The Pharmacy Guild of Australia

Pre-Budget submission

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About The Pharmacy Guild of Australia

The Pharmacy Guild of Australia ('the Guild') is an employers' organisation servicing the needs of independent community pharmacies. It strives to promote, maintain and support community pharmacies as the most appropriate primary providers of health care to the community through optimum therapeutic use of medicines, medicines management and related services.

The Australian network of Community Pharmacy

There are more than 5,350 community pharmacies in Australia, with a net increase of more than 300 in the last 4 years[1]	**A well distributed network, with Pharmacy Location Rules ensuring that new pharmacies open where communities need them.**
More than 90% of community pharmacies are accredited under an Australian Standard[2] quality management system, the Quality Care Pharmacy Program (QCPP)	**Consistent, high quality levels of service.**
Around $5 billion of privately funded assets[3], utilised for the public good	**A successful Public-Private Partnership, efficiently managing the best pharmaceutical subsidy scheme in the world.**
More than 55,000 staff including almost 20,000 pharmacists[4]	**A highly qualified and trusted healthcare workforce.**
More than 1,400 new pharmacy graduates each year[5]	**An ample supply of young, knowledgeable and enthusiastic professionals.**
300 million patient visits per year[6]	**The most visited healthcare destination.**
425 towns with only one pharmacy	**Vital to local communities, large and small.**
94% of Australian adults use a pharmacy each year[7] and 3.9 million Australians ask a pharmacist for health advice each year, with 79% reporting that the advice met their needs completely[8].	**The most accessible health professional, providing free advice, no appointment needed. These consultations free up resources elsewhere in the health system, but at a cost to community pharmacies.**
Australians express a higher level of satisfaction (89%) with pharmacists than with any other health care professional[9]	**Trusted, quality service and advice.**
More than 3.6 million pharmacist clinical interventions were recorded in 2013 alone[10]	**Documented evidence of the value and health outcomes being delivered by community pharmacists. Some of the most frequent interventions relate to prescribed dosages being too high, as well as to toxicity risk, allergic reactions and adverse effects.**
More than 9 million dose administration aid devices are provided each year to Australians living in their own homes[11]	**Devices that ensure that patients take the right medicine at the right time – a vital service to reduce medication misadventure and keep people living independently in their own home rather than in aged care facilities.**
99.6% of PBS prescriptions checked and claimed online, in real time	**The most connected and technologically-ready part of the health sector.**

[1] Department of Health data
[2] Australian Standard 85000:2011
[3] 2011-12 estimate, The Pharmacy Guild of Australia, 2013 Guild Digest
[4] 2011-12 estimates, The Pharmacy Guild of Australia, 2013 Guild Digest
[5] 2009 estimate, Committee for Heads of Pharmacy School Australian & New Zealand (CHPSANZ) survey
[6] 2011-12 estimates, derived from 2013 Guild Digest survey
[7] Menzies-Nous Australian Health Survey 2012
[8] Australian Bureau of Statistics, 4839.0.55.001 - Health Services: Patient Experiences in Australia, 2009
[9] Menzies-Nous Australian Health Survey 2012
[10] Guild data
[11] Guild data

Background

Community pharmacy in Australia is an essential, cost-effective and highly accessible health care destination. It has the capacity, skills and willingness to deliver a considerably broader set of services and functions for the Australian community, in collaboration with other health professionals, to improve health outcomes. However, this opportunity is currently being undermined by the adverse flow-on impacts of PBS price disclosure. The Pharmacy Guild of Australia and community pharmacies have consistently supported price disclosure as a means of ensuring that taxpayers get maximum value for money from the PBS. However, as the impact of price disclosure increases during 2014-15 many pharmacies may have no option but to reduce staff and services just to remain viable (see page 11). This issue has been exacerbated by the previous Government's election eve decision to move the price disclosure goalposts during 2014-15 without any recognition of the significant flow-on impact on pharmacies during the final year of the current Community Pharmacy Agreement.

The Government must now work in partnership with the Guild to ensure the ongoing viability of the network which delivers the PBS to patients – a network which also has the potential to deliver many more primary health care services. The Government should use the 2014 Federal Budget as a prime opportunity to lead the transformation of community pharmacy into a core primary health care destination, with the objective of delivering better and more cost-effective health outcomes for all Australians.

Broadening the role of Community Pharmacy - international trends

Governments in other countries are recognising the additional value community pharmacy can bring to their health system – an opportunity that exists now in Australia.

Pharmacy transformation has already started in other countries. Governments of nations with similar modern healthcare systems, similar patient and community health needs, and similar challenges in relation to community pharmacy viability are making greater use of community pharmacies and pharmacists. This is ensuring that the populations in those countries derive full value from their investment in subsidised medicines and that other healthcare resources are used as efficiently as possible.

Below are just a few examples of community pharmacy-based services that exist now in other countries and could be readily implemented in Australia.

In Canada, Scotland and the United Kingdom	Governments fund community pharmacies to **manage minor ailments**, including conditions such as urinary tract infections, allergic conjunctivitis, back pain, mouth ulcers, eczema, thrush, stings, head lice and acne. Promotional material for the Scottish NHS Minor Ailment Service can be seen at Attachment 1.	**These services reduce costs in other areas of the healthcare system, provide convenient, quality service for patients and ensure that the skills of all health care professionals are put to best use.**
In the United Kingdom	In January 2014 23 key health groups, including the Royal College of GPs, the Royal College of Nursing and the College of Emergency Medicine, wrote an open letter in The Times saying that **one in seven GP appointments could be dealt with by pharmacists** to take the burden off the National Health Service. The Times article can be seen at *Attachment 2*.	
In the United States of America	The government provides free Medicare Wellness Visits focusing on education and prevention. These can be conducted by qualified pharmacists in several states.	

In Canada and Scotland	Pharmacists are paid for prescription renewal and to **manage the ongoing supply of prescribed medicines** for chronic conditions without the need to continually return to the prescriber.	
In the United States of America	Since 2009, **pharmacists have been authorised to administer vaccinations in all 50 US States**[12], with more than 150,000 pharmacists trained to administer vaccinations. Pharmacist vaccination is also common in many other countries.	**Pharmacists provide increased access to vaccination through extended business hours and locations. Vaccinations administered by trained pharmacists help to increase immunisation rates.**
In New Zealand	Pharmacies are paid to **deliver smoking cessation support services**	**Reducing smoking rates and reducing the burden on society of smoking-related disease.**
In New Zealand	Pharmacies are paid for **after-hours support and services**	**This ensures patient access to medicines when they are needed. No such arrangements exist in Australia and extended hours pharmacies will be some of the most at-risk from the effects of PBS price disclosure.**
In Canada	Pharmacies are paid to produce and **manage a comprehensive annual care plan** for people with a mental health disorder, heart failure or ischaemic heart disease and other eligible chronic diseases or risk factors	**An example of pharmacists being central to the collaborative approach to personalised care.**
In the United States of America	Pharmacies are paid for **anti-coagulation management**, including in-pharmacy blood testing, International Normalised Ratio (INR) monitoring and warfarin dose adjustment	**Ensuring the correct management of this high risk medicine, minimising adverse events due to bleeding that would result in hospitalisation.**
In Portugal and Denmark	Pharmacies are paid to provide training and guidance on the correct **technique for inhaler devices**.	**Ensuring that medicines for asthma and chronic obstructive pulmonary disease (COPD) are taken properly and safely, reducing the risk of emergency room visits and hospitalisation.**

Those listed in the table above are just some examples of funded services that community pharmacy could deliver in Australia. These countries are recognising the importance and accessibility of pharmacists, and their range of knowledge and expertise, and are initiating reform which fully integrates community pharmacies into the health care system and makes the most cost-effective use of all available health care resources.

[12] Traynor K. With Maine on board, pharmacists in all 50 states can vaccinate. American Journal of Health-System Pharmacy 2009; 66: 1892-94.

Transforming Community Pharmacy's Role: the greatest opportunities

Primary health care and disease prevention are critical areas of our health system and there is much potential for greater efficiencies if the Commonwealth Government was to embrace an enhanced role for community pharmacies.

Areas where pharmacies can play an enhanced, cost-effective role include wellness, screening and disease prevention services; supporting chronic disease monitoring and self-management; in-home aged care; administering vaccinations; addressing minor ailments; smoking cessation services; and wound and pain management. Pharmacist involvement in these areas would free up scarce doctor resources to allow them to provide medical care for patients with serious, complex and chronic conditions. It would also reduce preventable and unnecessary hospitalisations through a greater emphasis on early detection and intervention and ongoing management of chronic conditions. As shown in the previous section pharmacists are now being remunerated for greater roles in these types of services overseas.

Some of the areas where community pharmacy has the greatest ability to deliver cost-effective improvements in health outcomes, including savings to other parts of the national health budget, are outlined below. Pharmacy programs in these areas would deliver accessible, affordable, patient-centric care, in collaboration with other health care professionals, including general practice and allied health. They are either not funded at all or not funded adequately under the Community Pharmacy Agreement.

All of these opportunities draw on the accessibility of community pharmacies as the most visited healthcare destination, the skills of the existing workforce, and the role of pharmacists as the medicines experts.

More detail can be provided on request in relation to any of the programs outlined below. The Guild has done considerable work in the development and costing of new and expanded programs and initiatives and would welcome any opportunity to provide further information.

Aged care in the home

Keep aged people living in their homes longer, saving the aged care budget

Community pharmacy is ideally placed to provide a personalised service targeted to the cohort of aged and infirmed people who have been assessed as likely to move into a Residential Aged Care Facility or are at risk of hospital admission/re-admission if they do not have sufficient support, including support in managing their medicines. Elements of this service, which would be performed in collaboration with the patient's GP, could include but may not be limited to:

- development of an agreed action plan
- the provision of all appropriate medicines in dose administration aids;
- home delivery of medicines where required;
- regular medicine reviews undertaken in the patient's home (focusing on education, adherence, compliance, interactions and adverse effects) - **30% of hospital admissions for the elderly are from adverse medicine events**[13]**;**
- regular monitoring of blood pressure and other health indicators;
- management and monitoring of any devices that are used by the patient;
- administering prescribed medicines as required;

[13] Medication safety in acute care in Australia: where are we now? Part 1 (Review 2002-2008), Aug 2009

- reducing the risk of falls and other injuries in the home – **this is a large and increasing reason why older people are hospitalised**[14]; and
- liaising with allied health care professionals such as occupational therapists and podiatrists, as well as local support agencies.

Screening, prevention and wellness checks

Address health risks before they develop into costly chronic conditions, and assist to diagnose conditions early to reduce costs associated with more advanced cases

Community pharmacies are ideally placed and pharmacists well trained and skilled to assist in the detection, education and referral of individuals at risk of chronic disease.

A comprehensive in-pharmacy health check service would assist in early identification of disease risk in order to encourage lifestyle behavioural changes and address identified risk factors, as well as referrals to other health professionals such as GPs where required. A health and wellness check may include blood pressure, cholesterol, blood glucose, body measurements, lung function, bone density and deal with lifestyle risk factors such as smoking, diet, sleep and exercise. Results can be used in established tools such as the Stroke Foundation's Know Your Numbers and the AUSDRISK Type 2 diabetes tool.

While services such as these are provided by some Australian pharmacies, often at the patient's cost, it would be advantageous to establish a consistent, broader program and/or specific targeted programs enabled by government funding. The results would also be recordable in any patient's shared electronic health record and aggregated, de-identified information would provide a wealth of epidemiological data.

In the USA, the government's Medicare Part B insurance scheme provides for a free annual Medicare Wellness Visit which can be conducted by qualified pharmacists in several states and includes:

- recording and reviewing the patient's medical and family history, current health conditions, allergies and medications;
- checking the patient's blood pressure, vision, hearing, height and weight;
- screening for depression;
- providing the patient with a checklist to make sure they are up-to-date with preventive screenings and services that are needed or due, such as cancer screenings and adult vaccines; and
- offering recommendations and education on conditions and lifestyle issues impacting the patient's health

Community pharmacy is also ideally placed to assist in the screening for a range of conditions. In addition to cardiovascular disease, diabetes, asthma/COPD and osteoporosis community pharmacy can screen for conditions such as chlamydia and bowel cancer.

Minor ailments and triage

Reduce the number of unnecessary visits to GPs for minor conditions treatable with pharmacist advice or non-prescription medicines

Many people visit their GP as the first line of treatment for what are relatively minor ailments. These doctor visits represent an inefficient allocation of our scarce health resources, including the time of busy GPs, whose skills would be better utilised addressing more complex medical problems. These minor

[14] Productivity Commission, Report on Government Services, January 2014

ailment consultations are a major contributor to the fact that 23% of Australians in capital cities and 42% of Australians in other areas are forced to wait at least three days for a GP appointment[15].

A study commissioned by the Australian Self Medication Industry (ASMI) and conducted in 2008 by international health industry consultants IMS, found that 15% of all GP consultations involve the treatment of minor ailments, and 7% involve the treatment of minor ailments alone. When projected nationally, this equated to 25 million GP consultations annually, or approximately 96,000 consultations per day.

Community pharmacy already provides advice, usually for free and with no structured program in place, in relation to many minor ailments such as coughs and colds, headache, skin disorders, constipation, diarrhoea, haemorrhoids, ear aches, back pain, eczema, cold sores, conjunctivitis and many others.

A structured minor ailments scheme that included a consumer education campaign to raise the awareness of the choices available to consumers in relation to these minor ailments, together with appropriate remuneration that recognises community pharmacy's enhanced role, would ensure a better allocation of health resources. It would also provide greater convenience and more timely treatment for patients suffering from these ailments. The program would include protocols relating to the need for GP or emergency referral, with the pharmacy playing a triage role.

In implementing such a program Australia would be following the lead of other forward-thinking countries. A pharmacy-based National Health Service (NHS) Minor Ailments Scheme has already been implemented in Scotland (see the promotional material at Attachment 1), and programs also exist in some Canadian provinces. In January 2014 23 key health groups in the UK, including the Royal College of GPs, the Royal College of Nursing and the College of Emergency Medicine, wrote an open letter in The Times saying that one in seven GP appointments could be dealt with by pharmacists to take the burden off the National Health Service. The Times article can be seen at *Attachment 2*.

Adherence and compliance

Ensure that medicines are taken as intended by the prescriber, and that side-effects are managed, so that the maximum health benefits are derived from the community's investment in subsidised medicines.

Medication adherence rates in Australia are low, averaging only 50 to 65% for many medicines. This leads to poor health outcomes, preventable hospitalisations, and unnecessary increased health care costs. An IMS Study[16] in 2012 identified six main levers to lower overall health system costs and improve health outcomes:

- non-adherence to medicines;
- untimely medicines use;
- antibiotic misuse/overuse;
- medication errors;
- suboptimal generic use;
- mismanaged polypharmacy.

This IMS study estimated that a $6 billion avoidable cost opportunity, or 7.7% total health expenditure, exists in Australia across these areas with non-adherence contributing more than 50% of this figure.

[15] Menzies-Nous Australian Health Survey 2012
[16] IMS Institute for Healthcare Informatics: Responsible use of medicines report, October 2012

If medicines are not taken in accordance with the prescriber's directions, or the patient discontinues treatment early due to a lack of support or understanding of the medicine's purpose or its side-effects, some or all of the taxpayer cost of subsidising the medicine can be wasted as the desired health benefits are not achieved. By ensuring that the medicine is prescribed and taken as envisaged when it was assessed by the Pharmaceutical Benefits Advisory Committee and approved for listing on the PBS, a comprehensive community pharmacy program addressing prescribing, adherence and compliance issues would provide the full value of the community's investment in PBS medicines.

Improving compliance is an important element of the Medscheck and Diabetes Medcheck services currently funded under the 5th Community Pharmacy Agreement. However, funding for these services is limited. There is a need for an increase in funding for them or, alternatively, additional services should be funded, focused on medication compliance for the most appropriate patients and drug categories.

There are a number of medication compliance focus areas that are recognised in countries around the world as producing the most beneficial health outcomes as well as reducing unnecessary costs in the wider health system. These include adherence services relating to patients who are new to therapy, those recently discharged from acute care and those who have a mental health condition. Ensuring that these adherence services are available in both cities and in regional and rural areas is important, particularly in locations where other health services are not as readily accessible.

Medication adherence is also a particular problem in the Aboriginal and Torres Strait Islander population and a funded program to meet their specific needs has the potential to produce significantly enhanced and more cost-effective health outcomes, particularly in the areas of diabetes, cardiovascular conditions and chronic obstructive pulmonary disease. A number of existing medication adherence programs could be readily tailored to address these needs.

Community pharmacy has a unique ability to implement these programs, and to monitor and report on their effectiveness, through the use of the comprehensive Guildcare software platform. More than 60 per cent of pharmacies are already using one or more modules of this platform.

Medication management post discharge from acute care

Reduce the rate of hospital re-admissions due to medication misadventure or non-adherence

The increased prevalence of chronic and complex health conditions, which are managed across various parts of the health system, has placed a greater emphasis on the interface between acute and primary health care. These conditions are often associated with complex medication issues.

Evidence indicating that significant patient harm and sub-optimal use of medicines frequently result when consumers move between different health settings and health care providers includes:[17]

- On admission to hospital, up to one in two patients had an incomplete medicine list provided, resulting in a medicine not being provided during the hospital stay.
- 1.6% of hospital admissions are associated with the occurrence of an adverse medicine event accounting for an estimated 190,000 hospital admissions per year with costs to the health system estimated at $660 million annually, with half of these events considered to be avoidable[18].
- 30% of hospital admissions for the elderly are from adverse medicine events.
- Medicines are considered to be the cause for 10% of all adverse events experienced in hospitals.

[17] Continuity in Medication Management powerpoint; http://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-publications-a_z.htm-copy2

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- 78% of GPs were not directly informed that their patient had been admitted to hospital and 73% of GPs did not directly receive discharge summary information.
- 14.5% of consumers take four or more medicines.
- 12% of patients had an error in their hospital discharge prescription.
- Omission of medicine from the discharge summary list sent to community health care professionals was associated with an increased risk (by a factor of 2.3) of hospital readmission or an adverse medicine event.
- 9% of patients were discharged from hospital with insufficient medicine supplies.
- Less than 2% of people leaving hospital receive a discharge plan, case conference or medication review within the first month after discharge.

The increased availability of generic medicines also impacts on the quality use of medicines and continuity of care. Patients are often provided with different generic brands of medicines in the hospital setting and confusion occurs when they return to the community setting. Medicine Discharge Summaries are rarely given to the patient's regular community pharmacy and confusion leading to duplication of generics can occur.

There is good evidence that continuity in medicine management can improve with a systematic approach.[19] Community pharmacy is an underutilised resource in supporting continuity of care. Within 30 days of hospital discharge, 71% of patients visit their General Practitioner (GP) within a median time of 12 days, whilst 86% of patients visit their pharmacy within a median time of 6 days to have a prescription filled.[20]

There is a clear need for improved coordination between the hospital and primary health care systems in terms of managing the medicines aspects of patients transferring out of acute care back into the community setting. There is no funding for medication management services at this critical juncture – the very time when it is most important that patients' medicine regimen is correct, is properly understood by all involved and is effectively monitored. A coordinated approach is required involving the hospital pharmacist, the GP and the community pharmacist – with an agreed plan to check adherence and any other issues that may otherwise result in a high risk of readmission to hospital.

Vaccination

Improve vaccination rates and coverage, and reduce costs associated with administering vaccines in the general practice setting.

Pharmacists commonly administer a range of vaccines in countries around the world, including the USA, Canada, the United Kingdom and New Zealand. In addition to increasing accessibility and reducing costs, the availability of pharmacist vaccinators ensures that the risk of major influenza pandemic can be reduced through more efficient and widespread access to vaccines. There has been no evidence of any increase in risk to patients in countries that have allowed pharmacists to vaccinate. In the USA, no anaphylactic reactions have been reported following their administration in pharmacies over the last 12 years, across about 5 million doses[21].

[19] National Medicines policy - APAC Guiding principles to achieve continuity in medication management July 2005, www.health.gov.au

20 EE Roughhead et al; Continuity of care: when do patients visit community healthcare providers after leaving hospital?; Internal Medicine Journal; Vol 41, Issue 9; pp 662-667; Sept 2011

[21] Menighan T.E., Executive Vice President and CEO, American Pharmacists Association, Country case-studies: The role of pharmacists in vaccinations – USA, Oral Presentation at FIP, Hyderabad, India, September 2011

Vaccination by community pharmacists has become commonplace, with international experience overwhelmingly positive. Examples of this include:

- Pharmacy vaccination services have been in place in the USA since the mid-1990s and since 2009 all 50 states in USA have allowed vaccination by pharmacists. The universal acceptance of pharmacist vaccination in the USA was driven in part by data showing that adult influenza vaccination rates increased faster in states that were early adopters of this model. In the 2010-2011 influenza season, it was estimated that almost 20% of adult vaccinations nationwide were delivered by pharmacists.
- An English program saw an increase in influenza vaccination rates for seniors from 59% to 76% following introduction of pharmacist vaccination.
- The Isle of Wight & Wales saw increases in influenza vaccination rates from 64.1% to 70.3% among those aged 65 years and older & from 46.4% to 51.2% in those younger than 65.
- In Canada, over 2012-13 flu season, 150,000 people in Alberta & 200,000 in Ontario received influenza vaccine from a pharmacist.
- With the introduction of the first national Pharmacy-Based Influenza Campaign in Portugal in 2008, a quarter of all influenza vaccines were estimated to be administered in pharmacies and 13.1% of these people were first time recipients, demonstrating the role of pharmacy in improving access to the population and increasing vaccination uptake.

The Pharmacy Board of Australia has now recognised that vaccination is within a pharmacist's scope of practice once guidelines and training requirements are established. This process is underway.

The Productivity Commission[22] has recently reported that more than 25 per cent of eligible patients do not receive a subsidised influenza vaccination, and about 20,000 preventable hospitalisations annually are due to conditions for which vaccinations are available. A Commonwealth government subsidised, community pharmacy based influenza vaccination program, following the successful lead of other similar nations, should now be introduced to improve accessibility and coverage.

[22] Productivity Commission, Report on Government Services, January 2014

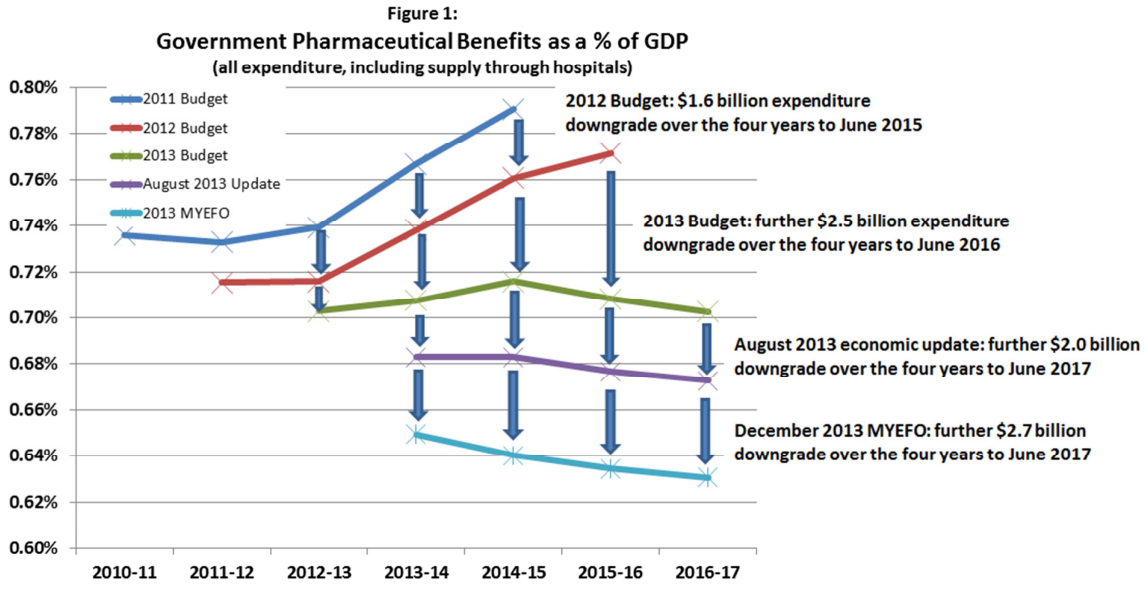
The Current Threat to Community Pharmacy Viability

Price disclosure has ensured the sustainability of the PBS. The government must now reinvest a fraction of the savings from price disclosure into the future sustainability of the community pharmacy network.

As a result of the price disclosure policy, expenditure on the PBS is now well contained. The Productivity Commission's *Report on Government Services 2014* confirmed that the PBS cost government less in 2012-13 than in any of the preceding four years in real terms[23]. Forward estimates have been downgraded by more than $8.9 billion since the 2011-12 Commonwealth Budget (see Figure 1). Less than $1 billion of this has been due to the introduction of new policy. The only new policy was the further acceleration of price disclosure (referred to as Simplified Price Disclosure) as announced by the previous government in August 2013. This significant change, which takes effect in the 2014-15 financial year – the final year of the Fifth Community Pharmacy Agreement (5th Agreement) – was announced without consultation despite such consultation being expressly required under the conditions of the 5th Agreement.

Community pharmacies now face a much more difficult end to the 5th Agreement period than was expected when that agreement was signed in May 2010.

Figure 1:



[23] Productivity Commission, Report on Government Services, January 2014, Table 11A.4

PBS Price Disclosure – what it means for community pharmacy

Community Pharmacy Financial Impact of Price Disclosure, 2014-15 Financial Year only

	Mark-up Loss	Trading Terms Loss	Total Loss
Existing Price Disclosure	$73.2m	$236.5m	$309.7m
Changes contained in 2013 Economic Update	$35.5m	$112.4m	$147.9m
Combined Impact	**$108.9m**	**$348.9m**	**$457.6m**

There are about 5,350 community pharmacies in Australia, resulting in a total per pharmacy impact of almost $90,000 in 2014-15. Some $60,000 of this impact is as a result of the pre August 2013 price disclosure regime, which is now resulting in savings much larger than expected. The remaining $30,000 is a direct result of the August 2013 announcement of Simplified Price Disclosure, was not known or recognised in the 5th Community Pharmacy Agreement negotiations and needs to be ameliorated. The longer term impact of price disclosure will need to be addressed in the next five-year Community Pharmacy Agreement (from 2015-16) if Australia is to maintain a viable network of community pharmacies providing high quality dispensing, advice and professional health services to patients. Safe, high quality dispensing of prescription medicines is a vital and complex professional activity (see Attachment 3 – *Medicine Dispensing Process chart*). It will remain a core service and it must remain viable regardless of enhanced roles in other areas. A continual decline in margins on a core function (prescriptions represent about 70 per cent of community pharmacy revenue), accompanied by ongoing inflation in operating costs, is unsustainable for any health care or business sector.

The solution for 2014-15

From 1 October 2014, pharmacies are seeking amelioration of the adverse impact of Labor's election eve changes to price disclosure which were announced without consultation on their flow-on impact to community pharmacy under the 5th Community Pharmacy Agreement. This amelioration equates to an estimated 88c per script or $148 million. This will only ameliorate about one-third of the total impact of price disclosure on pharmacies in 2014-15. As the government's estimate for PBS expenditure in the 2014-15 year alone is now $2 billion lower than it was at the time of the signing of the Agreement in 2010, this represents only a fraction of the additional savings being made.

In each of the forward estimates years, the PBS is forecast to grow at a rate less than GDP. It is clear that further savings measures which are designed solely to reduce overall PBS expenditure are no longer necessary or sustainable, unless accompanied by measures to ameliorate the flow-on impact on community pharmacies. **What is now required is an approach to PBS related pharmacy remuneration that ensures the ongoing viability of efficiently run community pharmacies and that the current level of consumer access to medicines and services provided through the community pharmacy network is not threatened.**

The need for a co-ordinated approach to the MOU and PBS Pricing

Community pharmacy is impacted by off-patent drug pricing more than any other part of the industry. Community pharmacy must be represented in consultations on drug pricing policies.

The Guild is in favour of a transparent set of remuneration arrangements for community pharmacy, whereby dispensing and other services are properly remunerated without the need for pharmacy businesses to rely on temporary cross-subsidies through trading terms on generic medicines. However the

Guild has not previously been invited to participate in discussions around medicine pricing that are necessary to establish such a transparent arrangement. This is in spite of the critical role that pharmacies play in the successful implementation of such reforms and the significant flow-on impact on their ongoing viability.

The previous government's Memorandum of Understanding (MOU) with Medicines Australia ends on 30 June 2014. The current MOU was negotiated without the involvement of the Guild or other major stakeholders in the PBS despite the serious flow-on effects it would have and the lack of any detailed process to monitor, measure or address those flow-on effects. A co-ordinated approach to the next MOU is essential. The process must be consultative. An arrangement that has primary focus on the pricing mechanism for off-patent medicines should not be negotiated solely with the organisation that represents patented medicines without consultation with other parts of the broader medicines sector, including pharmacies, which are the most impacted by changes in prices on off-patent medicines. Nor can the MOU be viewed in isolation to the 5th or 6th Community Pharmacy Agreements – an integrated approach is essential.

The Commonwealth Government should now engage with the Guild in relation to off-patent medicine pricing, including in relation to the renegotiation of the MOU. The Guild strongly supports cheaper medicines for taxpayers and consumers as long as they do not continue to undermine the viability the 5,350 community pharmacies that have the responsibility for safely dispensing these medicines to the public. We also support consumers having access to high quality, trusted, professional dispensing and other services provided by their community pharmacy.

Attachment 1: NHS Scotland Minor Ailments Service – promotional material

More information: http://www.psd.scot.nhs.uk/docs/minor_ailment.pdf

Attachment 2: The Times (UK) article, 15 January 2014

Seeing the pharmacist not the GP 'key to survival of health service'

Chris Smyth Health Correspondent

Millions of patients should go to a high street pharmacist for minor ailments rather than bothering their GP, health leaders say today.

Pharmacists should be the first port of call for coughs, flu, aches, pains and common childhood sickness as part of efforts to ease the burden on the NHS, doctors, nurses, patients and managers say. Family doctors and A&E units are facing intolerable demands and the health service will collapse if patients do not agree to go elsewhere, they say.

One in seven GP appointments could be dealt with by pharmacists, who need to be seen as more than just prescription dispensers, say the heads of 23 key health groups, including the Royal College of GPs, the Royal College of Nursing and the College of Emergency Medicine. One in twelve emergency hospital visits could also be handled on the high street and patients need to think differently to help to solve the A&E crisis, the health-sector leaders write in a letter to *The Times*.

Local pharmacies "should be actively promoted as the first place of advice and treatment for common ailments. The NHS depends on community pharmacy, and it depends on people changing their behaviours for its very survival," they write.

Maureen Baker, chairwoman of the Royal College of GPs, said: "For coughs, colds, runny noses, problems of the eyes and skin, if people recognise they have a problem but don't feel very ill, it's reasonable to think 'maybe this is something the pharmacist can help with'. If people are thinking of the pharmacist, that's the first step. We're not trying to discourage people if they really want to see a GP, but we're saying it's an option. They can walk in and see the pharmacist very quickly, so it isn't dangerous."

Robert Darracott, of the professional association Pharmacy Voice, said: "We're talking about minor aches and pains, cold and flu symptoms, conditions where over-the-counter treatments can give relief. If you've got a cold, antibiotics are not what you need. You might need paracetamol, you might need cough medicine to make you feel a little bit better, but you don't need to go and bother your GP."

Pharmacists were the forgotten part of the health service and Britain needed to take a lead from other countries, where it was normal to turn to the high street first, he said. The bulk of pharmacists' earnings came from the NHS, which explicitly paid them to advise patients, yet relatively few people took advantange, he added.

A report by Professor Darracott's group estimates that 51 million GP visits could have been dealt with at a pharmacy, but "if you could shift just some of them that would make a huge difference to the system as a whole," he said. Many pharmacists were open at evenings and weekends when GP surgeries were shut, he pointed out.

GP consultations have almost doubled in the past two decades to about 340 million a year, while A&E attendance has gone up by more than 50 per cent in the same period, prompting an urgent search among health chiefs for alternatives to both. Sir Bruce Keogh, medical director of NHS England, said that more patients must be treated by pharmacists as part of his overhaul of urgent care services.

Roger Goss, of Patient Concern, said that pharmacists should not try to become "ersatz GPs", adding: "Many don't have the facilities to talk to you privately, and if you turn up at lunchtime the pharmacist is on a break.

"It's irresponsible to tell people to avoid their GP. We're constantly being told to go to the GP for potential cancer symptoms and it's muddled messaging. One of the reasons people go to a GP is they don't know if they're ill and want professional advice."

Professor Darracott said that pharmacists had five years' training in medicines and were able to spot "red flags" that indicated patients needed to see a doctor. "Day in, day out pharmacists are making these decisions and saying, 'If you're still not better there's something else that's going on and you need a GP.' If you're not sure about whether you should see a GP, you can get advice on that, too."

Michael Dixon, president of the GP group NHS Alliance, said: "There needs to be that shift in perceptions. It's about patients feeling able to ask a little more than 'can I have some paracetamol?' Having someone you can ask advice from first of all is important."

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Help on the high street

High Street chemists have widened their remit beyond dispensing prescriptions and selling sunscreen, toothpaste, lipsalve and nit shampoo. Checks on blood pressure, cholesterol and blood glucose levels can be done in-store, while many offer pregnancy testing services and screening for allergies and sexually-transmitted infections. Smokers who want to quit and hernia patients in need of a truss can visit a pharmacist rather than their family doctor. Some pharmacists can even prescribe.

Attachment 3 – Medicine Dispensing Process chart