

SUBMISSION FOR REVIEW OF PHARMACY REMUNERATION AND REGULATION

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THE COST OF NON-COMPLIANCE

This will be the theme of my submission.

It is well documented that many patients cease their prescribed medicines within 6 months of commencing them, statins being a prime example.

It is well documented that not taking prescribed drugs regularly, increases burden to society in terms of increased mortality and morbidities. Admission to hospital is a prime example of expensive acute care being provided which is preventable.

In my experience, as a previous Hospital Pharmacist, a current proprietor Pharmacist whom works in the shop, and as a current Accredited Pharmacist, the reason patients stop taking medicines are:

- * No immediate net tangible benefit of taking the prescribed drugs. For example, Diabetes and hypertension have immediate tangible but statins, corticosteroid/LABA inhalers do not and as such, use of these is erratic at best apart from the diligent few.
- * No perceived benefit of Prescribed drugs. People feeling that the tablets are not working.
- * Reference to Google, next door neighbours, friends seems to have quite an influence, negative media, for example, Catalyst.
- *Lacking motivation to take prescribed drugs.

- * A lack of explanation by the prescribing Doctor as to what the drugs are for, and the benefits.
- * The Natural versus Conventional drug argument. Surprisingly people of all walk of life still seem to find the money for "natural" therapies given the lack of evidence for these and lack of subsidies.
- *The amount of items removed from the PBS becoming OTC has created problems, particularly Panadol Osteo. This was an interesting decision considering how long it took us to get people to take it rather than codeine based or stronger products, then to have it taken off.
- * The high Co-Payment. This is relevant for both C and G categories. In terms of both categories, the questions are the same, namely, "Do I really need to take this? What are the benefits for me in the short term, long term?". I am sure a large number discontinue or in some cases, stagger their drug therapy based on perceived cost with little regard for the benefit. The advent of CTG subsidised drugs has had a major impact of drug adherence in Aboriginal customers we see.

It is interesting to note that NZ has a far more generous co-payment system.

There is definitely a new category of the "working poor", namely, those slightly over the threshold and unable to access the Concession Card. This sub-group definitely struggles with their drug costs and from what I see, are the most likely to abandon drug therapy.

- * Confusion about Brands and drugs. Currently, there is a very large number of drugs unavailable across the board. We reluctantly have to find alternative brands which only adds to the confusion of patients. I do not blame the drugs manufacturers for this situation as the nature of Price Disclosure precludes just-in-time stock control with them and us.

- * The advent of the big box discounter in the marketplace has been totally detrimental to the Profession of Pharmacy. Medicines that have for so long not been regarded as normal items of commerce have become price sensitive. How does this improve health outcomes when items are purchased which may not be indicated or necessary.

*The advent of Price disclosure and big box discounters has meant that services and staff may need to be curtailed. You can't have it both ways.

*The pharmacy industry itself seems to be funding some of the recent cuts. Many customers asking for the \$1.00 co-payment discount say that they don't want to pay the Government anymore than they have to. Little do they know that individual Pharmacists are funding this.

What we can do to IMPROVE drug adherence:

*Our role seems to be evolving into a Reassurance and Referral role. Quite often we are getting asked "Do I need this" and "what will this drug do". I very frequently provide eMIMS print-outs particularly when a new drug is prescribed. It is always beneficial to focus on the benefits of the drug, NOT the adverse effects.

*Having the MEDSCHECK and HMR programs capped was a backward step. I have had many customers derive benefit from these programs. Medicine management couple with knowledge empowerment is a powerful tool to encourage drug adherence.

*Trust in the Patient-Doctor-Pharmacist triad is a positive tool. It takes a long time to develop these relationships and can only be beneficial to individual health outcomes. This element of trust is more powerful than Dr Google and all other various sources of information.

* To have proper customer relations, there needs to be quality time spent with the Pharmacist. In today. A funding model that rewards this time and enhances the Professional role can only enhance quality use of medicine. Reduced funding does not allow resources to be allocated to do this, namely, a second, third or fourth Pharmacist is paramount for this to happen but revenues are declining. I can only see this going backwards. I welcome schemes such as Medscheck, PPI clinical interventions and Referral letters to other health professionals and I am grateful we have what we have.

I find conducting Medschecks and HMR's the most professionally satisfying aspects of the job. Engaging on a one to one basis with the customer and then their respective GP is a great model. The future of Pharmacy and improved

outcomes is dependent on this style of engagement. Anything less is just not doing the job properly.

*Blister packing definitely helps adherence and this is well documented. I welcome the PPI incentive for community blister packs. We have invested in Robotic technology for this purpose as I believe in this system and how it improves health outcomes, particularly in my large cohort of Aboriginal patients, some urban, some remote. Fortunately we are able to access QUMAX funding, although not entirely, for our Aboriginal patients. An expansion of this service would be welcomed.

Blister packing is a time consuming and expensive service but in my view, is totally essential if health outcomes are to improve moving forward. We are trying to be proactive in this regard moving forward at a time when PBS margins are declining due to Price Disclosure, rent and wages are increasing, pressure on margins on OTC products due to big box discounters and internet providers. Robotics do provide efficiencies but these have ongoing costs and it is starting to get difficult to provide this service to those whom need it the most.

*I offer a free delivery service to my customers. These customers are usually elderly, Aboriginal or both. We have no problem doing this service as it is needed for blister pack delivery and provides us a means of monitoring adherence. A quick phone call "you have not been home when we came or you have not called for a delivery recently" are frequently undertaken.

This is not a funded service and it should be. Patients should be identified and this service funded as it is expensive to maintain. I have a feeling this will be a casualty in the near future given the current environment unfortunately.

* I provide in store monitoring services such as blood pressure testing, blood sugar levels. cholesterol and soon, Hb1ac levels. I have invested in these services as I believe in the power of screening and Referral of Pharmacies. People can walk in when they like unlike waiting lag times of medical centres.

These services again are not funded. How long I can maintain them, I am not sure given the pressure on margins. These services should be identified and funded.

*I provide CPOP services which AGAIN is unfunded. This is a necessary service to the community and yet, has still not been recognised to be funded by the PBS not unlike NZ which funds this on the NHS.

*The current location rules seem to be working well in most instances in terms of spreading Pharmacies out from CBD areas into medical centres and the suburbs. We have an instance in town at the moment though where a national big box pharmacy discounter is relocating an Approval number from a Large Medical Centre into a retail strip area.

I find this detrimental and should not be allowed.

The patients have been forgotten.

It denies a service for patients of this medical centre which previously was very convenient and was in the spirit of the Location Rules and a service by the Pharmacy Profession. I feel any relocation such as this MUST be approved by the CEO of the Medical Centre and I would like this included in the revised Location Rules.

*I offer a Compounding service which is PCCA approved. Not all proprietary medicines are palatable or useful in their current form for many patients.

This service requires funding.

This not only provides customised user-friendly drug forms, but also helps improve health outcomes by improving adherence.

This is a forgotten, but extremely essential service.

*I offer accounts for my customers whom often struggle to pay for their medicines. I try to manage payments using Centrepay and this has been an excellent system. I will not be able to run accounts indefinitely.

*I offer patients taking the new Hep C drugs a dispensing service. Not everybody does this. This is a huge impost on our cashflow with very little margin.

This model is wrong and PBS funding for these items need to be revisited. It is clearly inadequate with the capital expenditure needed to fund these drugs.

*I have an AHS100 contract with our local AHS. I find this an extremely worthwhile program and certainly works well for our AHS designated outstations. We work extremely closely with our AHS and we have a very large mutual respect built up over many years.

I have offered full dispensing and packing services right from the outset. I felt this was the correct decision to provide a service like this even though we do not get full funding. Adherence rates and consequent health outcomes have improved dramatically as exhibited by the uptake of these medicines and packs with few left not picked up.

Now that margins are declining, it is time a full dispensing AHS100 service such as ours should be fully funded. We cannot maintain this service without the correct funding.

*Our wholesalers provide a great service even with their limited margins. They are great to deal with and even though ours and their Terms have declined, a good service is still maintained. An essential part of the industry.

Summary:

The Pharmacy industry is now a mature industry.

It is in my view in a state of decline and I feel that services that I currently offer will not be able to continue in the future unless we have a review of the funding model.

The Location Rules are the least of our problems.

I can see the future being dominated by big box discounters with few services and the smaller full-service, independent pharmacies like mine disappearing.

I fear for the future.

We cannot pay Pharmacy Graduates anything like they deserve. The pay rates are not even comparable with like Professions or graduates.

Would I let my kids become Pharmacists, I would answer no given the current decline. The hours and financial pressures are too much of a burden I would not like them to bear.

I love my job, my customers and the Profession and will continue as long as I can afford to.

I take students from many universities and I try to be positive about the future with them.

It is still a good job but getting much harder.

Sincerely,

Ross McKay ...