Submission to the Review of Pharmacy Remuneration and Regulation

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Marc Segler registered as a Pharmacist in 1982. Marc bought his first Community Pharmacy in Noranda in 1983 and his second Community Pharmacy in South Perth in 1987. Marc still owns both of these Pharmacies and continues to work as a Community Pharmacist in both on a daily basis. In addition, Marc is a sessional tutor in the School of Pharmacy at UWA.

In my submission to the Review panel, I will address

1. Both the comments on page 4 paragraph 2 that “this is primarily a consumer focussed review that aims to identify which services and programs consumers value from community pharmacy” and the comment made by Professor King at the national webcast on September 7th that “the key driver for this review is the consumer experience: are people getting the right medications at the right time?”

2. the comment on page 9 paragraph 4 that “In making its recommendations, the Review will consider: page 9 heading 2 Pharmacy Remuneration for Dispensing.

I will address Q15,16,17,25,28,29,30,31,32,33 and 34.

3. the comment on page 9 paragraph 4 that “In making its recommendations, the Review will consider: page 10 heading 2 Consumer Experience 5c consumer priorities regarding access to and quality use of medicines.

I will address Q12,100,106,107 and 112.

4. As requested by the panel, I will provide an evidential case study to support my Remuneration submission.

This is primarily a consumer focussed review page 4 paragraph 2. As this is primarily a consumer focussed review, it is important to ascertain what consumers want, need and expect from Community Pharmacy. This may be very different from what Community Pharmacy “thinks” their patients/consumers want and expect although many may need this without realising the value that it makes to their health optimisation. This may also be very different from what the umbrella Pharmacy organisations push for and tell the Government to fund.

I asked Jo Watson from the CHF via the Perth meeting of the Review Panel “What has CHF determined that customers want from their Pharmacy interactions?” Jo Watson replied
“CHF conducted a membership survey back in September last year about a range of issues and the themes below were the most common responses:
a) High number of respondents value community pharmacists.
b) Value and rely on being able to access information and advice about their medicines and medication management.
c) See merit in pharmacists having an enhanced role in primary care, but not to the extent that it duplicates or fragments other primary care arrangements.
d) Consumers have privacy concerns in many pharmacies, citing this as a disincentive for accessing clinical services in a retail setting.
e) Consumers value access and extended hours.

Response b) Value and rely on being able to access information and advice about their medicines and medication management ties in with Professor King’s opening remarks to the national webcast “the key driver for this review is the consumer experience: are people getting the right medications at the right time?” This further aligns with the comment on page 4 paragraph 2 …seek to ensure that future arrangements will support reliable and affordable access to medicines by the Australian community and will promote the quality use of medicines and relates to Q25 posed in the Discussion Paper As medicine specialists, what are the professional programs and services that pharmacists should or could be providing to consumers in order to best serve the consumers?
In my opinion, there is nothing more central to the Community Pharmacy role than providing available access to a Pharmacist who can then provide information on the quality use of medicines.
Pharmacists are the foremost medicine specialists amongst all the health professions and before they move onto any other professional service, Pharmacy should ensure that medicines and medicine advice is given out each and every time and only by a Pharmacist.
It is a fact, perhaps not admitted by many umbrella Pharmacy organisations or by many Pharmacy marketing groups, that this is not always the case and in many Pharmacies, often not the case.
It is a fact that in many Community Pharmacy interactions with patients/consumers, it is the Pharmacy Assistant and not the Pharmacist who takes in the prescription, dispenses the prescription (dispensary assistant) and takes out the prescription.
This, in my opinion, is totally unacceptable and surely does not meet the wants, needs or expectations of the patient/consumer and certainly does not promote the quality use of medicines.
There is a lot of talk by the umbrella Pharmacy organisations about “scope of practice”.

My comment is that Community Pharmacy should master its primary scope of practice, accessibility to a Pharmacist and the Pharmacist being the sole interaction in all aspects of provision of both prescription and scheduled medicines to the patient/consumer, before moving on to further scopes of practice. Surely, this is a no-brainer.

So why doesn’t it happen?
It doesn’t happen because it is not viable (see the case study at the end of my submission) and for Community Pharmacy to exist at all, even if only as a lesser vehicle than it could be, it must be viable. Community Pharmacy is not a Government funded department that can run at a loss because it provides an essential service, though perhaps it should be. Community Pharmacy and its 27,000+ Pharmacists, 40,000+ Pharmacy Assistants and 5000+ privately owned Pharmacies is a private resource privately funded by individuals to serve the public and ensure the timely and accessible provision of medicines under the PBS for the Federal Government of Australia.

My submission to the Review Panel, addresses page 9 heading 2 part d, different funding structures … is that if consumer expectation is to be met, then the Government must fund adequate numbers of Pharmacists in each and every Community Pharmacy in Australia so that all aspects of prescription and scheduled medicines are handled solely by a Pharmacist.

How could this be done?
My submission to the Review Panel is that this could be done by remunerating Community Pharmacies for the number of Full Time Equivalent (FTE) Pharmacists employed by the Pharmacy less some algorithm for the number of FTE Pharmacists required solely to physically dispense the number of prescriptions that that Pharmacy dispenses on average.
My contention is that if the Pharmacists are there, in excess of the dispensing requirements, then they will be utilised where their expertise is, in taking scripts in (a most important part of the process as it is here that all initial information eg age of child, known allergies, prior medicine and medical history, doctor explained information etc), in prescription counselling and in scheduled medicine advice. The medicine specialists will be utilised in ensuring the quality use of medicines. This is currently not the reality of Pharmacist numbers per Community Pharmacy and hence tasking in Community Pharmacies in Australia. In my opinion, it must be.

Referring to Q17 posed in the Discussion paper, Are the current fees and charges associated with the dispensing of medicines appropriate? ....Do they provide
appropriate incentives for community pharmacists to provide the professional services, such as provision of medicine advice, associated with dispensing – in my opinion, the fees are not appropriately based. Because they are a flat fee regardless of the Pharmacist input, there is no incentive and certainly no evidence that they ensure that the Pharmacist is involved in this most basic of duties – to promote the quality use of medicines. In my opinion, it is not a question of complexity as asked in Q16, there should be no differentiation between initial and repeat scripts (in fact, compliance with chronic medications is possibly more of a health imperative than the correct taking of acute medicines) as suggested in Q16, the swings and roundabouts referred to in Q15 due to little interaction or considerable amount of Pharmacist involvement shouldn’t matter as all interactions, initial or repeat, little or considerable, are all of equal importance and should all, only be carried out by a Pharmacist. But to do so, as above, there must be Pharmacists in excess of the physical dispensing requirements so that they are available to ensure the optimum use of medicines.

This then relates to Q28 …is there a need for new business models in pharmacy?… yes, a Pharmacist staffed Pharmacy model.

Q28…what would such a model look like – it would have multiple Pharmacists, only Pharmacists/Interns taking in prescriptions, dispensing and taking out prescriptions and only Pharmacists advising in the Schedule 2/Schedule 3 (WA regulations mandate that both are kept behind the counter, out of the reach of the public) area. Furthermore, larger Pharmacies could have additional specialist Pharmacist staff such as Accredited Pharmacists to do offsite HMR (so need to be additional to dispensing needs), Diabetic Educators, Mental Health First Aid Pharmacists, Geriatric Pharmacists, Paediatric Pharmacists etc available (on roster) and accessible to patients/consumers to just walk in and consult.

Q28…how would it lead to better health outcomes? – provision of clinically trained health professionals in excess of the dispensing requirements will result in those excess Pharmacists having the time and availability to perform the clinical functions that will better ensure the quality use of medicines rather than lesser trained staff performing roles that they are not experts at.

I have suggested to the Review Panel that this model could be remunerated on the basis of FTE Pharmacists outside of the physical dispensing requirement because in my opinion, this rewards the employment of Pharmacists by the Pharmacy rather than as in Q29, the sale of medicine. Not all quality use of medicines advice is related to the dispensing of a prescription or the sale of a medicine and therefore remuneration should not be based on sales but rather, availability of a Pharmacist and therefore more likely accessibility to advice on the quality use of medicines.
Q30, *remuneration through a MBS payment* is an interesting suggestion but again, where is the “proof” that the advice was given when the medicine was dispensed or sold. Although my suggestion also lacks the onus of proof, in my opinion, it is more likely that an available and accessible clinical Pharmacist will provide advice than an overworked, under resourced Pharmacist.

Q31 If an MBS payment for professional pharmacy advice was introduced, what level of service...complexity of particular medicines...particular patient groups with higher health needs? introduces it’s own complexity to the remuneration level. Given the complexity and the questions on the integrity of the MBS schedule and claiming, why introduce that to Pharmacy? All employed Pharmacists in Australia should be able to promote the quality use of medicines no matter how complex the medicine or the health needs of the patient are. It is the resource of the “excess” Pharmacist that should be funded, not the exact task that the Pharmacist carries out. Why would a Pharmacist in a multiple Pharmacist Pharmacy, in excess of dispensing requirements, do anything other than clinical Pharmacy tasks?

Again, Q32 ...identify and supply the health services - just identifying them doesn’t make them available, having more Pharmacists available makes the health services available. Q33 ...how could pharmacy services be made more accessible? - by providing more Pharmacists who themselves will be more accessible because they are in excess of dispensing requirements. Q34 *How should government design the provision and remuneration of new programs...* - start by remunerating the provision of the critical provider of the service, the excess Pharmacist.

Again, my contention is that if the Pharmacists are there, in excess of the dispensing requirements, then they will be utilised where their expertise is.

Applying this to the Discussion paper questions relating to Consumer Experience, Q12 *Do current arrangements under the 6CPA lead to ... If not, why not and how could ...be improved* – I don’t believe that the 6CPA focuses enough on the resources required to provide all the services and increased scopes of practice that it aspires to fund.

All the best designed health programs will come to naught if there are no Pharmacists on hand to provide them. The 5CPA and now the 6CPA can offer payments for Medschecks and Clinical Interventions and Pharmacies may lodge claims (more so Pharmacy groups who have admin staff preparing these claims) but without adequate Pharmacists with adequate time, from my own experience, these vital health services cannot be carried out as the CPAs intend them to be carried out.

Compare this to HMRs where there are many self employed Accredited Pharmacists independent of Community Pharmacy (and therefore independent of the time
requirement needed to dispense prescriptions) whose service levels and savings to the overall Health budget far exceed their cost which is capped because the availability of these Pharmacists mean that these services can and are taken up in excess of the funding provided. Why is one under utilised and the other over utilised? Because HMRs are carried out by available Pharmacists and Medschecks/Clinical Interventions are done in amongst the daily dispensing and serving of a busy community Pharmacy.

Q100 What are the minimum services that consumers expect and should receive at the time of dispensing and Q107 What do consumers expect from community pharmacy in relation to their medicines – the very minimum they should receive is that a Pharmacist takes in their prescription, asks them relevant questions, dispenses their prescription and counsels them adequately on their medicine, it’s use and it’s effects. The very minimum a consumer should receive when they walk into a Pharmacy is to see a Pharmacist. But to do so, they must be available.

Q106 How do we measure the level of service provided by the pharmacy? – clearly as it is a Pharmacy, it must be a measure of the level of service by a Pharmacist. Clearly, the more Pharmacists on the floor, the greater the likelihood of service by a Pharmacist. This then flows to Q112 In your experience, do community pharmacists provide appropriate advice for schedule 2 and 3 medicines? - Of course they do. When they are the person in the schedule 2 and 3 area providing the advice. Question 112 should have been, in your experience, when you come into the Pharmacy is there a Pharmacist in the schedule 2 and 3 area? or at the very least, in your experience, when you (think you) require a schedule 2 or 3 medicine, does a Pharmacist come to listen to your health query and advise you? Sadly, but factually, in many Pharmacies around Australia, there is no Primary Care Pharmacist stationed in the schedule 2 and 3 area which should (in my opinion, must) be a requirement for a schedule 2 and schedule 3 poisons licence. Why is there no Pharmacist stationed there? And why are these health queries often served by a Pharmacy Assistant? Because there are no Pharmacists in excess of the dispensing requirement available in the Pharmacy and therefore there is no Pharmacist available to achieve the quality use of medicines essential to health enquiries that require a schedule 2 or 3 medication.
My submission to the Review Panel is to give consumers what they want - Pharmacists in Pharmacies. By funding Pharmacists into Pharmacies, the quality use of medicines, professional services and required health services that consumers want, need and expect, will all be able to be provided.

Case study into the viability of employing Pharmacists in excess of the dispensing requirement.

At the Perth meeting, the Panel implored Pharmacists to provide evidence to back up their submissions. I made the comment to the Panel that independent Pharmacists that spend their day with their patients, don’t have ready access to the type of evidence that the panel may be looking for. The Panel asked Pharmacists to provide whatever evidence in whatever form they could.

To illustrate my comments on the viability of having excess Pharmacists available and therefore accessible, I present the following financial information which I declare to be as accurate and as complete as I am able to provide. I am aware that submissions to the Review Panel are published on the DOH/Review of Pharmacy Remuneration and Regulation website and are therefore accessible to the public. I am aware that I may ask that segments of my submission are hidden from the public due to commercial sensitivity. I respectfully ask the Review Panel to consider this information but not publish my case study due to commercial sensitivity.

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