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Review Panel
Pharmacy Review – Remuneration and Regulation 2016

Dear Panel Members,

I am a pharmacy practice researcher who lead and was involved with a number of pharmacy trials of professional services unrelated to dispensing principally focused on examining the clinical and cost effectiveness of chronic disease support services delivered by the community pharmacist for patients with type 2 diabetes and asthma. The disease management support models for both services, initially tested in small trials and subsequently in randomised controlled trials funded by 3CPA research and development program, were shown to be clinically and cost effective. They were then trialled as small pilot programs in the 4CPA and again shown to be clinically effective services which were very favourably received by trial participants and importantly were seen to complement existing health services support available to patients with these conditions. [1-9].

However, in the Stage 2 roll of the diabetes medication assistance service known as DMAS, to 800 pharmacies, uptake of the services was limited leading to the decision by policy makers not to fund the service under the 5CPA. The lesson of this was that it was unreasonable to expect that all pharmacies could offer such as service nor that there would be a similar need/demand for these services across Australia. Moreover during the

trial the pharmacists were remunerated for the services but once the trial ended the services were no longer able to be delivered.

In the 5CPA the evidence based DMAS service was truncated to the Diabetes Medscheck, a one off meeting with the pharmacist to review their medications and management of type 2 diabetes. This removed the most valuable component of DMAS which was the monthly follow/monitoring which helped empower and motivate patients to better self-manage their condition.

Thus a valuable opportunity to integrate the community pharmacist into a community delivered chronic care model was lost. With the escalating epidemic of type 2 diabetes there is a need to leverage all support resources in the community to address the care needs of this population of patients.

Effective funding models are urgently needed. The reliance on the CPAs for funding professional services has been problematic, overly bureaucratic and inadequate to deliver the quantum of service needed in the community. For example, the HMR budget ceiling was reached well before the end of the 5CPA and many consumers on multiple medication who could potentially have benefited from the service were unable to access it. .

Annual capitation models for care of a chronic patient by pharmacists such as have been introduced in New Zealand are worth investigating. At the

very least there needs be a payment system that recognises the inadequacy of one off services such as HMR and Medscheck with no allowance for payment for follow-up/monitoring. For example in the state of Alberta in Canada they have separate payments for the components of pharmaceutical care shown in the table below.

Prescription renewal	\$20
Adaptation of prescription (dose regimen, discontinuation)	\$20
Administration of Injection	Service
Assessments (assess or mange ongoing therapy etc)	\$20
Standard Medication Management Assessment (SMMA) initial /follow-up	\$60/\$20 or \$75/\$25 (APA)
Comprehensive Annual Care Plan (CACP) - initial / follow-up	\$100/\$20 or \$125/\$25 (APA)
SSMA Diabetes initial /follow-up	\$60/\$20 \$75/\$25
Tobacco cessation initial /follow-up	\$60/\$20

Overall I believe that remuneration for some pharmacy professional services could be separated from the CPAs, especially those that are

not directly linked to access to the prescription record or provision of prescription or OTC medication. Medicare items may be an option.

Please see the attached review (Houle et al 2016) for more information. This summarises remuneration systems for professional pharmacy services in several countries including Australia, US, Canada and the United Kingdom.

Minor ailments schemes such as exist the UK and parts of Canada are also worth considering. Remuneration for professional services/conselling/adherence support needs to be separated from supply role. Traditionally the triage services delivered in community pharmacy were cross subsidized by profits from markups on prescription and OTC medication/front of shop sales.

We recently conducted a qualitative study with a range of key stakeholder examining the current state of community pharmacy. I have attached the paper as I believe it may be a useful source of data for the committee to consider in making their recommendations. (Hermansyah et al, 2016.). It emphasizes the untapped potential of community pharmacy to contribute to health care and explores the possible reasons for failure to realise this potential to date.

Yours sincerely,



Ines Krass

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