We need to know how many prescriptions are dispensed.

Now, at the moment, 12 per cent of original prescriptions are never filled. We don't know why. We need to know that. Fifty per cent of repeats are never filled.

The Guild also has some key criteria that need to be in place. One is a fill notification going back to the doctor each time a pharmacist dispenses a script, whether it's an original or a repeat. Now this is going to be increasingly important as we deal with the burden of chronic disease. Because, for chronic therapy medicines, a lot of patients see the doctor once for the six times they see their pharmacist - the original and five repeats.

Now, in the Federal Budget in May, there was an announcement they're going to increase some prescriptions to 12 repeats. So it's even more compelling reason why this should be put in place.

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The notification system does not exist now. The Guild always uses its innovation to improve the health system. We look at the best systems all over the world, we then bring them to Australia, but Australia will always have a unique system.

There are other key differences with overseas pharmacy systems. In Australia we have two schedules that don't exist in other countries like the USA. Pharmacist only medicines are those that must be supplied by a pharmacist with appropriate recording and labelling. Pharmacy medicines can be sold by pharmacists and trained pharmacy assistants, and these health professionals are available to give advice on those products.

Now, in the US by comparison, things are either on a prescription or available anywhere, for example in a gas station.

Now the difficulty with that approach is that basic ingredients, even low-dose codeine in everyday products like Mersyndol and chemist-own pain relief, these products in that system on, are on prescription. If that system was here in Australia, ladies and gentlemen that would add 180 million to Medicare alone. It shows the true value of a high service model, the model that is Australian.

Now relating to e-health innovation, the Guild has developed a world class IT product called Project Stop. It monitors pseudoephedrine sales, again the

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most effective product for cold and flu remedies for symptomatic relief. Unfortunately the same product can be used to make methamphetamine, which is the common illicit drug as we know as Ice.

Now that's sad, because we didn't want to disadvantage patients. So the Guild developed this IT system where, on a national database, sales are recorded. So if that person goes to a nearby pharmacy even 10 minutes later, that pharmacist knows that sale has occurred. It's stopped drug running by - drug runners who used to go from pharmacy to pharmacy getting - purchasing just one under the radar. It stopped it overnight. That's the value of IT in the pharmacy network.

Now some wanted this product to become prescription only. But that would have added \$80 million, just in Medicare costs, for people wanting to see their doctor just to get some decent symptomatic relief for cold and flu. The Guild's own IT department developed this technology. And it's a true collaboration. We work with Federal Attorney-Generals, Federal Police, state health and police departments, because that's what was needed to stomp out this scourge on our society of drug running of pseudoephedrine.

This is a world class system and I'm very proud to announce that the Pharmacy Guild is now selling this technology in the USA.

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Now setting aside all these outstanding developments in pharmacy professional services and e-health innovation, I would like to address one topic that comes up periodically; the suggestion by the supermarket operators that somehow they should operate and own community pharmacies. The most important concept to be aware of is that medicines are not normal items of commerce.

The US experience demonstrates that a supermarket model treats medicine as a mere commodity. There is no focus on the patient, no focus on patient outcomes, certainly no focus on compliance, no focus on effective use of Government resources. The supermarkets in Australia have one focus: that is to generate profits for their shareholders at any cost. It is at any cost. Let me give you the evidence.

The biggest selling products in supermarkets today, according to the AC Nielsen report, is the following; I'm going to read it out in order. Number one Winfield Cigarettes, nearly \$1 billion of sales. Number two Coca-Cola. Number three Longbeach cigarettes. Number four Peter Jackson cigarettes. Number five Horizon cigarettes. Number six Benson and Hedges cigarettes. Number seven Holiday cigarettes.

[Laughter]

Do I need to go on? Slogans like 'The Fresh Food People' should be replaced with something more

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appropriate. In fact Treasury should be sending the supermarkets a bill for \$3 billion each year, because that's the cost to the health system and lost productivity to our Australian society.

Now if that ethical approach isn't enough for you to consider they shouldn't be anywhere near a pharmacy operation, then consider for a moment that between Coles and Woolworth's they sell alcohol worth more than the Federal Government's total investment in the PBS.

Now people think alcohol is just a recent concern. Well groups like the Guild and other key bodies have been talking about it for years. In 2003 the New South Wales Government put on the alcohol summit and they put some figures on what the cost of alcohol is to our community. Let me give you those figures. They may be outdated but they still make a key point. Health and medical costs \$225 million. Road accidents \$1.8 billion. Lost productivity \$1.9 billion. Alcohol related crime \$1.2 billion.

Now sure some supermarkets are good at selling cigarettes and alcohol and if that's what they want to do, so be it. But ladies and gentlemen, health should be left to health professionals.

So we need to consider that the regulation of pharmacy will lead to other options and we need to consider that. I am sure many pharmaceutical

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companies would love to own pharmacies. You would go into their pharmacies and you would get their brand. I don't know if that's in the patients' best interest. In addition the corporatisation of medical practice has seen GP services vertically integrated and the Government has concerns with that. The concerns have been shown in various audits and in the May Budget the Government decided to invest more money to ensure there's no rorting of the system.

The Guild believes in the key principle that prescribing and dispensing should be kept separate. It provides checks and balances in the system. It provides protection for the public.

The Australian community pharmacy network is a delicately balanced system with pharmacies providing the link to patients. In Australia we have a strong manufacturing sector, it's very important that we nurture and support that. Both branded pharmaceuticals and generic pharmaceuticals. It's good for the country, it's good for the balance of payments, it's good for our economy and it gives patients confidence when they're taking Australian products. These medicines are then distributed by three wholesalers. Distributing sometimes products that are rarely used; 3630 products are distributed products are distributed on a daily basis by these wholesalers. They form an important part of the network.

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The pharmacies then complete the distribution system. It provides - pharmacies obviously provide health education, professional care, advice and an increasing range of professional services reflecting the obviously changing and increasing role of pharmacy in the community. Pharmacists are supported by highly dedicated and trained pharmacy assistants. They form the front line to assist patients. Their high service levels are vital for our whole system. They've been performing a triage role in pharmacy way before terms such as preventative health became a trendy term.

Now the Guild leads a proactive profession. There are 16 pharmacy schools across Australia delivering 1500 graduates all with at least four years of university training. On top of that these pharmacists complete an intern year. The vast majority of them will end up working in community pharmacy. These pharmacists want to continue to work in a professional environment, they're ready to take on an increased role, they don't want to work for supermarkets.

The Guild's focus in the next few years will be to work with Government and industry to develop these e-health solutions and to help shape a modern health system.

I have listed some of those innovative solutions today. The Guild will focus on one step at a time. That is our track record of success. There's one key

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ingredient as we go on that journey that we must take into consideration. The public is suspicious of online systems. The public is suspicious about most Government programs. The public however trust their pharmacists, they trust community pharmacy and they trust the network that delivers them benefits every day of the year.

I am proud to lead the Pharmacy Guild. I am proud to lead our profession. We thank the Australian public for their support. We will continue to be there for you and if you have any questions about the changes to the PBS on 1 August, as we say in our advertising, ask your pharmacist.

Thank you very much.

[Applause]

KEN RANDALL:

Thank you, Kos Sclavos. As usual we have a period of questions from our media members today starting with Sue Dunlevy.

QUESTION:

Mr Sclavos, Sue Dunlevy from *The Daily Telegraph*. The Health Minister has made it clear that she wants allied health professionals to take on a bigger role in our health system, and you've outlined today some areas where the guild would like to have a bigger role. In the past the guild has also talked about issues such as doing immunisation in their pharmacies and perhaps even at one stage, I

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think, were considering doing some diabetes management.

Do you have other growth areas in your profession that you would like to take over from doctors? And can I ask you when you embark on this path, are you expecting Medicare to be paying you a payment for managing the prescription drugs, carrying out an immunisation, doing these extra tasks?

KOS SCLAVOS:

Well, thank you for that question, Sue. I guess, in starting off, the Guild's always taken the attitude that we need to be responsible for our spending. The benefit of the agreement that we have is that there's fixed amounts and we need discipline, all professions need discipline.

This is public money, this is not our money. We're spending taxpayers' money. The reason why we support our process and our five year agreements is if one area is being overspent then we need to rein that in with spending in another area. If not, pharmacists' remuneration is penalised, that's in our agreement. We have risk share where the government penalises, in essence, if we're overspending in one area.

So I think we will not touch - apart from the fact my brother is a doctor and he'll be very upset if I announce that we're taking Medicare costs - we certainly would see our pool of money so, therefore,

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we're responsible for that pool. That's how we've always operated since 1990 in our first agreement.

I think - the Guild's approach is always to take baby steps. It's the burden of chronic disease that's affecting our health system. As I said, what I've outlined today is that in 10 years' time conditions such as asthma - and some of our peak groups are here in asthma and diabetes - patients want support. Even if it's just a helping hand knowing that the pharmacist is monitoring, keeping a score of how they're going with their compliance.

I think with the area of immunisation that's not at the top of our ladder. Certainly in the US our pharmacy colleagues, our sister organisation, pharmacists do immunise. But I think there are some very easy early wins that we can have, and I guess as president my approach is to implement easy steps, get those done before we move onto the next. And our priority certainly will be on chronic disease. That's where the big costs to the health system are.

So immunisation isn't there. Certainly diabetes we already have an agreement program on diabetes. We're soon to roll out an asthma program. As you can see, the government's focus is in these chronic disease areas, that's where they see the role of pharmacists increasing.

KEN RANDALL: Next question is from Mark Metherill.

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QUESTION:

Mark Metherill from *The Sydney Morning Herald*, Mr Sclavos. If I can have two questions. Have you discussed with your local federal member the idea of giving pharmacists a greater role in healthcare?

And secondly, you've spoken today about the professional and ethical standing of pharmacists. Doesn't this get detracted by the walls of unproven complementary medicines that now occupy pharmacies which cost quite a lot of money, but for which there's no evidence that they actually work?

KOS SCLAVOS:

Thanks, Mark. Well I'll deal with the first one first. Obviously, over many years coming to Canberra and leaving Canberra, and back then my mate Kevin was just on the same plane and we were sitting together over many trips and have had many meetings. I think the big picture - and that was certainly some of those discussions before our Prime Minister became Prime Minister - is that he wants to see an interlink. At the moment, for example, someone is in a nursing home; there should be a better link as they're leaving hospital, so that the pharmacist and the doctor knows what drugs have been changed on therapy, what are the new medicines the patient has been put on, have particular medicines been ceased.

In the hospital system, for example, a patient generally always gets generics medicines, Mark. They then leave, they go home, they take their own generics. We need to use IT to link the health

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system better together. And it's not about taking turf or turf wars, it's about using technology.

But, as I've said, we speak - probably no-one in this country speaks to more health groups than me, and consumers are suspicious. They're suspicious of government programs on online systems. So there's going to be a lot hand holding along the way.

I think in dealing with the issue of complementary medicines, there's lots of what we call levels of evidence. Two neighbours over a fence, that's a level of evidence. The highest is a Cochrane double-blind study and I guess, at the end of the day, we depend on groups like the Therapeutic Goods Administration, others, to give us a national prescribing service and others to give us fearless independent advice.

If there is an area of activity that I think is - and it's not like as if it would be a new way to look at it, it's always been looked at - and I know the boss of Therapeutic Goods Administration is here today so I'll be careful in my comments - I think all health professionals need more fearless advice.

Like my brother - I'll only speak to my brother as a doctor - he said if he had to read everything that comes across his desk he'd need three hours a day just for reading. The pharmacy figures probably at two hours. So we don't have time to read every bit of information. We depend a lot on the integrity of

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the pharmaceutical companies we deal with. And at the end of the day I'm confident my pharmacists are certainly acting in an ethical manner. If products are identified that they don't work, generally that's a very quick process where they're taken off what we call the recommended list, and they come off the shelves.

But I think, moving forward, the issue we need to face is Australians have a love affair with complementary medicines and we need to make sure that - the boundaries are being blurred. When a patient goes into my pharmacy, Mark, they don't care whether an item is prescription or over-the-counter or comp, they want a solution. And that's why you're seeing pharmacists having an increased range of products, because we're there to give solutions not sell products.

KEN RANDALL:

Next question is from Matthew Eaton.

QUESTION:

Matthew Eaton, the *Australian Journal of Pharmacy*. Mr Sclavos, there's a significant base of research now that demonstrates that extended pharmacy services do add value to primary care.

Now what's it going to take to bring general practice and, I guess, more specifically the AMA to agree with this concept? And is there anything that the guild is doing to try and bring the two health professionals closer together?

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KOS SCLAVOS:

Sure. Well, thanks for that question, Matthew. Look, I think - and Rosanna is here and welcome Rosanna from the AMA. The Guild and the AMA, without much fanfare, we get on particularly well. We have our executive, or our senior management teams meet four times a year. Two meetings then are between myself and Rosanna and we cover a whole range of issues. They can add agenda items, we can add agenda items.

I guess one of our primary focuses on the discussions so far this year has been on the registration and the national registration of health professions and moving to a national model. But we do discuss other things such as, for example, - I'll give you an example - we believe that pharmacists should give medical certificates. Now the AMA didn't agree with us. However, I do thank the AMA's [indistinct] because we gave them our draft materials which were protocols which we developed with our sister organisation. They said, well, a pharmacist shouldn't give a medical certificate for longer than a day, because otherwise they should be going to the doctor. We thought that was a very valid point so we changed our system. So, even though on the surface you may see there's a lot of argy-bargy on medical certificates alone, that's one example where we did work together. We agreed to disagree, but the AMA helped shape our final documentation. I think, for the health system to work, peak bodies need to be involved.

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If anyone thinks we can develop a national e-health network without groups like the AMA or the Guild, they're kidding themselves. So I think we should all get around a tree, hold hands and sing Kumbaya, because that's what we need to do to build a better health system.

KEN RANDALL:

And for those not terribly familiar with the health system, Rosanna is - Dr Rosanna Capulingua who is the president of the AMA who was here a few weeks ago. Next question's from Leo Shanahan.

QUESTION:

Leo Shanahan from the *Age Newspaper*. I was just wondering, Mr Sclavos, you spoke about wanting to expand the Pharmacist Only Medicines Notifiable Scheme.

KOS SCLAVOS:

Yes.

QUESTION:

Can you just give us an idea of drugs you'd like to see listed or expanded under that scheme?

KOS SCLAVOS:

Sure. Well, at the moment there's a debate on high-dose codeine products. So this is patients perhaps that have got chronic pain conditions. We know for example that codeine can be abused. Under this technology, that's it's existing, we could have, for example, that no one can get more than another dose of high-dose codeine combination products with ibuprofen say, for example, earlier than 30 days.

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It's world class technology. No other system in the world has that. So with pseudoephedrine for example now, maybe I should deal with what we do now. If a sale is within a certain period, a second sale, and I - obviously for police reasons I can't inform you of that - the trigger, then police are informed. Furthermore, if there are a certain number of, a lot of sales in a short period, the police are actual SMSed the details of that individual. Now that's very important because we've got something like 3 million Australians use pseudoephedrine products every year. Through a few drug runners, there was a real threat to make this product prescription only or remove it totally.

So, for example, under this co... high-dose codeine issue, especially because it's not so much the codeine that's causing the problem, it's the ibuprofen which can cause gastric bleeding and other problems, we would record that; it would be a Notifiable Scheme, so that if somebody purchased this every third day, if - and a lot of times these patients go from pharmacy to pharmacy so that they're under the radar so to speak, then that pharmacy would be notified.

The pharmacists would then know, counselling would be given to the patient and obviously health authorities could also - would know so that perhaps there could be professional intervention. We have got professional intervention programs in various states and territories to assist patients. Because not

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all abuse of medication is deliberate. There's inadvertent misuse. These are - I know first hand that patients who - when you say to them, oh, Mrs Jones you've gone through eight packets in a month of this product, they go, well, I thought that was okay, you know and they're quite alarmed when you tell them it's a dangerous amount to have.

So there's this notion sometimes that anyone who is taking an over amount of a particular medicine is doing deliberately or sneakily or they're some crook. The Guild doesn't judge people. Pharmacists don't judge people. We don't know what circumstances brought them to need those painkillers. It could have been an accident, it could have been a death in the family. Pharmacists just deal with those patients. The beauty of this online system is we don't have to categorise anyone.

If you walked in, good looking gentleman like yourself, then we would say, that's a legitimate user. But if it was on one of your bad days...

[Laughter]

...I don't want to be saying, well, you like a criminal. The great thing is these IT systems, we take all that judgement out. Pharmacists just deliver medicines, even if a pharmacist suspects that it's inappropriately being used by recording it the next pharmacy picks up the problem. That's the benefit

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of the IT system and the pseudoephedrine example has shown us that we can move lots of products.

For example the contraceptive pill, I'll pick a controversial one. That obviously would have to be an initially prescribed by the doctor, we would record that. There would be, for example, an interval for example, I know that we would want to set a protocol that the person must go back to the doctor for example, a pap smear, et cetera, so it could be a trigger that A, you could get it, only within a certain period but then refer the patient back to their GP. That's what the technology of the guild has developed can do, tailored to each individual product. And we're looking forward to implementing that system in Australia.

KEN RANDALL:

Question from Siobhan Ryan.

QUESTION:

Hello, Siobhan Ryan from the *Australian*. You made mention that are seven health professional groups who are kind of knocking on your door, talking about access to the PBS, I am just interested in which groups they are and what's your view on which of the groups are best suited to be added to the PBS in terms of prescribing rights. Thank you.

KOS SCLAVOS:

Sure. Well, that's a very good question. The Pharmacy Guild owns a company called Guild Group. We are very proud of it, it's an insurance company that's the leading insurer for most health professionals in Australia, including the leading

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health prof...health insurer for the childcare industry. So we own an insurance company. Naturally we're involved because from a professional indemnity point of view we need to check what, perhaps, these health professionals will do in the future, because we'll be looking after their insurance, that's our company the Guild's Company.

We've obviously been in controver... not controversial discussions but secret discussions; I'll put it that way. And I guess, one, I'll give an example which was in a doctors' magazine. So I'll pick one group because they're already on the record.

For physiotherapists, I believe that they should have a limited prescribing right. For short-term, perhaps symptomatic relief or short-term care. At the moment, for example, a physiotherapist may say, look, you really need this anti-inflammatory, perhaps it's stronger than the strength you can get over the counter. At the moment that person has to go back to the GP see them. We're talking about long-therapies, such as the COX-2, the long-term anti-inflammatory medications, just the short-term. Probably a dozen medications would suffice for a physiotherapist to have PBS prescribing rights.

That's the sort of thing we will sit down in due course with groups like the doctors groups that we work with, with a physiotherapist, with our insurance company, with the Guild because at the

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end of the day, our system have to work. I will be the pharmacist who'll be dispensing these medicines. But I believe that's like a practical solution. You start with a small number of products, you make sure they're implemented. And I can only give the optometrist as an example. That was implemented seamlessly. The average Australian doesn't know how well that went, but we had IT issues, we had professional indemnity issues and the Guild played a central role in it.

KEN RANDALL: Steven Scott.

QUESTION: Steven Scott from the *Financial Review*. It was interesting that you mentioned the argument at supermarkets wanting to break into the pharmacy game. Given that the Rudd Government has made a big deal of reducing costs for consumers in groceries and petrol, for example, are you concerned that that kind of argument from supermarkets would find favour with this government?

And if there were the proper protections in place, would we see a reduction in costs for consumers if you could walk into a supermarket and get a script filled?

KOS SCLAVOS: Well, thank you for that question. I think there's a few issues there I need to address.

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Well first of all, all medicines that go on the PBS are not negotiated by the Guild. We've got the Pharmaceutical Benefits Advisory Committee that look at those and then there's negotiations with the drug company.

So, a supermarket can't bring any benefit to the process. There's a very rigorous process, as you regularly see from drug companies who are complaining that their drug hasn't been added to the PBS.

So supermarkets add no value. I won't go over the fact that supermarkets cost the health system. But lets look at the Rudd Government's record for a moment. There's no good news in there for supermarkets. We've seen what they do, their tactics with supermarket prices, with petrol prices. The last thing I think they want to do is give a key piece of government infrastructure, the PBS, over to these people to play their little tactics and games like they've done, as they've already done in the ACCC and announced the way they manipulate town planning laws et cetera.

The PBS is a key bit of government infrastructure. It's too important to hand - to do a duopoly that has a track record of mischievously misleading processes in other areas.

So, no I don't see that anything the Government has said, currently gives supermarkets any joy. But we

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need to address - look unfortunately I was only given half an hour and I probably went over Ken, and I apologise if I did.

But let me give you another example. We have laws right now that on low dose medicines, 24 pack, you can buy those anywhere. I won't name the products, there's seven or eight of these. But for higher strength, 48, 50, you need to go to a pharmacist. That's there for a reason. It's a risk base approach. But you can go to any supermarket today and shove five or six or twenty in your supermarket trolley and they won't do a thing about it.

They've got the technology. They could stop multiple pack selling right now. They are rorting the system right now with many of these products. So, why are they allowed to sell multiple packs of many of these products where a 48 pack size is only available in a pharmacy?

Why are they able to allow consumers when they have the technology? They haven't as you know. Sometimes if there's a limit of one, you try and buy more, it'll come up on their till. So, they have the technology, they don't care because that's a minimum standard, it's not about what's best for the consumer, it's about what's best for their shareholders and bottom line profits.

QUESTION:

Question from Laurie Wilson.

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Laurie Wilson, freelance journalist and director of the National Press Club. Unfortunately the last question was the one I was going to ask you.

So, I'd better think about something else. I thought I might go back to...

KOS SCLAVOS: Something easy Laurie.

QUESTION: ...back to the new category that you've discussed, the pharmacist only medicines notifiable.

Is this a new idea that you're floating today or have you begun discussions with people about this? And if so, what reception have you had so far?

KOS SCLAVOS: Thank you. Obviously the peak body with over-the-counter medications in Australia is ASMI or Australian Self Medication Industry.

The CEO and the chairman are here and we've certainly been in discussions for well over a year. They, in fact helped us to implement the pseudoephedrine system and it was a lot of work.

As I said, there's a whole lot of government agencies, attorney-generals and so forth. The great thing is, is that they support this process. We're going to implement that process certainly and this year will be a major focus for us.

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And I guess at the end of the day they also - their manufacturers want to be responsible for their sales. So, the great thing is that yes, we do have industry support and it will be one of our priority areas this year.

KEN RANDALL: Tony Melville.

QUESTION: Tony Melville, director of the National Press Club. I think if you want Australians to understand the benefits of the PBS, you send them to the US to get sick. I was over there at Christmas and got - I got pneumonia and got eight pills and it was \$300. So, I don't know what that's per pill, thirty something.

But just a question about the issue of medication continuance. It was *Choice* magazine I think, a year or so ago, sent shoppers around to chemists and they were quite critical at the advice that they were given. Just from an operational sense, you know, what's been the response since then? You know, what sort of - what has happened in chemists that you can say would give people a confidence that medication continuance should be expanded?

Well the product you're referring to was Xenical. At the time, there are protocols which a pharmacist must have in place. This is the - in fact the only affective weight loss product available. So, as pharmaceutical society developed these protocols, we've put them in place, we've added them to various groups such as the major pharmacy brands

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like Terry White et cetera, have put in mystery shop to make sure they're ongoing and testing those products. Because at the end of the day, I'm not here to apologise for any pharmacy doing the wrong thing.

You know, if any pharmacy's doing the wrong thing, then we want to know about it, because even one can let the whole team down. I think with regards to the US, let me give you some other examples, because unfortunately with our sick child we were there.

Worming medication, because it can be abused, is only available on prescription in the US. It's cost, \$100, to get a worming medication for one child. The doctor's visit is \$200. But this in Manhattan where we were. There's eight million people who live there, 20 million who work there. I have a sick child. My wife and I are running around, you cannot get all your medications from the one pharmacy, because they don't stock all brands.

They say, oh we don't make enough profit out of that so we don't stock it. So I've got a sick child and we had to go to four pharmacies to get medicine for our child. That disgusts me. In Australia, every Community Pharmacy, everyone in the 5,000 strong network can get medication overnight, 24 hours, in any pharmacy. That's the record that we keep. That's because that's in the public interest, not in my

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interest as a pharmacy owner, that's in the public interest.

KEN RANDALL: Kos, thank you very much. It's been a very informative hour.

[Applause]

[Indistinct] you another open invitation for next year...

KOS SCLAVOS: Thank you very much, Ken.

KEN RANDALL: ...membership. Thank you again.

KOS SCLAVOS: Thank you, Ken.

[Applause]

* * **END** * *

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