

Combined Thematic Review of  
Access, Consumer Experience  
and Quality Use of Medicines  
under the Fifth Community  
Pharmacy Agreement

Final Report

March 2015

This report contains 82 pages

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No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by, stakeholders consulted as part of the process.

KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

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The findings in this report have been formed on the above basis.

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## Acronyms

3CPA	Third Community Pharmacy Agreement
4CPA	Fourth Community Pharmacy Agreement
5CPA	Fifth Community Pharmacy Agreement
ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
ACPA	Australian Community Pharmacy Authority
ACT	Australian Capital Territory
AHPRA	Australian Health Practitioner Regulation Agency
AHS	Aboriginal Health Service
ATSI	Aboriginal and Torres Strait Islander
CALD	culturally and linguistically diverse
CD	continued dispensing
CHF	Consumer Health Forum
CPE	continuing professional education
CtG	Closing the Gap
CSO	Community Service Obligation
DHS	Australian Department of Human Services
EPF	electronic prescription fee
ERRCD	Electronic Recording and Reporting of Controlled Drugs Initiative
GP	general practitioner
HMR	Home Medicines Review
ICDP	Indigenous Chronic disease Package

MBS	Medicare Benefits Schedule
MMR	Medication Management Review
NACCHO	National Aboriginal Community Controlled Health Organisation
NDSS	National Diabetes Services Scheme
NMP	National Medicines Policy
NRMC	National Residential Medication Chart
NSW	New South Wales
PBAC	Pharmaceutical Benefits Advisory Committee
PBS	Pharmaceutical Benefits Scheme
PES	Australian Bureau of Statistics Patient Experience Survey
PFDI	Premium Free Dispensing Initiative
PPI	Pharmacy Practice Incentives Programme
PPQ	Pharmacy Patient Questionnaire
PRG	Programmes Reference Group
PSA	Pharmaceutical Society of Australia
PSP	Prescription Shopping Programme
QCPP	Quality Care Pharmacy Program
QUM	quality use of medicines
QUMAX	Quality Use of Medicines Maximised for Aboriginal & Torres Strait Islander People
S100 RAAHS	Section 100 Remote Area Aboriginal Health Services Programme
RACF	residential aged care facility
RMMR	Residential Medication Management Review
RPLO	Rural Pharmacy Liaison Officer

RPMA	Rural Pharmacy Maintenance Allowance
RUM	Return of Unwanted Medicines
SA	South Australia
SEIFA	Socio-Economic Index for Areas
SLA	Statistical Local Area
SPD	Simplified Price Disclosure
TAS	Tasmania
VIC	Victoria
WA	Western Australia
WCI9	Wage Cost Index 9

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# 1 Executive Summary

The Fifth Community Pharmacy Agreement (5CPA) between the Australian Government and the Pharmacy Guild of Australia (the Guild) provides up to \$15.67 billion to around 5,450 community pharmacies for dispensing Pharmaceutical Benefits Scheme (PBS) medicines, providing pharmacy programmes and services; and to pharmaceutical wholesalers for the Community Service Obligation (CSO) arrangements. The 5CPA also sets out the Community Pharmacy Location Rules arrangements. KPMG was engaged to undertake a combined Thematic Review (Review) of Access, Consumer Experience and Quality Use of Medicines (QUM).

Key findings relating to Access are that:

- The number of pharmacies has increased over the life of the agreement and there continue to be applications for new pharmacies.
- The number of PBS eligible scripts dispensed per person in Australia remained stable between 2010-11 and 2013-14.
- That cost remains a barrier for some consumers, however there are a number of existing mechanisms outside of 5CPA that seek to address cost as a barrier to consumers accessing prescribed medicines.
- Within 5CPA, the Premium Free Dispensing Initiative (PFDI) provides incentives for pharmacies to make consumers more aware of premium free brands, so they can access their prescribed medicines more cheaply.
- The CSO has effectively facilitated access to medicines to consumers through community pharmacy and there is strong support for its continuation and retention within the community pharmacy sector.

Key findings relating to Consumer Experience are that:

- Consumers are generally unaware of 5CPA funded services offered via community pharmacy beyond dispensing of medicines.; and
- Consumers are generally satisfied when they receive such services, although there is limited information available on consumer experience despite tools available to collect this information;

Key findings relating to QUM are that:

- QUM principles are supported throughout the various 5CPA services and programmes;
- The aim of various 5CPA medication management programmes is predominantly to improve the quality use of medicines, however it is difficult to assess the impact of the various QUM focussed programmes.
- There is little QUM related outcomes information available and particularly a lack of accessible data that allow measurement of the effectiveness and relative value of different QUM initiatives within 5CPA.

The Review, where applicable, had a particular focus across the following population groups of aged care recipients; Aboriginal and Torres Strait Islander people; carers; rural and remote populations; culturally and linguistically diverse populations; and consumers with a mental illness. In relation to these six population groups of interest there are specific 5CPA initiatives or

programmes targeting four of the six population groups of interest. There are no specific 5CPA initiatives targeted at carers or culturally and linguistically diverse (CALD) populations.

While not attributable to the Aboriginal and Torres Strait Islander Pharmacy Workforce Programmes directly, there was substantial growth in numbers of Aboriginal and Torres Strait Islander pharmacy workforce between 2006 and 2011. The Review found there is scope for better integration of the three initiatives that affect access to and quality use of medicines by Aboriginal and Torres Strait Islander people-S100 RAAHS, CtG scripts and QUMAX.

Rural pharmacy support programmes are well known. They are working coherently to support a sustainable rural pharmacist workforce, as well as ensuring that pharmacists currently working in rural pharmacies are able to access professional education and that rural pharmacies remain open and viable.

Both the National Residential Medication Chart (NRMC) and Residential Medication Management Reviews (RMMRs) target people living in residential aged care. The Review found information supporting the effectiveness of the NRMC pilot. There was no comparable information available for RMMRs, due to lack of relevant data. This made it impracticable to assess the relative effectiveness of the two programmes, thus limiting scope to consider what future programme arrangements would provide the best QUM and health outcomes for consumers in residential aged care.

Based on these key findings the review identified five areas for consideration in the design and development of any future community pharmacy agreements and programmes. The five areas identified are:

- 1 A needs based, medication management continuum for consumers;
- 2 Consistent QUM indicators for evaluating programmes;
- 3 Continued and consistent measurement of the consumer experience;
- 4 Integration of 5CPA Aboriginal and Torres Strait Islander programmes with related programmes outside of 5CPA; and
- 5 Overarching evaluation through the life of the community pharmacy agreement.

## 2 Themes identified from this Review and areas for future consideration

The Fifth Community Pharmacy Agreement (5CPA) between the Australian Government and the Pharmacy Guild of Australia (the Guild) provides up to \$15.67 billion to around 5,450 community pharmacies for dispensing Pharmaceutical Benefits Scheme (PBS) medicines, providing pharmacy programmes and services; and to pharmaceutical wholesalers for the Community Service Obligation (CSO) arrangements. The 5CPA also sets out the Community Pharmacy Location Rules arrangements. KPMG was engaged to undertake a combined Thematic Review (Review) of Access, Consumer Experience and Quality Use of Medicines.

The subsequent chapters of this report present detailed review findings relating to the specific components of 5CPA. There were some findings that applied at the whole of agreement level. This chapter summarises those findings separately for each theme of Access, Quality Use of Medicines (QUM) and Consumer experience. Where applicable, there is discussion as to how these themes relate to the population groups of aged care recipients, Aboriginal and Torres Strait Islander people, carers, rural and remote populations, Culturally and Linguistically Diverse (CALD) populations and consumers with a mental illness.

This chapter also presents high level areas for consideration when designing future community pharmacy agreements and are intended to stimulate discussion and debate. These areas have been synthesised from the detailed review findings presented in later chapters of the report.

### 2.1 Access

The 5CPA facilitates consumer access to medicines through community pharmacies. One of its primary objectives is to ensure that “there is a network of accessible and viable community pharmacies throughout Australia including in rural and remote areas”.<sup>1</sup> A key mechanism for achieving this objective are the location rules, which are designed to ensure a network of viable community pharmacies in areas of need throughout Australia.

Throughout the period of the 5CPA’s operation there have continued to be applications for new pharmacies submitted to the Australian Community Pharmacy Authority (ACPA). Many of these have been recommended for approval. As a result, the number of community pharmacies has grown over the life of the Agreement. By this measure, overall access to community pharmacy has been maintained or improved.

In terms of access to Pharmaceutical Benefits Scheme (PBS) medicines, the number of PBS scripts dispensed per person in Australia remained stable between 2010-11 and 2013-14. However, this has varied by concessional status, with numbers of scripts dispensed to general PBS patients falling and those to concessional patients rising, during this period. This suggests differential trends in access to medicines for these two groups, most likely explained by the differential impact of cost of medicines for each group.

As stated in the National Medicines Policy “cost should not constitute a substantial barrier to people’s access to medicines they need.” However cost appears to remain a barrier for a cohort of consumers. The Australian Bureau of Statistics (ABS) runs an annual Patient Experience Survey (PES). The survey collects data on access and barriers to a range of health care services.

<sup>1</sup> Section 1.2b of the Fifth Community Pharmacy Agreement between The Commonwealth of Australia and The Pharmacy Guild of Australia, May 2010.

In the 2013-14 survey it was identified that approximately one in thirteen persons aged 15 years and over in 2013-14 (7.6 per cent) delayed getting or did not get prescribed medication (which may include non-PBS private prescriptions) due to cost. This proportion has remained steady over the period 2010-11 to 2013-14 (see Table 20 in the Appendix).

The ABS PES provides this statistic on delaying getting a prescribed medication due to cost by remoteness, socio-economic index for areas (SEIFA) and long term health condition status. In 2013-14 this figure was generally consistent across remoteness areas, higher in the most disadvantaged areas (10.5 per cent) and lowest in the least disadvantaged areas (4.8 per cent) and higher in patients with long term health conditions (9.2 per cent) versus those without long term health conditions (5.1 per cent).

There are a number of existing mechanisms that seek to address cost as a barrier to consumers accessing prescribed medicines. In the large, these mechanisms operate outside of the 5CPA. Examples are:

- PBS itself, through its subsidies for the costs of listed medicines;
- PBS Safety Net arrangements, which target consumers with very high costs of medicines on an ongoing basis;
- Closing the Gap (CtG) scripts, which target Aboriginal and Torres Strait Islanders with or at risk of chronic disease; and
- Section 100 Remote Area Aboriginal Health Services Programme (S100 RAAHS), which subsidises PBS medicines' supply to approved Aboriginal and Torres Strait Islander health services in remote and very remote areas and with limited or no access to community pharmacy.

## 2.2 Consumer experience

Consumers are generally unaware of 5CPA funded services offered via community pharmacy beyond dispensing of medicines. As noted in the *Consumer Needs Report*,<sup>2</sup> the “majority of consumers do not actively seek health promotion and prevention services in the community pharmacy setting.” However, when consumers have accessed such services, “they are largely satisfied.”

It is not unreasonable to consider that consumers have an awareness of some services given the volume of some services that are delivered each year and that some of these services (e.g., Residential Medication Management Reviews (RMMR)) were being provided to consumers many years prior to the commencement of 5CPA. Some services require awareness on the part of general practitioners (e.g., Home Medicine Reviews (HMR) and RMMRs). The *Medication Management Report*<sup>3</sup> noted that general practitioner (GP) awareness of these services was generally considered low.

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<sup>2</sup> PwC (2014), Consumer Needs Full Final Report. PwC.

<sup>3</sup> PwC (2015). Combined Review of Fifth Community Pharmacy Agreement Medication Management Programs: Final Report. PwC.

## 2.3 Quality Use of Medicines

QUM principles are supported throughout the various 5CPA services and programmes. This ranges from a base level of QUM support that is expected to be provided with every script that is dispensed (e.g., advice to the consumer), to more in-depth reviews that occur in the patient's home or aged resident's accommodation (e.g., HMR, RMMR).

The 5CPA provides for a suite of Medication Management programmes and services<sup>4</sup>, in which the Government has invested approximately \$427 million over 5 years. The aim of these individual programmes is predominantly to improve the quality use of medicines. However it is difficult to assess the impact of the various QUM focussed programmes. Data is available on the volume of services delivered and limited demographic information for some services (e.g., Medschecks, HMR and RMMR). However there is no agreed set of QUM indicators across the suite of QUM focussed programmes.

## 2.4 Population groups

There are specific 5CPA initiatives or programmes targeting four of the six population groups of interest. Those populations groups are aged care recipients (RMMRs, National Residential Medication Chart (NRMC)), those living in rural and remote areas (Rural Support Programmes), Aboriginal and Torres Strait Islanders (Aboriginal and Torres Strait Islander Programmes) and consumers with a mental illness (Pharmacy Practice Incentive – staged supply<sup>5</sup>). For the Aboriginal and Torres Strait Islander population there are a range of government initiatives outside of the 5CPA, specifically S100 RAAHS and CtG scripts, which target access to medicines for this population group.

There are no specific 5CPA initiatives targeted at carers or CALD populations. This lack of specific initiatives and programmes is not surprising given the size and demographic spread of these two population groups. For CALD populations there is an unmet need in terms of community pharmacy being able to accommodate the needs of people from a non-English speaking background relating to medicines and other services.<sup>6</sup> However, pharmacies, for the purpose of dispensing PBS medicines, may be eligible for free interpreting services through the Translating and Interpreting Service (TIS) National.<sup>7</sup>

## 2.5 Areas for future consideration

This review identified five areas for consideration in the design and development of any future community pharmacy agreements and programmes. Their primary purpose is to stimulate discussion and debate, rather than to prescribe or recommend future directions. The five areas identified are:

- A needs based, medication management continuum for consumers;

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<sup>4</sup> . Clinical Interventions, Dose Administration Aids, Staged Supply, Medschecks, HMRS and RMMRs

<sup>5</sup> Note: This also targets other population cohorts but is likely to be particularly valuable for consumers with a mental illness.

<sup>6</sup> PwC (2014), Consumer Needs Full Final Report. PwC.

<sup>7</sup> See <https://www.tisnational.gov.au/Agencies/Charges-and-free-services/Free-services-through-TIS-National>), accessed 18 December 2014. Note this is not a 5CPA initiative.

- Consistent QUM indicators for evaluating programmes;
- Continued and consistent measurement of the consumer experience;
- Integration of 5CPA Aboriginal and Torres Strait Islander programmes with related programmes outside of 5CPA; and
- Overarching evaluation through the life of the community pharmacy agreement.

Each of these areas is presented in detail below.

### 2.5.1 Consumer Experience and QUM foci: A Medication Management Continuum for Consumers

Consideration should be given to the consolidation of 5CPA medication management programmes that have a QUM focus. Such consolidation should aim for a holistic approach to QUM services based on consumer needs, with consistent governance and funding arrangements. This would mean that a consumer would receive the service(s) they need and only the service(s) they need to deliver the desired QUM outcome.

Reasons for considering this include:

- A general lack of consumer awareness of medication services, in particular medication management programmes such as Medscheck, HMR and RMMR. However consumers are generally satisfied upon receiving the services.<sup>8</sup>
- The 5CPA Medication Management programmes have a consistent collective aim to improve the quality use and individual management of medicines, including minimising the number of adverse events experienced by people taking multiple medicines, particularly high-risk groups such as the elderly.<sup>9</sup>
- These QUM focussed programmes have been established over an extended time period (e.g., RMMR 1997, HMR 2001, Medscheck 2012) and over the life of different agreements, which to an extent, explains the different guidelines and administrative structure. In line with this some stakeholders commented that programmes had been “bolted on” over time rather than part of a holistic QUM approach. Future pharmacy agreements should consider integrating these programmes.
- Funding per QUM service should be clear across the suite of services. Currently some services operate on a fixed fee per service (e.g., HMRs are \$208.22 per service as at 1 July 2014) and some services are based on a post-hoc calculation based on number of services provided and budget available (e.g., funding per clinical intervention (CI)). This means that funding for a given service can vary, regardless of the consumer’s level of need and the efficient time and resources required to deliver the QUM outcome consistent with that need. Stakeholder input confirmed that this disparity does arise in practice without quantifying its frequency.
- It provides an opportunity to consolidate documentation and streamline administration and claiming processes. Currently there are separate guidelines and fact sheets for each of these programmes – a total of 184 pages of factsheets, guidelines, service agreements and claiming

<sup>8</sup> PwC Consumer Needs Full Final Report op. cit.

<sup>9</sup> Price Waterhouse Coopers (PwC), 2014. Combined Review of Fifth Community Pharmacy Agreement Medication Management Programmes: Final Report. PwC

documentation for the six different programmes stored across both the 5cpa.com.au website and the Pharmaceutical Society of Australia (PSA) website. The number of service claims rejected across Medication Management programmes was around 10%.<sup>10</sup>

- Bringing together these programmes may better enable the consistent collection of QUM focussed information across the suite of programmes. This will ultimately enable better comparison between programmes and reviewing whether programmes are cost effective.

## 2.5.2 QUM focus: Consistent QUM indicators for evaluating programmes

Future pharmacy agreement programmes and services for consumers should gather consistent QUM information on a prospective basis. This is needed to address the lack of accessible, comparable and consistent data on consumer need and 5CPA service effectiveness.

Reasons for considering this include:

- Some QUM related information is collected for some programmes but it is generally not readily accessible. For example, QUM related information is collected when a pharmacist delivers a CI. This QUM information is about the reason for and the recommendation from a CI, which can be – and sometimes is – captured in pharmacy information systems like Guildcare. Nonetheless, this information is not consistently collected across all pharmacies and is not readily accessible for analysis to inform policy and decision makers, such as the Programmes Reference Group (PRG).
- By virtue of its design, there was a wealth of information available to this review on the effectiveness of the NRMC pilot (e.g., reduction in medicines prescribed, reduced medication errors<sup>11</sup>). There was no comparable information available for RMMR, which has been delivered since 1997. Given the two programmes target QUM outcomes for the same consumer group, the inability to compare effectiveness of the two programmes limits the scope to consider what future programme arrangements would provide the best QUM and health outcomes for this consumer group in the future.
- The D.O.C.U.M.E.N.T. approach described in the Clinical Interventions guidelines<sup>12</sup> provides a platform for collecting consistent information on the reason for undertaking a CI (i.e., the drug related problem) and also outcomes of the CI (i.e., the recommendation(s) made). All CIs for which pharmacists claim must be recorded using these D.O.C.U.T. classes. Such information would provide a consistent basis for assessing why particular programmes are delivered and the outcomes they produce. Such data analyses would better inform design and funding of future related programmes than does currently available data.
- The *Medication Management Report* provided only limited statistics across the six programmes within scope. These statistics were generally process type statistics such as number of services provided, number of service providers and number of service recipients (although not unique recipients for Dose Administration Aids (DAA) and CIs) and average age of consumers. There was also information on the number of rejected claims. The

<sup>10</sup> Ibid

<sup>11</sup> Australian Commission on Safety and Quality in Health Care (ACSQHC) 2014. Phased implementation of the National Residential Medication Chart in NSW residential aged care facilities: Summary of evaluation June 2014. ACSQHC.

<sup>12</sup> Pharmaceutical Society of Australia (PSA) 2011. Standard and guidelines for pharmacists performing clinical interventions. PSA.

exception to this is the Medschecks data, which provide information on the number of medicines and health conditions of consumers. On the whole though the *Medication Management Report* did not provide information on why certain services were delivered to consumers and the outcome, in terms of recommendations for consumers who received each type of service.

### 2.5.3 Consumer Experience focus: Continued and consistent measurement of the Consumer Experience

Future pharmacy agreement programmes and services for consumers should gather consistent consumer experience information on a prospective basis. This is needed to address the lack of accessible, comparable and consistent data on the consumer experience. In particular, there is a lack of data that allows understanding of if and how consumer experiences are affected by 5CPA programmes and services.

Reasons for considering this include:

- Consumers are generally unaware of 5CPA funded services offered via community pharmacy beyond dispensing of medicines. As noted in the *Consumer Needs Report*,<sup>13</sup> the “majority of consumers do not actively seek health promotion and prevention services in the community pharmacy setting.” However, when consumers have accessed such services, “they are largely satisfied.”
- Information about consumer/patient experience is important to guide health care quality improvement and may also be used for health performance reporting for the community pharmacy sector. There have been developments in the capture of patient experience information in hospital and GP settings but little is known about the extent of data capture in the broader non-GP primary health care sector.<sup>14</sup>
- The Consumer Needs project developed and validated a tool (Measurement Tool) to measure consumer health impact and outcomes sensitive to the community pharmacy context. It is a validated survey tool that can be used in the future to determine the impact of community pharmacy services on consumers. The Measurement Tool can be used at various levels e.g. measuring change at a community pharmacy agreement level or for a specific intervention or programme within a community pharmacy agreement.
- The Quality Care Pharmacy Programme (QCPP) provides a patient experience survey, the Pharmacy Patient Questionnaire (PPQ), to members. The PPQ provides benchmarked feedback of consumer/patient experience to participating pharmacies, to enable them to improve their service quality. Pharmacies have taken action and made changes to improve the consumer experience based on the results from this survey tool. The PPQ can also be used for at various levels e.g. comparing the difference in consumer perception of community pharmacy in metropolitan and rural areas.

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<sup>13</sup> PwC (2014), Consumer Needs Full Final Report. PwC.

<sup>14</sup> Australian Institute of Health and Welfare 2014 The measurement of patient experience in non-GP primary health care settings. Cat. no. WP 66. Canberra: AIHW. Available at: [www.aihw.gov.au/publication-detail/?id=60129547332](http://www.aihw.gov.au/publication-detail/?id=60129547332)

#### 2.5.4 Access, Consumer Experience and QUM foci: Integration of 5CPA Aboriginal and Torres Strait Islander programmes with related programmes outside of 5CPA

There is an open question of whether some of the Aboriginal and Torres Strait Islander specific QUM programmes within 5CPA should be integrated with Aboriginal and Torres Strait Islander specific programmes that operate outside 5CPA. Doing so would address concerns with existing policy and administrative disconnects between programmes affecting access to medicines and programmes providing for QUM. It would also offer scope for greater efficiency and flexibility in programme design and delivery, with an improved focus on overall health outcomes for Aboriginal and Torres Strait Islander people.

Reasons for considering this include:

- Establishment of the CtG script subsidy separated this programme, aimed at increasing access to medicines for Aboriginal and Torres Strait Islander people with or at risk of chronic disease, from QUM initiatives within Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People (QUMAX) programme. Early evidence indicates CtG scripts are dispensed through most community pharmacies in Australia and are leading to increased use of medicines by Aboriginal and Torres Strait Islander people. However, this increased exposure to medicines and community pharmacy is happening with little or no alignment with (access to) QUM services. For example, subsidised QUM services are only available to Aboriginal and Torres Strait Islander people through QUMAX eligible pharmacies.
- There are concerns over general lack of integration among S100 RAAHS, CtG scripts and QUMAX. The Senate Inquiry into S100 RAAHS<sup>15</sup> raised this concern. Community pharmacists also have raised related concerns over confusion caused by this lack of integration when consulted for the evaluation of the Indigenous Chronic Disease Package.<sup>16</sup>
- AHSs are seeking greater flexibility in the range of devices for which QUMAX will provide support, including for devices available through community pharmacy that would enhance chronic disease management but are not for delivery of medicines or for an individual consumer's use. An example provided to this review was weighing scales. Current QUMAX guidelines don't permit support for such devices. Importantly, they do not provide the scope to consider health benefits such devices might generate, much less assess them relative to individual health benefits from alternative devices currently within scope of the guidelines.

#### 2.5.5 Evaluation focus: Overarching evaluation through the life of the community pharmacy agreement

Consideration needs to be given to carrying out ongoing evaluation of agreement programmes and initiatives throughout the life of any future agreement. Doing so would ensure a continuing focus on whether the desired return on investment, in terms of agreed health outcomes, is being delivered.

<sup>15</sup> The Senate Community Affairs References Committee (October 2011). The effectiveness of special arrangements for the supply of Pharmaceutical Benefits Scheme (PBS) medicines to remote area Aboriginal Health Services. Parliament of Australia: Canberra.

<sup>16</sup> KPMG (2013). National Monitoring and Evaluation of the Indigenous Chronic Disease Package First Monitoring Report 2010-11. Commonwealth of Australia: Canberra.

Reasons for considering this include:

- The 5CPA was established with the requirement for its review prior to its expiry.<sup>17</sup> The Evaluation Framework to guide that review was developed in the first 18 months of the operation of the Agreement.
- Some aspects to the 5CPA are lacking the specific data to support adequate review of their performance relative to their objectives. It is even more difficult to compare aspects or programmes within the 5CPA, even though some have similar objectives.
- Evaluation or review considerations and data requirements should be incorporated into negotiations for future community pharmacy agreements and into preparations for implementation of any agreement. Ongoing evaluation, capitalising on existing operational monitoring and reporting processes, is preferable to time limited evaluation at the end of an agreement. The review processes for the 5CPA go some way towards that model but there may be scope to improve.

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<sup>17</sup> Department of Health (December 2011), Evaluation Framework for the Fifth Community Pharmacy Agreement. Australian Government: Canberra.

## 3 Introduction

### 3.1 The Fifth Community Pharmacy Agreement

The 5CPA between the Australian Government and the Pharmacy Guild of Australia (the Guild) provides up to \$15.67 billion to around 5,450 community pharmacies for dispensing PBS medicines, providing pharmacy programmes and services; and to pharmaceutical wholesalers for the Community Service Obligation arrangements. A breakdown of the \$15.67 billion is outlined in Table 1 below.

Table 1. 5CPA funding elements presented in millions of dollars (\$m)<sup>18</sup>

Element	\$m
Dispensing fees, Retail and Wholesale Markups, Extemporaneously Prepared Items and Dangerous Drug Fees	13,076.1
Premium Free Dispensing Incentive	912.1
Electronic Prescribing Fees	75.5
<b>Total Pharmacy Remuneration</b>	<b>14,063.7</b>
Programmes and services	386.4
Additional programmes to support patient services	277.0
<b>Total programmes</b>	<b>663.4</b>
Community Services Obligation	949.5
<b>Total</b>	<b>15,676.6</b>

The 5CPA, which commenced on 1 July 2010, recognises the key role played by community pharmacies in primary health care and provides support for retaining services that enhance patient medication management. These include a focus on improving quality use of medicines by Aboriginal and Torres Strait Islander peoples, supporting rural pharmacies and the rural pharmacy workforce and commissioning research into evidence-based best practice in quality pharmacy services. The 5CPA also includes a commitment to maintaining location rules for approved pharmacies.

### 3.2 Review Purpose and Scope

The Pharmaceutical Access Branch, Pharmaceutical Benefits Division in the Department of Health (the Department) engaged KPMG to undertake the Combined Thematic Review (the

<sup>18</sup> Source: Department of Health

Review) of Access, Consumer Experience and Quality Use of Medicines under the 5CPA. The purpose of the review is to understand the degree to which (and in what ways) the 5CPA:

- Supports access to PBS medicines (Access);
- Provides support to consumers of PBS medicines (Access);
- Addresses community needs in relation to the objectives of the agreement (Consumer Experience); and
- Supports Quality Use of Medicines principles (QUM).

The Access component will explore:

- How the 5CPA supports access to PBS medicines, including support to consumers and the wider community; and
- How 5CPA investments are contributing directly to achieving the objectives of the 5CPA and the National Medicines Policy in relation to access to medicines.

The Consumer Experience component will explore:

- Whether 5CPA investments are contributing directly to achieving the objectives of the 5CPA and broader government policy in relation to addressing consumer needs.

The QUM component will explore:

- Whether QUM principles are supported through 5CPA activities.

A full list of the specific questions/activities to be addressed as part of this review is available in Table 17 in the Appendix.

### **3.3 Review Methodology and timeline**

The methodology underpinning this Review has involved:

- The Department of Health supplying relevant materials and data;
- A workshop on the 8<sup>th</sup> of October with the Programmes Reference Group (PRG), where KPMG presented information gaps to the PRG and the PRG suggested stakeholders to consult and reports to source to inform the Review;
- Consulting with a list of stakeholders to address the information gaps and source information and reports;
- Preparation of a progress report for discussion by the Department, the Guild and members of the PRG; and
- Additional work to address areas of the progress report noted by those stakeholders as requiring attention.

The timeline and key activities are outlined in Figure 1 below.

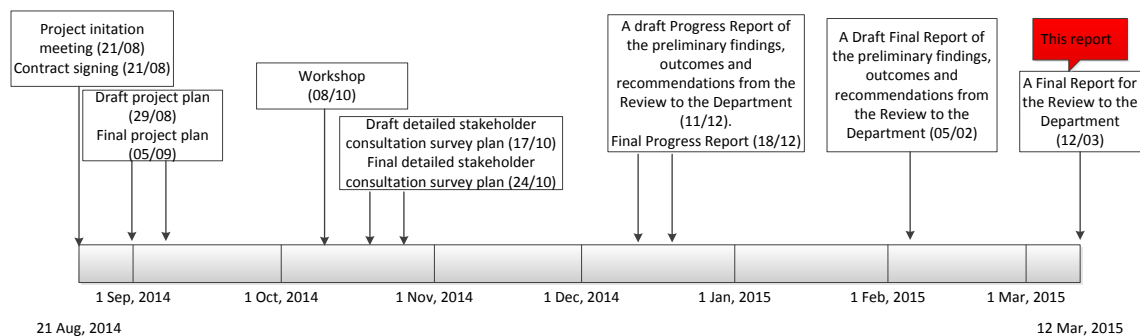


Figure 1. The Review timeline<sup>19</sup>

### 3.4 Structure of the Final Report

This report is the Final Report, containing findings from the project and options for consideration in future community pharmacy policy and agreements. It is intended to be used by stakeholders that have been involved in the design, delivery, administration and oversight of the 5CPA and to inform considerations for direction of future Community Pharmacy Agreements (in design, development and administration of the relevant programmes). In light of this intended audience, the chapters and sections of this report reflect the structure and operation of the 5CPA itself.

The themes of access, consumer experience and QUM are closely inter-related. Specific parts of the 5CPA, and programmes within it, may relate more closely to a particular theme than others. For example the Location Rules are principally about ensuring all Australians have access to PBS medicines; while a Home Medicines Review aims to enhance the quality use of medicines. The Review also, where applicable, has a particular focus across the following population groups:

- aged care recipients;
- Aboriginal and Torres Strait Islander people;
- carers;
- rural and remote populations;
- CALD populations; and
- consumers with a mental illness.

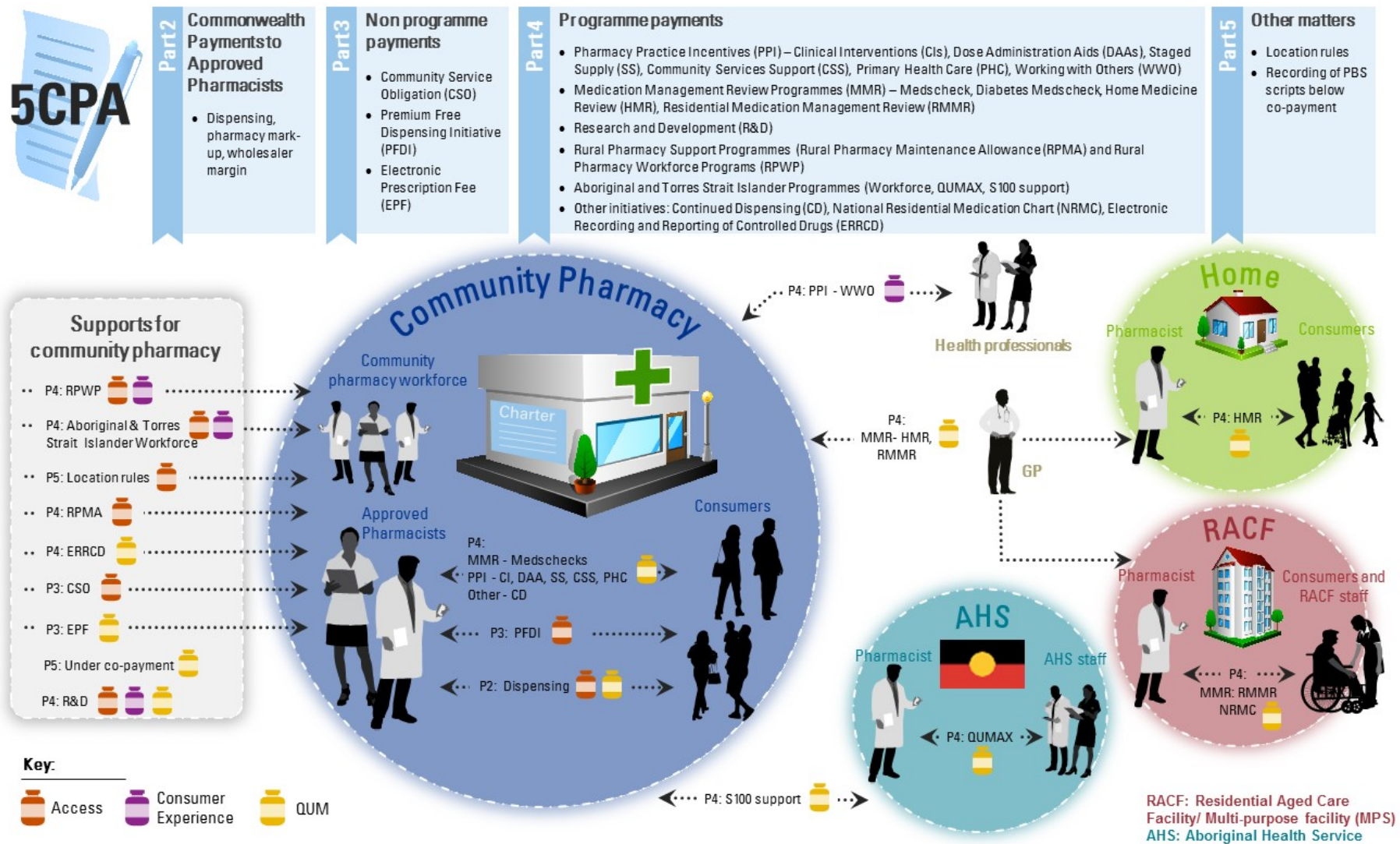
### 3.5 The Fifth Community Pharmacy Agreement - A visual

**Error! Reference source not found.** below is a visual depiction of the 5CPA in relation to the combined thematic review. The background circles/rectangle shows the location of where transactions occur (e.g. HMR occurs in the home, dispensing occurs within a community pharmacy), the arrows indicate between whom those transactions occur (e.g. dispensing is between the pharmacist and the consumer in a community pharmacy) and how those transactions, or arrows, relate to the review themes of Access, Consumer Experience and Quality Use of Medicines (e.g. an HMR has a QUM focus) is designated by a coloured medicine bottle. The abbreviations in the text (P2, P3, P4, P5) indicate from what part of the 5CPA the programme or

<sup>19</sup> Source: KPMG and the Department of Health.

support is articulated within. The visual depiction is included as an aid for readers in understanding the types, range and location of programmes and supports funded under 5CPA.

Figure 2. 5CPA a visualisation and the review themes



## 5

## Part 2: Commonwealth Payments to Approved Pharmacists

### Combined Thematic Review findings



Access

Consumer  
Experience

QUM

- Access focussed component with a QUM element to dispensing
- Access to medicines for consumers has remained steady based on the fact that scripts per capita are steady, number of pharmacies has grown, pharmacies are regularly accessed and proportion of the population that received a script is steady.

The 5CPA, consistent with the relevant clauses in the *National Health Act 1953*, sets out the amount paid to approved pharmacists when supplying a PBS medicine to a consumer, as agreed between the Australian Government and the Guild. The majority of 5CPA funds are directed towards assuring this supply of medicines to the Australian community, which is consistent with the related review theme of Access. In addition, Section 8.2 c of the 5CPA identifies “*the pharmacists specialised skills in dispensing the medicines*” as a consideration in determining the quantum of the Commonwealth Price for PBS medicines, therefore, there is an expectation of a certain level of service and QUM also attached to dispensing fees.

The 5CPA has sought to ensure that there is a network of accessible and viable community pharmacies throughout Australia including in rural and remote areas. There have been a number of applications for a new pharmacy approval to supply PBS medicines considered and recommended in both rural and metropolitan areas by ACPA (see section on Location Rules) through the life of the 5CPA. Overall the number of community pharmacies has grown over the life of the agreement (from 5,088 in 2010 to 5,457 in 2014 see Table 15) and the ratio of people per pharmacy has remained steady in urban areas and decreased slightly in rural areas (see Table 15). This suggests that gaps in access to community pharmacies are being appropriately filled.

Over the life of the 5CPA, the estimated resident population of Australia will have grown from 22 million people (30 June 2010) to a forecast 24 million people (30 June 2015). Most of the Australian population is able to readily access a community pharmacy - it is one of the most frequently accessed primary health care services and is often the first point of contact between consumers and the health care system.<sup>20</sup> On average, a person will visit a community pharmacy around 14 times a year.<sup>21</sup>

The volume of scripts dispensed per capita, excluding under-copayment scripts, has dropped slightly from 2010-11 to 2013-14 (see Table 2 below). Including under-copayment scripts, for which there is two full financial years of data, there has been a slight increase in scripts per capita from 12.1 in 2012/13 to 12.3 in 2013/14.<sup>22</sup>

A discussion paper from the National Rural Health Alliance suggests that “*Compared with those who live in the major cities, people in Australia's rural and remote areas have reduced access to prescribed and non-prescribed medicines.*”<sup>23</sup> Scripts per capita vary across remoteness areas although not as clearly as the NRHA discussion paper might suggest with regional areas having higher scripts per capita than major cities. In 2013-14 inner regional areas had an estimated 11.4

<sup>20</sup> PwC. Consumer Needs Full Final Report. op. cit.

<sup>21</sup> Ibid

<sup>22</sup> Data on private prescriptions, funded by the patient or private health insurer, were not available. Private prescriptions represented 7.2% of community prescriptions in 2011. Source: <http://www.pbs.gov.au/info/statistics/asm/asm-2011>, accessed 4 March 2015.

<sup>23</sup> National Rural Health Alliance (NHRA) 2014. Discussion paper on Access to Medicines and pharmacy services in rural and remote Australia. NHRA.

scripts per capita; outer regional areas had 10.4 scripts per capita; major cities had 8.6 scripts per capita; remote areas had 6.3 scripts per capita; and very remote areas had 3.4 scripts per capita (see Table 21 in the Appendix). The low volume of scripts per capita in remote and very remote areas does not necessarily translate to lower access due to arrangements such as S100 Remote Area Aboriginal Health Service (S100 RAAHS) existing in these areas.

Scripts per capita vary markedly across age groups. Scripts per capita increases with each age group. For example in 2013-14 there were 1 script per capita for those aged 0 to 9 years and 62.8 scripts per capita for those aged 90 to 99 years. The change in scripts per capita within age groups over the life of the 5CPA can be broadly described as decreasing slightly for those aged between 0 to 69 years and remained steady or increasing slightly for those aged 70 years and over (See Table 22 in the Appendix).

There is variation in scripts per capita by concessional status. During the 5CPA the numbers of scripts dispensed to general PBS patients has fallen and those to concessional patients have risen. This suggests differential trends in access to medicines for these two groups, most likely explained by the differential impact of cost of medicines for each group.

In addition the proportion of the population that received a prescription for medication has remained steady between 2010-11 and 2013-14 at just under 70 per cent (see Table 20 in the Appendix). This can be considered to be consistent with the Australian population being able to continue to readily access PBS medicines via a community pharmacy. Commonwealth Payments to Pharmacists (Part 2 of the 5CPA), which receives the majority of the allocated funding, can be considered as a key enabler of access to medicines.

Pharmacy remuneration components for dispensing a PBS medicine include wholesale mark-up, pharmacy mark-up, dispensing fee and special handling fee. The wholesale mark-up is paid in recognition of the costs involved in the transportation of PBS medicines to community pharmacies. The pharmacy mark-up is paid to pharmacists for the costs associated with the storage and handling of PBS medicines. The pharmacy mark-up is fixed for the term of the agreement i.e. it is not indexed as is the ready-prepared dispensing fee.

The pharmacy mark-up is dependent on the price of the medicine being dispensed. The simplified price disclosure (SPD) measure was introduced in August 2013<sup>24</sup> and sought to streamline the operation of the existing price disclosure arrangements. There has been criticism more generally of price disclosure as a mechanism to reduce medicine prices.<sup>25</sup>

SPD would allow price reductions to medicines to occur sooner, and more frequently, after medicines become subject to market competition than previous arrangements.<sup>26</sup> There was concern the amendment would have a significant impact on community pharmacies both financially<sup>27</sup> and in services offered. The impact was expected to be particularly felt by community pharmacies that are independent or in rural and regional areas, who had not factored such changes into their forward financial planning.<sup>28</sup> Given the first price reduction under SPD

<sup>24</sup> [http://www.aph.gov.au/Parliamentary\\_Business/Bills\\_Legislation/bd/bd1314a/14bd039#\\_ftn64](http://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/bd/bd1314a/14bd039#_ftn64), accessed 5 February 2014

<sup>25</sup> S Duckett et al, Poor pricing progress: price disclosure isn't the answer to high drug prices, Grattan Institute, Melbourne, December 2013, p. 2, accessed 17 January 2014

<sup>26</sup> [aph.gov.au](http://www.aph.gov.au) Op.cit.

<sup>27</sup> [http://www.guild.org.au/docs/default-source/public-documents/news-and-events/Community-Pharmacy-Under-Threat/media-release---pharmacy-jobs-services-to-go-after-shock-government-decision-\(metro\).pdf?sfvrsn=0](http://www.guild.org.au/docs/default-source/public-documents/news-and-events/Community-Pharmacy-Under-Threat/media-release---pharmacy-jobs-services-to-go-after-shock-government-decision-(metro).pdf?sfvrsn=0), accessed 5 February 2014

<sup>28</sup> [aph.gov.au](http://www.aph.gov.au) Op.cit.

only occurred on 1 October 2014 there was limited evidence available to assess the impact on community pharmacies and the impact is likely to be unevenly distributed among pharmacies given the diversity in the size, type and location of community pharmacies.

There are two dispensing fees under the 5CPA - the ready-prepared (currently \$6.76) and extemporaneously-prepared (currently \$8.80) dispensing fees. The ready-prepared dispensing fee is paid to pharmacists for the provision of professional advice, counselling and relevant medicine information to patients and consumers (i.e. QUM advice). The extemporaneously-prepared dispensing fee is a combination of the current ready-prepared dispensing fee and the extemporaneously-prepared special handling fee. The extemporaneously-prepared fee (\$2.04) and the Dangerous Drug fee (\$2.71) are known as special handling fees, and are fixed for the life of the 5CPA.

*Table 2. Population, scripts dispensed and scripts dispensed per capita, including under co-payment scripts in square brackets, for 2010-11 to 2014-15*

<b>Statistic</b>	<b>2010-11</b>	<b>2011-12</b>	<b>2012-13</b>	<b>2013-14</b>	<b>2014-15 (Forecast<sup>29</sup>)</b>
<b>Population as at 30 June<sup>30</sup></b>	22,031,750	22,340,024	22,728,254	23,135,281	23,559,362
<b>Scripts dispensed<sup>31</sup></b>	206,089,977	210,028,225	210,751,540 [275,371,805]	213,294,476 [283,960,108]	Not available
<b>Scripts per capita</b>	9.4	9.4	9.3 [12.1]	9.2 [12.3]	Not available

<sup>29</sup> Australian Bureau of Statistics (ABS) 2014. Population Projections, Australia, 2012-2101. Cat. No. 3222 ABS, Canberra.

<sup>30</sup> Australian Bureau of Statistics (ABS) 2014. Regional Population Growth, Australia. Cat. No. 3218. ABS, Canberra.

<sup>31</sup> PBS Date of Supply data supplied by the Department of Health. Excludes Under Co-payment scripts.

## 6 Part 3: Other Payments (Non-programme)

### 6.1 Additional charges - Premium Free Dispensing Incentive payment and Electronic Prescription Fee

#### Combined Thematic Review findings



Access

Consumer  
Experience

QUM

- Access focussed component to PFDI and QUM focus to EPF
- PFDI has assisted in decreasing the cost of PBS medicines to consumers
- Uptake of EPF lower than anticipated potentially limiting QUM outcomes

The Premium Free Dispensing Initiative (PFDI) encourages pharmacies to make consumers more aware that a premium free brand of the prescribed medicine is available. Pharmacies are provided with incentives to increase consumer awareness, so that consumers can, if they wish, exercise their right to choose their preferred brand of medicine.

The PFDI has been retained under the 5CPA and is indexed annually on 1 August of each year based on Wage Cost Index 9 (WCI9). From 1 August 2014 the PFDI increased by 3 cents, from \$1.65 to \$1.68 per eligible prescription. The original funding allocation for 2010-15 was \$620m. An estimate variation for an additional \$226m was approved by the Department of Finance in January 2011 bringing the total budget allocation up to \$846m. A subsequent estimates variation in January 2013 further increased the PFDI budget allocation to \$912m to take into account the listing of generic brands of Atorvastatin (the most prescribed PBS medicine), as each prescription for this medicine in effect became potentially eligible for this incentive payment.

In relation to the Review, the PFDI has an access focus, as increasing the rate of substitution from premium to premium free brands by pharmacists, assists the Government to uphold its commitment that PBS Reform will not increase the cost of PBS medicines to consumers.<sup>32</sup> This is important given that cost of medicines remains a barrier to some consumers.<sup>33</sup>

In relation to the Review, the Electronic Prescription Fee (EPF) has a QUM focus. The EPF will improve patient care by contributing to the safe and effective prescribing and dispensing of medicines. Studies in Australia and abroad of e-prescribing systems have shown enhanced safety and quality of prescribing by ensuring complete and legible prescription orders and reducing medicine errors and adverse reactions.<sup>34,35</sup> However the take up of the EPF has been lower than expected and as such there has been a budget underspend. The main reasons for the lower than expected take up of the EPF include:

- A small number of prescriptions being electronically generated and uploaded by prescribers; and

<sup>32</sup> Australian Government Department of Health (2014). Internal working document.

<sup>33</sup> Australian Bureau of Statistics (ABS) 2014. Patient Experiences in Australia: Summary of Findings, 2013-14. Cat. No. 4839 ABS, Canberra

<sup>34</sup> Shamliyan TA, Duval S, Du J, Kane RL. Just What the Doctor Ordered. Review of the Evidence of the Impact of Computerized Physician Order Entry System on Medication Errors. Health Services Research. 2008;43(1):32-53. [PMC free article] [PubMed]

<sup>35</sup> Westbrook JJ, Reckmann M, Li L, Runciman WB, Burke R, et al. (2012) Effects of Two Commercial Electronic Prescribing Systems on Prescribing Error Rates in Hospital In-Patients: A Before and After Study. PLoS Med 9(1): e1001164. doi:10.1371/journal.pmed.1001164

- The inability of Prescription Exchange Service (PES) software to exchange prescription information.

The Department worked with PES providers to undertake system changes so that electronic prescriptions and associated repeats can be accessed by pharmacies regardless through which PES the prescription is lodged. To address the prescriber side issue, the eHealth Division within the Department of Health revised the Practice Incentives Program – eHealth Incentive (ePIP) to include a new ETP requirement for general practices to ensure that the majority of their prescriptions are sent electronically to a PES. The budget underspend has been utilised to fund overspends in some other 5CPA programmes (e.g. HMR) and to provide communication and education activities to increase the uptake of ETP by both prescribers and pharmacists.

## 6.2 Community Service Obligation Funding pool

### Combined Thematic Review findings



Access



Consumer  
Experience



QUM

- Access focussed component
- CSO has operated effectively and has support from pharmacy owners and managers

The Community Service Obligation (CSO) is an access related component of the 5CPA. It is intended to ensure timely access for all Australians to all PBS medicines through community pharmacies.

Under the CSO, participating pharmaceutical wholesalers are required to supply the full range of PBS medicines and to deliver PBS medicines ordered by a community pharmacy within 24 hours. This obligation covers almost all of Australia. Figure 3 shows the areas excluded from the 24 hour delivery requirement, which cover a few remote areas of the Kimberley, the Pilbara, and some islands of the Torres Strait, Northern Cape York, Tennant Creek and Christmas Island. Collectively, these excluded areas accounted for less than 0.2 per cent of the Australian population as at the 2011 Census.

A pool of funds is provided under 5CPA to make it commercially viable for the participating wholesalers to meet these community service obligations. Early in the 5CPA, a tender process led to the engagement of five wholesalers in the CSO arrangements.

The total allocation for the CSO pool under the 5CPA is \$949.5 million. This budget and expenditure were increased from the Fourth Community Pharmacy Agreement (4CPA), where \$663.4 million was allocated for the CSO.

The CSO has operated effectively over its nine year operating life to date and has seen the delivery of over 2 billion units to community pharmacies. The Pharmacy Barometer<sup>36</sup> found that there “was overwhelming endorsement to keep funding for the Community Service Obligation (CSO)” in the community pharmacy sector. In particular, owners (72 per cent) and managers (55 per cent) were highly supportive of the CSO arrangements. The vast majority (more than 90 per cent) of those supporting the CSO were of the view that the level of future funding should be either maintained or increased.

<sup>36</sup> University of Technology Sydney (October 2014). UTS: Pharmacy Barometer. UTS: Sydney. Note: Only 268 respondents to the qualitative questions

From February 2011, Pfizer introduced the Pfizer Direct pharmaceutical supply model, under which Pfizer guarantees next business day delivery to registered community pharmacies throughout most of Australia. Wholesalers participating in the CSO have argued that this exclusive distribution model threatens to undermine the CSO.<sup>37</sup> The 2014 Pharmacy Barometer results also show that some community pharmacists share the concerns of CSO wholesalers, regarding risks of undermining the CSO and its access objectives posed by the exclusive distribution arrangements such as the Pfizer Direct model.

To date, there has not been expansion of that model to a wider range of distributors and the published data<sup>38</sup> suggest the model is not operating at a level likely to threaten the CSO and its access objectives.

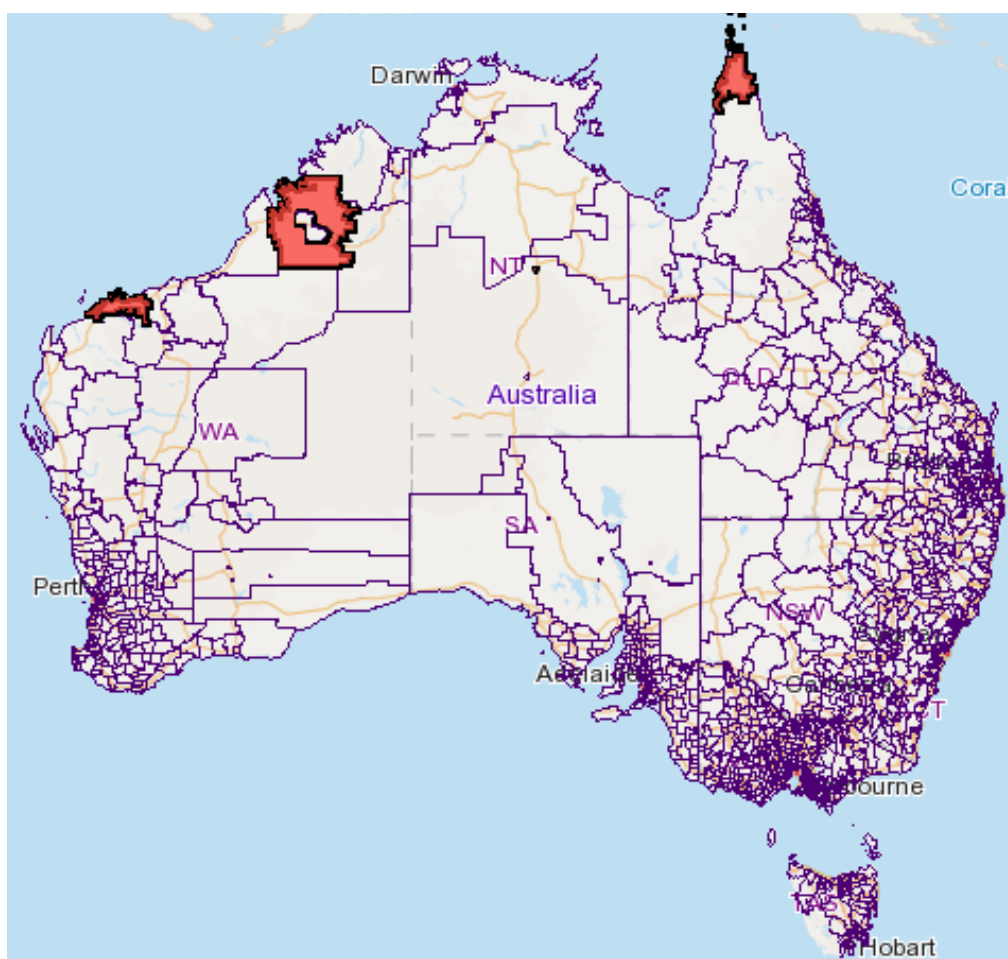


Figure 3. Post codes excluded (in red) from the CSO 24 hour delivery obligation, excluding Christmas Island<sup>39</sup>




<sup>37</sup> Stephen Greenwood (2012). NPSA: Fighting for patient and pharmacists rights. Advertorial: Supply Update. Australian Journal of Pharmacy vol. 93 September 2012.

<sup>38</sup> Ibid.

<sup>39</sup> Source: Australian Bureau of Statistics (ABS), 2012. ABS MapBuilder Online. ABS, Canberra.

## 7 Part 4: Programmes

### 7.1 Pharmacy Practice Incentives

**Combined Thematic Review summary findings**  Access  Consumer Experience  QUM

- PPI is QUM focussed suite of priority areas
- Majority of pharmacies are participating in PPI enabling access to the priority areas for consumers
- Low consumer awareness of some of the PPI services and limited consumer experience and QUM related outcomes information available

Under the 5CPA, \$344 million is provided for the Pharmacy Practice Incentive (PPI) Programme. The PPI Programme’s six priority areas recognise the beneficial health outcomes that can be achieved through the delivery of quality services by community pharmacies.<sup>40</sup>

To be eligible to participate in the PPI Programme, a community pharmacy must:

- Be a Section 90 approved Pharmacy;
- Be accredited by an approved Pharmacy Accreditation Programme;
- Agree to publicly display and comply with the Community Pharmacy Service Charter and Customer Service Statement; and
- Register for one or more of the PPI priority areas online at [www.5cpa.com.au](http://www.5cpa.com.au) and continue to meet the above Eligibility Criteria while participating in any priority areas of the PPI Programme outlined in clause 2<sup>41</sup>

There are six priority areas, summarised in the table below:

Table 3. PPI priority areas, a brief description and the policy intent<sup>42</sup>

Priority Area	Brief description	Policy Intent
<b>Clinical Interventions (CI)</b>	CIs are a professional activity undertaken by a Registered Pharmacist directed towards improving quality use of medicines and resulting in a recommendation for a change in a consumer’s medication therapy, means of administration or medication-taking behaviour.	Community pharmacies receive funding for a pharmacist to provide and record a CI using the D.O.C.U.T. system. All CIs are required to be recorded using the classes prescribed in this system.

<sup>40</sup> 5cpa website. [www.5cpa.com.au](http://www.5cpa.com.au)

<sup>41</sup> The Department of Health and The Pharmacy Guild of Australia (2014). Programme Specific Guidelines Pharmacy Practice Incentives (PPI).

<sup>42</sup> Source: 5cpa website. [www.5cpa.com.au](http://www.5cpa.com.au)

Priority Area	Brief description	Policy Intent
<b>Dose Administration Aids (DAAs)</b>	DAAs are a sheet of hermetically sealed blisters of medicines set out in a calendar pack that must be tamper proof once packed.	Community pharmacies have provided DAAs to consumers for approximately 20 years. This programme remunerates the pharmacy for providing the DAA to a quality standard.
<b>Staged Supply Support Allowance</b>	Involves the provision of PBS medicines in instalments where requested by the prescriber.	Community pharmacies receive an annual incentive payment for offering a Staged Supply service in accordance with the guidelines
<b>Primary Health Care</b>	Within these elements (Diabetes, Respiratory, Cardiovascular Disease, Mental Health Conditions, Health Promotion) an Eligible Community Pharmacy can provide various screening and risk assessment and/or disease state management services.	Community pharmacies receive an annual incentive payment for providing selected primary health care services
<b>Community Services Support</b>	Community Services Support includes eight elements focussed on medicine safety, harm minimisation and services to support the community. The eight Community Services Support elements are: <ol style="list-style-type: none"> <li>1 Needle and Syringe Programs</li> <li>2 Opioid Substitution Programs</li> <li>3 National Diabetes Services Scheme (NDSS) Access Point</li> <li>4 Pharmacy Delivery Service</li> <li>5 Mental Health First Aid Training (for pharmacists and staff)</li> <li>6 Return of Unwanted Medicines (RUM)</li> <li>7 Staff Training (including Certificate III or IV training in Community Pharmacy)</li> <li>8 eHealth</li> </ol>	Community pharmacies receive an annual incentive payment for providing selected medicine safety, harm minimisation and services to support the community

Priority Area	Brief description	Policy Intent
<b>Working with Others</b>	Recognises that pharmacists routinely collaborate with other health professionals as part of their daily professional duties. The main purpose of providing an incentive for this priority area is to encourage documentation by pharmacists of inter-professional collaborations and to promote the building of relationships with other non-pharmacy health professionals to improve patient health outcomes	Community pharmacies will be paid an annual incentive payment for documenting collaborations with other (non-pharmacy) health professionals from at least three different health professional groups.

Between July 2010 and February 2014 the distribution of pharmacists delivering 5CPA Medication Management programmes and services across Australia generally reflected the distribution of community pharmacy across the country.<sup>43</sup> This is not surprising given that the majority of pharmacies have been accredited and registered for the six priority areas within the PPI Programme. As of 31 March 2014, the following number of pharmacies were registered to participate in one or more priority areas of the PPI Programme out of 5,351 Section 90 pharmacies in Australia:

- 5,016 or 91% for Clinical Interventions (CIs);
- 4,848 or 88% for Dose Administration Aids (DAAs);
- 4,953 or 90% for Staged Supply Support Allowance;
- 4,292 or 78% for Primary Health Care;
- 4,974 or 90% for Community Services Support; and
- 4,955 or 90% for Working with Others.

Limited evidence was available on why pharmacies haven't registered to participate in the six priority areas. Some stakeholders suggested that it may relate to pharmacy ownership and that a pharmacist working as a locum (i.e. they don't own the pharmacy) has no financial incentive to sign up and participate. Some stakeholders also suggested it might be related to administrative burden of registration and service claiming processes. Stakeholders did not specify a timeframe around these comments. That is to say it was unclear whether these comments related to the Department of Human Services managing the claims and payments for these programmes prior to 1 March 2014 or whether it related to the Guild managing the claims and payments for the

<sup>43</sup> This statement relates to the combined Medication Management Review and Pharmacy Practice Incentives programmes, as this was the scope of the *Medication Management Report*. PwC Medication Management Programs op. cit.

programmes post 1 March 2014.<sup>44</sup> The *Medication Management Report*, suggested the following reasons for not participating:

- not applicable to their working arrangements;
- not being accredited/approved to provide the service;
- not having enough time; and
- not seeing the programmes as financially viable.

Stakeholders also pointed out that, while pharmacies may not be participating in the PPI Programme, they are likely to still be providing similar services, particularly DAAs and CIs. Some stakeholders noted that CIs recognised the work that pharmacists were already undertaking with consumers. Likewise DAAs themselves have been provided by community pharmacies for many years. Funding received by community pharmacies is not for the DAA itself but for providing this service to a quality standard.

Between July 2010 and February 2014 a total of 6,216<sup>45</sup> pharmacies submitted claims for PPI services overall. Across the three programmes that collect service level data the results were that:

- 5,909 pharmacies submitted claims for DAAs. 22,571,080 consumers were provided DAA services. Note: that this is not unique consumers. A consumer is likely to have received multiple DAA services of the collection period;
- 5,970 pharmacies submitted claims for 6,729,876 CI services; and
- 5,577 pharmacies delivered 6,541,195 Staged Supply services.<sup>46</sup>

Primary Health Care, Community Services Support and Working with Others priority areas do not involve the collection of individual claims or service related data. Annual payments are made for these three programmes. The *Consumer Needs Report*<sup>47</sup> touched on the issues of chronic disease management in pharmacies, which relates to the Primary Health Care priority area. The *Consumer Needs Report*<sup>48</sup> noted that there was:

- “Low consumer awareness of the pharmacists ability to provide chronic disease management,” and;
- “A lack of consumer confidence in positive patient outcomes from community pharmacist managed chronic disease management programs, decreasing consumer willingness to use these programs.”

The high participation by pharmacies in the PPI Programme and the volume of services delivered is indicative of there being limited barriers to access these programmes for consumers, although cost of DAAs was reported as being a barrier by consumers despite their perceived high value.<sup>49</sup>

<sup>44</sup> <http://guild.org.au/news-events/forefront/volume-4-number-5/5cpa-remuneration-streamlined>, viewed 1 February 2014

<sup>45</sup> Note that this number is not representative of the number of approved pharmacies, but instead represents the number of approvals in force during the reporting period for pharmacies claiming in PPI. This difference is because an approval number is revoked and a new approval granted whenever there is a change to the ownership or locality of a pharmacy.

<sup>46</sup> PwC Medication Management Programs op. cit.

<sup>47</sup> PwC Consumer Needs Final Report op. cit.

<sup>48</sup> Ibid.

<sup>49</sup> PwC Medication Management Programs op. cit.

The *Medication Management Report* also notes that the majority of stakeholders commented on the difficulty of accessing Medication Management programmes (note: this includes MMR) due to:

- low consumer awareness;
- information on programmes not readily available to consumers; and
- low GP engagement and awareness.

The *Consumer Needs Report*<sup>50</sup> also noted that there is a low level of awareness of medication management services being offered by community pharmacists, which translates to low expectations and demand for these programmes.

The Community Pharmacy Service Charter (Charter) provides information on the rights of consumers and responsibilities of pharmacists, and the level of service consumers can expect to receive when visiting a community pharmacy. It allows patients, consumers, families, carers and community pharmacies to share an understanding of the rights of people receiving health care.<sup>51</sup>

Pharmacies participating in the PPI Programme are also required to display and comply with the Charter. The Charter helps consumers understand what level of service they can expect to receive from their local community pharmacy. Pharmacies are also required to produce a Customer Service Statement with information specific to each pharmacy, including its opening hours and what professional services are offered.

In discussing the Charter with stakeholders as part of this Review, it was noted by a number of stakeholders, that when visiting a community pharmacy, they had often not been able to see or locate the Charter. This suggests that consumers are likely to be much less aware of the very existence of the Charter than the stakeholders consulted as part of this review. Therefore the Charter in and of itself is likely to have limited or no flow on impact to awareness of 5CPA programmes and services. No evidence was available to the Review in relation to the adequacy of the complaints mechanisms outlined in the Charter.

Information about patient experience is important to guide health care quality improvement and may also be used for health performance reporting. While there have been developments in the capture of patient experience information in hospital and GP settings, little was known about the extent of data capture and in the broader non-GP primary health.<sup>52</sup> The scope of this project did not include the community pharmacy sector though.

While not explicitly part of the 5CPA the QCPP provides a patient experience survey called the Pharmacy Patient Questionnaire (PPQ) as a member benefit. The survey assists pharmacies to meet their requirements under QCPP. The questions within the QCPP survey are based on a similar survey in the UK.<sup>53</sup> Some of the questions within this survey overlap with the questions that are in the Consumer Needs Measurement Tool. The PPQ has been validated and produces

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<sup>50</sup> PwC Consumer Needs Final Report op. cit.




<sup>51</sup> <http://www.health.gov.au/internet/main/publishing.nsf/Content/community-pharmacy-service-charter>, accessed 18 December 2014

<sup>52</sup> Australian Institute of Health and Welfare 2014 The measurement of patient experience in non-GP primary health care settings. Cat. no. WP 66. Canberra: AIHW. Available at: [www.aihw.gov.au/publication-detail/?id=60129547332](http://www.aihw.gov.au/publication-detail/?id=60129547332)

<sup>53</sup> See Community Pharmacy Patient Questionnaire at <http://psnc.org.uk/wpcontent/uploads/2013/07/cppq2020annex20a.pdf>, accessed 5 March 2015.

reliable data for pharmacies with 35 or more patient responses.<sup>54</sup> Pharmacies have taken action and made changes to improve the consumer experience based on the results from this survey tool. The PPQ can also be used for broader analyses such as the difference in consumer perception of community pharmacy in metropolitan and rural areas.

## 7.2 Medication Management Review Programmes

Combined Thematic Review summary findings  Access  Consumer Experience  QUM

- MMRs are a QUM focussed suite of programmes.
- Low consumer awareness of some services, including amongst key target groups.
- Limited QUM related outcomes information available, although QUM focus and programme rationale widely acknowledged.

The 5CPA provides for a package of Medication Management Review Programmes (MMRs) which aim to enhance the quality use of medicines by high risk consumers; in particular the elderly, those experiencing chronic disease and consumers taking multiple medications, who may require assistance to better manage their medication.<sup>55</sup> The intent of the MMRs is to reduce the number of medication misadventure events amongst such high risk groups.

Specific initiatives agreed to include:

- An in-pharmacy Medicines Use Review (referred to as a MedsCheck) designed to help patients better manage and understand their medicines, and an associated Diabetes Medication Management Service (Diabetes MedsCheck) for patients either newly diagnosed with Type 2 diabetes or whose diabetes is less than ideally controlled. The Diabetes MedsCheck programme is targeted at pharmacies in locations where diabetes services are insufficient to meet the needs of the local population. Indicative funds of \$29.6 million were identified for the MUR programme and \$12.2 million is available for the Diabetes Medication Management Service. Medschecks commenced in July 2012. As at 1 July 2014 a pharmacist received \$62.18 per Medscheck and \$93.27 per Diabetes MedsCheck.
- An in-home Home Medicines Review (HMR) designed to help patients better manage and understand their medicines through a medication review conducted by an accredited pharmacist in the patient's home. Indicative funds of \$52.11 million were identified for the HMR programme. HMRs commenced prior to the 5CPA in 2001. As at 1 July 2014 a service provider received \$208.22 per HMR. Service providers are also eligible to receive a further payment of up to \$125 if require to travel more than 200km round trip to a rural and remote area.
- A Residential Medication Management Review (RMMR) for accredited pharmacists to assist residents (and their carers) with the medication regimens of permanent residents of Commonwealth funded aged care facilities. Indicative funds of \$70 million were identified

<sup>54</sup> Narayanan A, Greco M, Reeves P, Matthews A, Bergin J. Community pharmacy performance evaluation: Reliability and validity of the Pharmacy Patient Questionnaire. *Int J Healthcare Management* 2014; 7(2): 103-118. Available at: [www.maneyonline.com/doi/full/10.1179/2047971913Y.0000000067](http://www.maneyonline.com/doi/full/10.1179/2047971913Y.0000000067)

<sup>55</sup> Section 19.1.A of the Fifth Community Pharmacy Agreement Between The Commonwealth of Australia and The Pharmacy Guild of Australia, May 2010.

for the RMMR programme. RMMRs commenced prior to the 5CPA in 1997. As at 1 July 2014 a service providers received \$105.29 per RMMR.

These three programmes are intended to be delivered to a smaller number of consumers than other initiatives funded under the Agreement, but to higher risk consumers with a greater level of need. Their place along a “Medication Management Continuum” is illustrated in Figure 4 below. Combined funding of \$164 million was allocated to these programmes over the term of the 5CPA. This funding only applies to HMR, RMMR, MedsCheck and Diabetes MedsCheck.

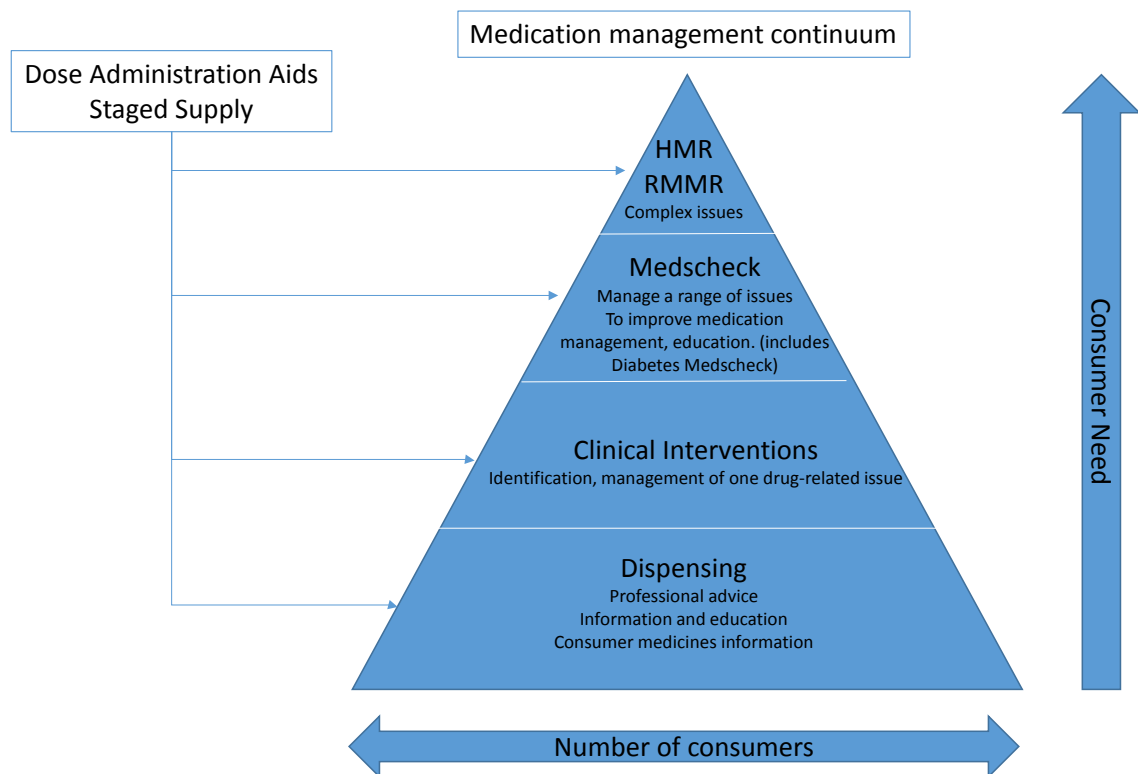


Figure 4. Medication Management Continuum<sup>56</sup>

The potential benefits to be realised by the suite of MMRs are widely recognised and stakeholder consultations with practitioners and consumers undertaken for a recent MMR review confirm this view.<sup>57</sup> The perceived benefits of MMRs include:

- Reduced adverse drug reactions resulting in reduced avoidable hospitalisations;
- Reduced cost to the health care system;
- Healthier consumers;
- Improved management of medication through better compliance rates;
- Increased confidence of the consumer;

<sup>56</sup> Supplied by Department of Health; adapted by KPMG)

<sup>57</sup> PwC Medication Management Programs op. cit.

- Reduced avoidable drug interactions through medication de-prescribing and improved dosing; and
- Increased GP knowledge of geriatric pharmacology.

### 7.2.1 Medication Management Programme Changes and Developments

Despite the extent of potential benefits, it has been suggested that the early roll-out of the MMRs was hampered, and access constrained, by a low level of GP and consumer awareness of the range of medication management services offered by community pharmacists.<sup>58</sup>

The Pharmacy Guild of Australia therefore responded with a range of marketing initiatives to increase demand, with a resulting increase in uptake reported.<sup>59</sup>

Table 1 below shows the total number of unique consumers for each programme. The sheer volume of consumers and number of GPs that have referred patients for a HMR or RMMR suggests that there is an established level of awareness of these services among a subset of GPs. By late 2013 the HMR and RMMR programmes combined were forecast to exceed their allocations by over \$14 million in both 2013-2014 and 2014-2015, while the MedsCheck programmes were forecast to exceed their allocations by at least \$12 million in 2013-2014, and up to \$29 million in 2014-2015.<sup>60</sup>

Table 4. MMRs and number of unique consumers per programme between July 2010 and February 2014<sup>61</sup>

Programme	Unique consumers
MedsCheck/ Diabetes MedsCheck	306,713
RMMR	304,510
HMR	278,835
Total	890,058

Notwithstanding evidence of high demand and a growth in the take-up of medication management services, anecdotally it has been suggested that the programme model over the 2010-14 period has fostered behaviours amongst some practitioners that have encouraged ‘output quantity’ over ‘service quality’ despite the existence of comprehensive programme specific guidelines.<sup>62,63</sup> There appears to have been no systematic audit process in place to assess that services are indeed delivered in accordance with these guidelines, prompting a recent review to recommend that “quality assurance could be enhanced by applying more stringent and appropriate monitoring and auditing of programs and services.”<sup>64</sup> Data on the frequency of service delivery by pharmacy should also be recorded to determine whether a broad base of pharmacies are regularly delivering the service (and establishing competency); data which could be used as the basis for the design of an audit sample.

<sup>58</sup> Consumers Health Forum (CHF) of Australia, February 2013, Consumer Uptake of Home Medicines Reviews (HMR): An Analysis of the HMR Program and its Sustainability

<sup>59</sup> Ibid

<sup>60</sup> Department of Health internal document supplied to KPMG

<sup>61</sup> Source: PwC Medication Management Programs op. cit.

<sup>62</sup> Ibid

<sup>63</sup> <http://www.pharmacynews.com.au/news/latest-news/chemist-warehouse-s-medscheck-push-sees-store-do-3>, accessed 5 February 2015

<sup>64</sup> PwC Medication Management Programs op. cit

Research has furthermore identified a number of barriers to access amongst specific target groups, including those from culturally and linguistically diverse backgrounds, older Australians and Indigenous Australians; that is, those most likely to experience relatively high rates of hospitalisation due to medication misadventure.<sup>65</sup> Moreover, an analysis of submitted claims for medication management services has shown a tendency over time for the growth in services to be increasingly delivered to a broader, arguably less vulnerable population, and consumers managing less complex health conditions and fewer medicines.<sup>66</sup>

To address issues of access, the HMR and RMMR programmes were specifically modified in the 5CPA to focus on those patients deemed most at risk of medication misadventure, such as patients returning home or to a place of care immediately following discharge from hospital. The RMMR was also modified to focus on funding best practice residential review services together with new funding for Quality Use of Medicines (QUM) services in aged care facilities.

As of 1 March 2014, further reforms to the Agreement to ensure better targeting and more effective delivery to people who will benefit most from the services introduced several changes to the programmes, including:

- A combined cap on the number of MedsChecks and Diabetes MedsChecks that can be delivered by a community pharmacy of 10 per calendar month;
- A cap on the number of HMRs that can be claimed by an accredited pharmacist or service provider of 20 per calendar month;
- A limit of 90 days between the date of a GP referral to when a HMR can be conducted;
- A timeframe of 24 months between the conduct of additional HMRs or RMMRs for patients, unless a GP considers it clinically necessary; and
- A timeframe of 30 days from the date of service for service providers claiming MedsCheck/Diabetes MedsCheck, HMR and RMMR services.

As yet, however, there was little or no data available to this Review to assess the specific impact of these changes on access to the programmes, with the overall perception being that while substantive benefits are likely to be realised across the MMR, the extent of value from individual programmes is unclear.<sup>67</sup> Overall, stakeholders have tended to indicate their support for medication management programmes and services, which are generally perceived to add value as part of an overall preventative health strategy for consumers.<sup>68</sup>

## 7.2.2 MedsCheck & Diabetes MedsCheck

A MedsCheck is an in-pharmacy review of a patient's medicine use and management focusing on at risk patients taking multiple medicines. A Diabetes MedsCheck extends this service to patients with recently diagnosed or poorly controlled Type 2 diabetes, and for whom timely access to other diabetes education or allied health services in their community is unavailable.

<sup>65</sup> White, L., Klinner, C. and Carter, S. (2011) 'Consumer Perspectives of the Australian Home Medicines Review Program: Benefits and Barriers.' *Research in Social and Administrative Pharmacy*. Available at: <http://www.sciencedirect.com/science/article/pii/S155174111000166X>, cited in CHF 2013 op. cit.

<sup>66</sup> PwC Medication Management Programs op. cit.

<sup>67</sup> Ibid

<sup>68</sup> Ibid

The MedsCheck services include a review of a patient's medicines and their use, with a view to better education and self-management, leading to improvements in the quality use of medicines and a reduction in the number of adverse drug events.

A typical MedsCheck service will aim to:

- Identify any problems that the patient may be experiencing with their medicines;
- Help the patient learn more about their medicines including any side-effects and how they may affect medical conditions;
- Improve the effective consumption of medicines by patients; and
- Educate patients about how best to use and store their medicines.<sup>69</sup>

A Diabetes MedsCheck will also typically include a review of the patient's use of blood glucose monitoring devices and practices of blood glucose control, and is aimed at improving the patient's understanding of their diabetes medication therapy in order to reduce the risk of developing complications associated with Type 2 diabetes.

These reviews must be carried out by a registered pharmacist face to face with the patient in an area of the pharmacy that is physically separated from the retail trading floor so that the privacy and confidentiality of patients is protected. Following this consultation, delivery of the services requires production of a written action plan, including agreed patient goals and any follow-up with the patient's GP or alternative healthcare provider (noting that the requirement for follow-up with these services is at the pharmacist's discretion).

For a patient to be eligible for a MedsCheck appointment, they must:

- Be a Medicare or DVA cardholder;
- Have not received a MedsCheck, Diabetes MedsCheck, Home Medicines Review or Residential Medication Management Review in the last 12 months;
- Be living at home in a community setting; and
- be taking five or more prescription medicines; or
- Have experienced a recent significant medical event that may increase the risk of medication misadventure (defined as a recent event or new diagnosis that has the potential to impact the patient's medication compliance or knowledge of their medicine regime).

For a patient to be eligible for a Diabetes MedsCheck they must:

- Be a Medicare or DVA cardholder;
- Have not received a MedsCheck, Diabetes MedsCheck, Home Medicines Review or Residential Medication Management Review in the last 12 months;
- Be living at home in a community setting; and
- be taking five or more prescription medicines; or

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<sup>69</sup> PwC Medication Management Programs op. cit.

- Have experienced a recent significant medical event that may increase the risk of medication misadventure (defined as a recent event or new diagnosis that has the potential to impact the patient's medication compliance or knowledge of their medicine regime);
- Have been diagnosed with Type 2 diabetes in the last 12 months, or have less than ideally controlled Type 2 diabetes; and
- Be unable to gain timely access to existing diabetes education or health services in their community. Barriers to 'timely access' are determined by the pharmacist based on factors such as appointment availability or practicality of travel to the nearest diabetes education or allied health service.<sup>70</sup>

A range of options are open to community pharmacies seeking to identify eligible patients who would benefit from a MedsCheck service. An approved pharmacist may:

- target patients for whom the pharmacy has established medication records;
- make a direct inquiry to a patient;
- receive a referral from the patient's GP or other healthcare provider; or
- receive a request from the patient or patient's carer.

### 7.2.3 Medschecks Service Outcomes

Assessing the extent of benefits to consumers as a consequence of the MedsCheck services is challenging given that longitudinal data is not available to determine whether there has been a reduction in the number of adverse drug events for the population accessing the programme. The lack of a direct link between the service and the patient's GP presents an additional limitation on the availability of data for evaluative purposes, in terms of understanding the contribution of any medication changes recommended by a pharmacist to the health and well-being of patients.<sup>71</sup>

Understanding the contribution of the Diabetes MedsCheck is particularly challenging given that this service is designed to fill a service gap in existing health services - making the attribution of benefits to the programme difficult in the absence of a mapping and analysis of these services. Consideration of whether or not a gap in diabetes education services exists is currently at the discretion of the pharmacist.

Based on the literature available the MedsCheck and Diabetes MedsCheck programmes have shown a mixed perceived benefit, with a perceived value in increasing the consumer's knowledge of their medication regimen within the pharmacy for less complex consumers, balanced against a perception that the programme may not be reaching its target cohort (including high risk consumers such as the elderly, those experiencing chronic disease and consumers taking multiple medications).<sup>72</sup>

This finding is to some extent validated by the available data. In absolute terms the take-up of the programme could be argued to be high - as indicated, between July 2010 and February 2014, over 300,000 individuals received a MedsCheck or Diabetes MedsCheck service, while the vast majority of registered community pharmacies (94 percent) are approved service providers -<sup>73</sup> yet

<sup>70</sup> Ibid

<sup>71</sup> PwC Medication Management Programs op. cit.

<sup>72</sup> Ibid

<sup>73</sup> Department of Health internal document supplied to KPMG

according to a recent community survey, only 9 percent of respondents had accessed a medicines review or MedsCheck in the last 12 months, compared to the benchmark of 14 percent of respondents taking five or more medicines who could be classified as high risk.<sup>74</sup>

The detailed results of the consumer survey were not available to KPMG (including the extent of cross-over between those accessing the service and their profile of risk) but the gap between the number of pharmacists approved to provide the service and the reach of the programme as indicated by the survey indicates that there continues to be an overall lack of awareness amongst high risk groups regarding the availability of the service. This assessment is backed by the same survey's finding that 19 percent of respondents reported that they would undertake a medicines review in the future (once the range of community pharmacy services available was explained).<sup>75</sup>

With regards to consumer experience, concerns that some pharmacists have been non-compliant with programme specific guidelines (PSGs), which require that services be carried out in an area of the pharmacy that ensures patient privacy and confidentiality is protected,<sup>76</sup> have yet to be substantiated quantitatively. A recent report on consumer needs which addresses these claims also commented that consumers were generally satisfied with the medication management services provided by pharmacies and felt reassured having their community pharmacist review and confirm practices regarding the use of medicines, such as dosages and frequency of consumption.<sup>77</sup>

#### 7.2.4 Home Medicines Review

A HMR is a comprehensive medication review by an accredited pharmacist conducted in the patient's home. Unlike an in-pharmacy MedsCheck review, a HMR is only available following a referral from the patient's GP and requires cooperation between the pharmacist, GP and other health professionals, together with the patient or their carer.

As with other MMRs, a HMR is intended to improve the patient's knowledge and use of medicines with the goal of reducing the number of adverse medication events. It is intended to benefit patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, or the complexity of their medication treatment.<sup>78</sup>

The specific objectives of a HMR are to:

- Achieve safe, effective, and appropriate use of medicines by detecting and addressing medicine-related problems that interfere with desired patient outcomes;

<sup>74</sup> PwC Medication Management Programs op. cit.. This statistic was most likely related to the following question in the Measurement Tool: "In the last month, have you used a medicine review service in a pharmacy? e.g. Home Medicines Review (HMR), Residential Medication Management Review. (RMMR), MedsCheck, Diabetes MedsCheck?"

<sup>75</sup> PwC Medication Management Programs op. cit. It was not specified whether this referred to a medicines review, an HMR or an RMMR. This statistic was most likely related to the following question in the Measurement Tool: "In the last month, have you used a medicine review service in a pharmacy? e.g. Home Medicines Review (HMR), Residential Medication Management Review. (RMMR), MedsCheck, Diabetes MedsCheck?"

<sup>76</sup> <http://5cpa.com.au/files/medscheck-and-diabetes-medscheck-programme-specific-guidelines-effective-1-mar-2014/>, accessed 18 December 2014

<sup>77</sup> PwC Consumer Needs Full Final Report, op. cit.

<sup>78</sup> Australian Government Department of Health and The Pharmacy Guild of Australia: Programme Specific Guidelines Home Medicines Review (HMR), March 2014

- Improve the patient's quality of life and health outcomes using a best practice approach, that involves cooperation between the general practitioner, pharmacist, other relevant health professionals and the patient (and where appropriate, their carer);
- Improve the patient's, and relevant health professional's knowledge and understanding about medicines and medication management;
- Facilitate cooperative working relationships between members of the health care team in the interests of patient health and wellbeing; and
- Provide medication information to the patient and other health care providers involved in the patient's care.<sup>79</sup>

A complete HMR service, therefore, includes the service provided by the GP and the HMR approved service provider, from the time the patient is identified through to the implementation of a medication management plan based on the findings of the pharmacist's review. A patient interview is conducted by the accredited pharmacist following the referral, but it is the responsibility of the patient's GP to assess the client's eligibility and suitability for the service and to arrange the referral with the patient's consent. The HMR service provider must also provide a copy of the written HMR report, on which the management plan is based, to the referring GP and the patient's choice of Community Pharmacy, and discuss any relevant findings or suggested management strategies as appropriate.<sup>80</sup>

The service is not intended to be part of an ongoing review cycle and a subsequent HMR may only be conducted after a period of 24 months has elapsed; although provisions are in place for reviews to be conducted out of cycle if the patient's GP deems this necessary on clinical grounds (such as a significant change in the patient's condition or medication regimen).

### 7.2.5 HMR Service Outcomes

Notwithstanding commentary that there has been a low level of awareness of the medicine management services offered by community pharmacies,<sup>81</sup> and that the take up of HMR services was initially low,<sup>82</sup> there has been a steady increase in the number of HMRs being referred, from just over 56,000 in 2010-11 to almost 94,000 in 2013-14 (see Table 2 below). This significant increase in uptake may be the result of improved marketing by the Pharmacy Guild of Australia, including education to encourage pharmacists to communicate the process and benefits of the service and to engage patients who might self-identify their eligibility.<sup>83</sup>

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<sup>79</sup> Ibid

<sup>80</sup> Ibid

<sup>81</sup> PwC Medication Management Programs Report, op. cit.

<sup>82</sup> White, L., Klinner, C. and Carter, S. (2011) 'Consumer Perspectives of the Australian Home Medicines Review Program: Benefits and Barriers.' Research in Social and Administrative Pharmacy. Available at: <http://www.sciencedirect.com/science/article/pii/S155174111000166X>, cited in CHF 2013, op. cit.

<sup>83</sup> CHF 2013, op. cit.

Table 5. HMR services claimed by GPs by financial year<sup>84</sup>

Service	2010/11	2011/12	2012/13	2013/14
<b>HMR (Item 900)</b>	56,036	77,932	98,522	93,950

Over 2013-14, of the 29,841 GPs who provided a “Level B” consultation,<sup>85</sup> 5,425 referred for a HMR. This equates to 18.2 per cent of GPs that are billing the Medicare Benefits Schedule (MBS) for referring a patient for a HMR service, suggesting that there is an established level of awareness of the programme amongst GPs. The *Medication Management Report* found that between July 2010 and February 2014, approximately 16,000 different GPs referred patients to receive this service<sup>86</sup> to approximately 279,000 consumers.<sup>87</sup> These 16,000 different GPs relates to the period July 2010 to February 2014.

While the uptake of the service has generally improved, it is unclear from the data available, whether the service is reaching those groups at most risk of medication misadventure, including those taking multiple or high-risk medicines immediately after discharge from hospital. Research has identified a number of barriers to access among specific groups, including those from culturally and linguistically diverse backgrounds, older Australians and Indigenous Australians, together with those located in regional and remote locations.<sup>88</sup> Although the notion that there are barriers to access for older Australians is inconsistent with the fact that for the period July 2010 to February 2014, the average age of a consumer receiving an HMR was 72.9 years and the median age was 75.0 years.

Furthermore, the impact of new initiatives to increase the uptake of HMR services amongst these populations, including the recent Hospital Referral Pathway (HRP), is not yet well understood. The HRP has been developed for patients deemed most at risk of medication misadventure within ten days of discharge from hospital, and is open to patients in urgent need of a HMR referral where a timely referral from a GP is not possible. The scheme allows a medical practitioner other than the patient’s GP to initiate the HMR service as part of the discharge coordination.

Two hospitals were identified to pilot this initiative and a phased implementation commenced in June 2014. It is too early, however, to evaluate the impact of the pathway on rates of medicine misadventure and hospital readmission, or the effects of improvements in the continuity of care between the hospital and the community. Both Australian and overseas studies suggest the need for the service, however, with the expectation that high rates of error in documentation during the transfer of care will be reduced through improvements in communication between health professionals.<sup>89</sup> Rates of prescribing errors were found to be as high as 32 errors per 100

<sup>84</sup> Source: MBS online. The MBS online statistics will not correlate with MMR claims under 5CPA as there was no time limit to lodge an MMR claim until March 2013 (HMR) and March 2014 (RMMR, MedsCheck/Diabetes MedsCheck)

<sup>85</sup> A “Level B consultation” is conducted by a GP in their consulting rooms with a patient and lasts less than 20 minutes. It is one of the most commonly billed GP items in the MBS and acts as a denominator.

<sup>86</sup> PwC Medication Management Programs Report, op. cit.

<sup>87</sup> Department of Health internal document supplied to KPMG

<sup>88</sup> White, L., Klinner, C. and Carter, S. (2011) ‘Consumer Perspectives of the Australian Home Medicines Review Program: Benefits and Barriers.’ Research in Social and Administrative Pharmacy. Available at: <http://www.sciencedirect.com/science/article/pii/S155174111000166X>, cited in CHF 2013 op. cit.

<sup>89</sup> CHF (2011) Adverse Medicine Events in the Community: Report from the National Consumer Workshop. Available at:

<https://www.chf.org.au/pdfs/rep/rep-738-adverseevents-May11.pdf>, cited in CHF 2013 op. cit.

prescriptions in overseas studies and up to 115 errors per 100 high-risk patients in Australian studies.<sup>90</sup> Another Australian study reported that a quarter of patients aged 65 and older required additional monitoring or intervention in the use of their medication after discharge from hospital.<sup>91</sup>

To extend the scope of access to consumers, provisions are also in place to allow for the delivery of HMRs to patients outside of their home setting (typically for cultural reasons) and to improve access to patients in rural areas, with prior approval from the Department. HMR services may also be provided by a non-accredited, registered pharmacist, subject to prior approval. Between the introduction of the 5CPA and March 2014, 726 prior approval applications were received of which 82 percent were approved,<sup>92</sup> although it has additionally been commented that the 14 day time frame for prior approval is impractical and could lead to delayed access to services.<sup>93</sup> Approximately 99 percent of HMR services delivered since March 2013 have continued to be home-based.<sup>94</sup>

The HMR Rural Loading Allowance is a payment of up to \$125 paid to service providers for visits to patients in approved locations where the pharmacist has travelled 200km or more.<sup>95</sup> In the case of this scheme it has been suggested that the quantum of the allowance available has been insufficient to cover the total costs incurred, and that this may have driven cost-cutting behaviours, such as combining multiple reviews in one trip, with the effect of inconveniencing the consumer.<sup>96</sup>

Findings to the effect that there are chronic and ingrained issues with the timeliness of HMRs, largely as a result of delays in communication between GPs and the pharmacist,<sup>97</sup> have not, however, been borne out in recent data, which shows that the median length of time between an HMR referral and a patient receiving the service is 12 days (by comparison, this is well within the limit of 90 days stipulated for services delivered after March 2014).<sup>98</sup> According to the Consumer Health Forum, professional collaboration between GPs and pharmacists has tended to improve over time through education, although some limiting factors persist, such as a large number of locum GPs and too few community pharmacies in rural areas.<sup>99</sup>

Overall, however, there continues to be widespread recognition of the need for HMR services and of the potential benefits of the programme. The *Medication Management Report* notes that practice nurses have consistently acknowledged the value added by pharmacists as a health provider with specialist knowledge of medicines, and the programme has been shown to

<sup>90</sup> Easton, K., Morgan, T. and Williamson, M. (2009) Medication Safety in the Community: A Review of the Literature. National Prescribing Service: Sydney cited in CHF 2013 op. cit.

<sup>91</sup> Cohen, A.L., Budnitz, D.S., Weidenbach, K.N., Jernigan, D.B., Schroeder, T.J. and Shehab, N. (2008) 'National surveillance of emergency department visits for outpatient adverse drug events in children and adolescents'. *Journal of Pediatrics*. 152(3): 416-21, cited in CHF 2013 op. cit.

<sup>92</sup> Department of Health internal document supplied to KPMG

<sup>93</sup> CHF 2013 op. cit.

<sup>94</sup> Department of Health internal document supplied to KPMG

<sup>95</sup> According to the Department of Health internal document supplied to KPMG, payments totalling \$147,875 (GST excl.) were made under the rural loading allowance from October 2011 to February 2014. This equates to 1,183 trips over the period.

<sup>96</sup> PSA: Better outcomes through improved primary care: optimising pharmacy contribution

<sup>97</sup> Campbell Research and Consulting (2008) Home Medicines Review Program Qualitative Research Project: Final Report. Department of Health and Ageing: Canberra. Available at: [http://www.health.gov.au/internet/main/publishing.nsf/Content/B2992EBF12BE7E1ECA2573D8007F91F3/\\$File/HMRpercent20Finalpercent20Report.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/B2992EBF12BE7E1ECA2573D8007F91F3/$File/HMRpercent20Finalpercent20Report.pdf), cited in CHF 2013 op. cit.

<sup>98</sup> PwC Medication Management Report op. cit.

<sup>99</sup> CHF 2013 op. cit.

successfully identify medication-related problems and improve the knowledge and compliance of consumers with their medication regime.<sup>100</sup>

A cost-benefit analysis of the HMR service, conducted during the 4CPA<sup>101</sup>, confirms this finding but unpacks details that in net present value terms these benefits are largely concentrated within 25 percent of recipients. While savings from avoided GP visits, specialist visits, reduced medical investigations, reduced drug costs and a reduction in hospital admissions for all HMR recipients did not offset the costs of conducting the reviews<sup>102</sup>, a net saving of \$308.35 was derived for the upper quartile of recipients<sup>103</sup>; demonstrating that savings are of course greatest when the service is targeted at those most likely to experience an adverse medication event.

Various reports have demonstrated a need for the service, given findings that up to 30 percent of hospital admissions among patients aged 75 years and over are related to medicine use, and that medication misadventure is attributed to around one third of unplanned hospital admissions (with claims that between 30 to 77 percent of these admissions are preventable by HMR-type services).<sup>104</sup> A review of the HMR programme by the Consumers Health Forum - in response to a call for a moratorium on HMRs by the Pharmacy Guild of Australia - concluded that on the strength and consistency of the evidence, "*HMRs should be entrenched as routine services for eligible consumers.*"<sup>105</sup>

### 7.2.6 Residential Medication Management Review

An RMMR is a comprehensive medication review conducted by an accredited pharmacist for eligible residents of an Australian Government-funded aged care facility.<sup>106</sup> As with a HMR service, an RMMR is provided following a written referral from the patient's GP who must confirm there is a clinical need and that the patient will benefit from the service (although another member of the patient's health care team, or the patient themselves, may also identify the need for an RMMR and bring this to the GP's attention).<sup>107</sup>

In limited circumstances, an RMMR service may be provided without a GP referral, with prior approval from the Department. A Pharmacist Only Review can be sought when a member of the patient's healthcare team has determined that an RMMR would benefit the resident and where repeated and reasonable attempts have been made to obtain a referral from the patient's GP.<sup>108</sup>

The RMMR service consists of a patient interview, clinical assessment and the production of a written RMMR report outlining the findings of the review and recommendations for the patient's

<sup>100</sup> White, L. 2011. Op Cit.

<http://www.sciencedirect.com/science/article/pii/S155174111000166X>, cited in CHF 2013 op. cit.

<sup>101</sup> Stafford A et al. 2010. VALMER (the Economic Value of Home Medicines Reviews). <http://www.guild.org.au/services-programs/research-and-development/archive---fourth-agreement/iig-021>

<sup>102</sup> Ibid

<sup>103</sup> Ibid

<sup>104</sup> CHF 2013 op. cit.

<sup>105</sup> CHF 2013 op. cit.

<sup>106</sup> To be eligible, a patient must be a permanent resident of an Australian Government funded aged care facility, including residents in flexible care arrangements, multi-purpose services (providing integrated health and aged care services to small rural and remote communities) or transitional care facilities (where residency is greater than 14 days).

<sup>107</sup> Australian Government Department of Health and The Pharmacy Guild of Australia: Programme Specific Guidelines Residential Medication Management Review Programme (RMMR) and Quality Use of Medicines Programme (QUM), March 2014,

<sup>108</sup> Ibid

medication management. A copy of the report must be provided to the referring GP and the suggested management strategies discussed with the patient and their health care team as appropriate, and in a manner agreed to by the facility and the patient's GP.

As with the HMR service, the objectives of the RMMR programme are to improve the quality use of medicines and reduce the number of medication misadventure events, with an emphasis on collaboration between GPs, pharmacists and the patients' health care teams. The specific objectives of the RMMR programme are to:

- Achieve safe, effective, and appropriate use of medicines by detecting and addressing medicine-related problems that interfere with desired patient outcomes;
- Improve the patient's quality of life and health outcomes using a best practice approach that involved cooperation between the general practitioner, pharmacist, other relevant health professionals and the patient (and where appropriate, their carer);
- Improve the patient's and health professional's knowledge about medicines;
- Facilitate cooperative working relationships between members of the healthcare team in the interests of patient health and wellbeing; and
- Provide medication information to the patient and other healthcare providers involved in the patient's care.

Like the HMR service, delivery of a subsequent RMMR must not be triggered solely by an anniversary date. A subsequent review may only be conducted if more than 24 months has elapsed since the date of the most recent patient interview, or if the patient's GP deems a subsequent review clinically necessary; for example after discharge from hospital after an unplanned admission, or following a significant change in the patient's medication regimen.<sup>109</sup>

### 7.2.7 RMMR Service Outcomes

Awareness of the RMMR programme appears strong, with approximately 95 percent of eligible residential aged care facilities signing service agreements with approved RMMR service providers.<sup>110</sup> The uptake of the service has also increased over time, from over 58,000 RMMRs referred in 2010-11 to a peak of close to 73,000 in 2012-13 (Table 3).

Table 6. RMMR services claimed by GPs by financial year<sup>111</sup>

Service	2010/11	2011/12	2012/13	2013/14
<b>RMMR (Item 903)</b>	58,469	66,128	72,639	70,560

Of the 29,841 different GPs who provided a "Level B consultation" in 2013-14, 3,431 GPs referred a patient for an RMMR, equating to 11.5 per cent of GPs that are billing the MBS for referring this service. The *Medication Management Report* suggested that between July 2010 and

<sup>109</sup> Ibid

<sup>110</sup> Department of Health internal document supplied to KPMG

<sup>111</sup> Source: MBS Online. The MBS online statistics will not correlate with MMR claims under 5CPA as there was no time limit to lodge an MMR claim until March 2013 (HMR) and March 2014 (RMMR, MedsCheck/Diabetes MedsCheck)

February 2014, approximately 33,527 different GPs referred patients to receive an RMMR,<sup>112</sup> which does not appear consistent with the information available through MBS online that has suggested 3,431 GPs referred this service in the financial year 2013-14. The *Medication Management Report* suggested that 304,510 unique consumers accessed the service over the period July 2010 to February 2014,<sup>113</sup> which is broadly consistent with the overall MBS referral figures.

There is little or no baseline data available, however, to assess how the RMMR programme has contributed to the patient's quality of life or to cooperation between members of the patient's healthcare team in the interests of the patient's welfare.

In an attempt to sustain the benefits of greater collaboration between pharmacists and the patient's health care team, however, the RMMR programme has been enhanced by a specific Quality Use of Medicines (QUM) service. The QUM service institutes a facility-wide approach to the RMMR programme by ensuring that medication reviews are conducted by the pharmacist in association with a member of the patient's health care team at the facility. The objective is to ensure the patient's continuity of care and ongoing quality use of medicines by improving the residential aged care health professional's knowledge and understanding of the patient's medication regimen.

Specific activities under the initiative include Medication Advisory Activities (including advice around medication storage, compatibilities and effects); Education Activities (such as in-service sessions for nursing staff and carers or residents on medication therapy) and Continuous Improvement Activities (including assistance to the facility to meet and maintain medication management accreditation standards and compliance with regulatory requirements).

While no specific evaluation of this initiative has to date been undertaken to date, it is likely that given the volume of claims and activity supplied that the overall health literacy of RACF staff has improved to a greater or lesser degree. Data on the volume of QUM services since the 5CPA's commencement to February 2014 shows that:




- A total of 426 different pharmacists submitted 18,574 claims for 105,201 QUM activities, including:
  - 15,751 interactions where a pharmacist provided drug information to medical practitioners and RACF staff;
  - 12,718 interactions where advice was given to the health care team on storage, administration, dose forms, compatibilities, therapeutic adverse effects and compliance;
  - 12,047 in-service sessions delivered to nursing staff, carers and residents on the topic of medication and disease management;
  - 11,676 activities that involved participation in medication advisory committees for the delivery of Medication Advisory Activities;
  - 10,235 activities to assist the RACF to meet and maintain medication management accreditation standards and comply with regulatory requirements; and
  - 2,636 assessments of residents' competency to self-administer medication.

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<sup>112</sup> PwC Medication Management Report. op. cit.

<sup>113</sup> Department of Health internal document supplied to KPMG

## 7.3 Research and Development

**Combined Thematic Review summary findings**  Access  Consumer Experience  QUM

- R&D programmes have an Access, Consumer Experience and QUM focus
- Range of research activities funded, with some that will influence future pharmacy agreements

The Research and Development (R&D) programme aims to contribute to maintaining and improving the health outcomes of Australians through evidence-based best practice based on issues related to pharmacy and the provision of quality services to patients. A description of the projects is outlined in Table 7 below.

Table 7. Research and development topics and a brief description<sup>114</sup>

Topic	Brief description
Consumer Needs	To undertake research into consumer needs, experiences, expectations and benefits in relation to community pharmacy services, in order to inform further development of consumer focused policy and pharmacy services
Mental Health	To develop a comprehensive training package for pharmacists to assist mental health consumers in the area of medication compliance (Note: report available in 2015)
Rural Pharmacy Workforce	To undertake research to examine the rural and remote pharmacy workforce and its impact on access to pharmacy services at a local level (Note: project terminated in November 2012)
Health Literacy	To undertake research in health literacy and the role community pharmacy can play in improving consumer outcomes through tailored communication of health information
Professional Collaboration	To gather data from a variety of sources on the best practice model for the professional integration of community pharmacists in the primary health care setting
Chronic Illness	To investigate the consumer perspective on the burden of chronic disease, and the role that community pharmacy can play in assisting them better manage their condition/s
HMR Patient Eligibility	To collate and assess evidence of the benefits of HMRs to different cohorts of patients and to draft a set of recommendations detailing appropriately targeted criteria for HMR patient eligibility (Note: report available in 2015)

<sup>114</sup> Source: 5cpa website, [www.5cpa.com.au](http://www.5cpa.com.au)

Funding of up to \$10.6 million (GST exclusive) was allocated under the 5CPA for the R&D programme.

Ongoing advice and input into the R&D Programme is provided by advisory panels which have been established to oversee the research projects. Advisory panels are responsible for: selecting tenders; ongoing advice and guidance; and approving interim and final project reports.

In relation to the Review the projects cut across the three themes: the Consumer Needs project was both access and consumer experience focussed whilst the Mental Health, Health Literacy, Professional Integration, Chronic Illness<sup>115</sup> and HMR Patient Eligibility projects are more QUM focussed.

The Consumer Needs project developed and validated a tool (Measurement Tool) to measure consumer health impact and outcomes sensitive to the community pharmacy context. It is a validated survey tool that can be used in the future to determine the impact of community pharmacy services on consumers. This has the potential for measuring the impact of programmes on consumer experiences which can inform ongoing development of policy relating to community pharmacy and its place in the primary health care system.

Examples of how the tool could be used in the future include:

- Identifying differences between population groups in terms of how consumers experience community pharmacy and what the barriers/enablers are in terms of accessing services – this can be achieved given the tool has proven sensitive to differences across demographic characteristics.
- Determining the impact of a community pharmacy intervention on a group of consumers – this could be achieved through administering the tool directly before and after the intervention to monitor the impact that it had. This may be in terms of a consumer’s health literacy, beliefs about medicines (measured through the Brief Medication Questionnaire), or medication adherence (measured through the Medication Adherence Questionnaire).
- Measuring change at a community pharmacy agreement level – for example administering the tool before and after the fifth community pharmacy agreement to monitor change in relation to consumers’ level of satisfaction with community pharmacy
- Monitoring differences in consumers’ perceptions and expectations relating to community pharmacy and medicines depending on a number of factors – e.g. whether they frequent a community style pharmacy versus a discount style pharmacy/how frequently they access community pharmacy/their gender or age.
- Applying the tool to measure change and impact in other areas of primary health, for example general practice. The broad question domains that make up the tool have been designed in a way that they can be replicated across other areas.<sup>116</sup>

The Chronic Illness project identified opportunities for community pharmacies to assist consumers with chronic conditions and their carers. In particular it was identified that consumers and carers wanted streamlined access to medication, both in consolidation of existing services such as home deliveries and innovative services such as continued medication supply. Another

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<sup>115</sup> Also has some consumer experience focus.

<sup>116</sup> PwC Consumer Needs Final Report op. cit.

key service was the potential for a pharmacy to provide quality advice and health information, identify specific consumer needs and connect them to relevant support services.

The Professional Collaboration project identified the positive impacts of professional collaboration on health care. It also identified that community pharmacists are not always seen as primary health care professionals. A number of potential outcomes from improved interdisciplinary collaboration included:

- Increased contact with other professional groups which will assist in breaking down biases between groups and allow collaboration across the boundaries of established professional silos;
- Improved understanding of the collective strengths and possible contributions of each primary health care provider within a collaborative team; and
- Enhancing patient-centred care.

The first dot point above is consistent with “Working with others” PPI priority area. Furthermore the RMMR and HMR programmes enable collaboration between GPs and pharmacists.

The Health Literacy project found that low health literacy is a statistically independent risk factor for poor health. It also highlighted that only 41% of Australians have adequate to high levels of health literacy to successfully access, understand, evaluate and communicate health information as a way to promote, maintain and improve health. To improve this health literacy, an educational package for Australian community pharmacies was developed. This is consistent with the fact that community pharmacy is often the first point of contact for a health consumer.

The outcomes of the R&D projects are at the broadest level about patient centred care and an expanded role for community pharmacy within the context of primary health care. Stakeholders consulted as part of this review noted that the R&D projects tend to influence future pharmacy agreements rather than the agreement in which they originate.

## 7.4 Rural Pharmacy Support Programmes

Combined Thematic Review summary findings  Access  Consumer Experience  QUM

- Access and consumer experience focussed components
- High level of awareness of rural pharmacy support programmes, which are working together to ensure that there are a future cohort of pharmacists interested in working in rural pharmacy, that those pharmacists currently working in rural pharmacies are able to access professional education and that rural pharmacies remain open

The Rural Pharmacy Support Programmes aim to maintain and improve access to quality community pharmacy services for the community in rural and remote areas of Australia and to increase the proportion of the total pharmacy workforce starting practice in rural and remote Australia and staying in rural and remote practice for at least five years.<sup>117</sup> Rural and remote Australia is defined as having the values of 2 to 6 in the Pharmacy Accessibility/Remoteness Index of Australia (PhARIA). Figure 6 in the appendix contains a 2014-15 PhARIA map.

<sup>117</sup> Australian Government & The Pharmacy Guild of Australia. The Fifth Community Pharmacy Agreement Between The Commonwealth of Australia and The Pharmacy Guild of Australia. Available at: <http://5cpa.com.au/about-5cpa/>. Accessed 26 November 2014.

Table 8. Description of rural pharmacy support programmes<sup>118</sup>

<b>Rural Pharmacy Support Programme</b>	<b>Description of Programme</b>
Continuing Professional Education (CPE)	Provides financial support (maximum limit of \$2,000 per claim ) to assist pharmacists from rural and remote areas to access CPE and other Professional Development
Intern Incentive Allowance for Rural Pharmacies	Aims to increase and support the rural and remote pharmacy workforce by encouraging new pharmacy interns to practice in rural and remote areas
Intern Incentive Allowance for Rural Pharmacies – Extension Program	Provides financial support to community pharmacy in rural and remote areas to retain a newly registered pharmacist beyond the initial intern period for a continuous period of 12 months. Up to 10 allowances are available per year, with a maximum value of \$20,000 each.
Rural Intern Training Allowance	Provides financial support to assist intern pharmacists from rural and remote areas to access compulsory intern training programme activities.
Emergency Locum Services	Provides support to pharmacists in rural and remote areas through direct access to locums in emergency situations such as illness, bereavement, or family emergencies.
Rural Pharmacy Scholarship Scheme	Provides financial support to encourage and enable students from rural and remote communities to undertake undergraduate or graduate studies in pharmacy at university. At least 30 scholarships are offered annually, with a value of \$10,000 per annum per student.
Rural Pharmacy Scholarship Mentor Scheme	Complements the Rural Pharmacy Scholarships. This scheme provides pharmacy students with guidance and support from a practicing rural pharmacist.
Rural Pharmacy Student Placement Allowance	Provides financial support pharmacy students who are in placements in rural and remote communities. The allowance provided helps to cover some of the accommodation and travel costs which are associated with a rural or remote placement.
Administrative Support to Pharmacy Schools	Complements the Rural Pharmacy Student Placement Allowance and provides for administrative support for universities to manage the Rural Pharmacy Student Placements.
Rural Pharmacy Liaison Officer (RPLO) Programme	This programme helps to implement local level projects that provide support to practising rural community pharmacies and pharmacy students undertaking placements in rural areas. RLPOs promote inter-professional collaboration with pharmacies, pharmacists, pharmacy students and universities and facilitate professional development and networking opportunities.
Rural Pharmacy Maintenance Allowance (RPMA)	A monthly allowance paid to eligible proprietors of section 90 approved pharmacies to help with the financial burden of maintaining a pharmacy in rural and remote areas of Australia.

<sup>118</sup> Source: 5cpa website, [www.5cpa.com.au](http://www.5cpa.com.au)

Across the RPWP the qualifying criteria was generally that the individual pharmacist/pharmacy student or pharmacy was from a rural or remote area or intended to undertake their placement in a rural or remote community pharmacy. Activity across each of the workforce programme elements through the 5CPA period is outlined below. The volume of applications received and accepted suggests high levels of awareness among pharmacists practicing in rural areas and pharmacy students. This high level of awareness is also attributable to the fact that the RPWP was introduced under the Third Community Pharmacy Agreement (3CPA).

*Table 9. Rural pharmacy support programme statistics<sup>119</sup>*

<b>Rural Pharmacy Support Programme</b>	<b>Programme statistics</b>
CPE	From 1 July to 31 March 2014, 263 applications were processed and paid and a further 22 were declined because of failure to meet the eligibility criteria
Intern Incentive Allowance for Rural Pharmacies	As of 31 March 2014, there have been 214 applications approved under the 5CPA
Rural Intern Training Allowance	From 1 July to 31 March 2014, 123 applications were processed and paid and a further nine were declined due to applicants living and working in PhARIA 1
Emergency Locum Services	From 1 July to 31 March 2014, a total of 33 requests for emergency locums were lodged and all were filled in less than one day. 14 of the requests were from PhARIA 5 or 6 localities; seven were from PhARIA 4 with the remaining twelve from PhARIA 2 or 3 localities
Rural Pharmacy Scholarship Scheme	There were 71 students continuing their studies in 2013
Rural Pharmacy Student Placement Allowance	Currently, 17 of the 18 pharmacy schools offering undergraduate and eligible graduate entry pharmacy degree programmes receive funding through the scheme. The Guild holds a subcontract with each participating university to administer the scheme
RPLO Programme	An internal review of the RPLO programme was conducted by the Department in consultation with the Guild. Outcomes of the internal review were: <ul style="list-style-type: none"> <li>• the extension of contracts between the Guild and the University Departments of Rural Health from 30 June 2013 to 30 June 2015 (end of the 5CPA); and</li> <li>• improvements to the reporting framework</li> </ul>
RPMA	For the March 2014 period, 755 RPMA applications were processed with an average payment of \$12,269.86 per year.

In 2012-13 a maximum script volume criteria was also introduced for the RPMA. The calculation of RPMA payments to an eligible pharmacy is dependent upon its remoteness (i.e. PhARIA category) and script volumes (see Table 25 in the Appendix).

<sup>119</sup> Source: Department of Health internal document supplied to KPMG

As noted in the *Consumer Needs Report*,<sup>120</sup> people living in rural and remote areas and Aboriginal and Torres Strait Islander people were more likely to rely on their community pharmacy for health care advice and information in absence of easy and/or affordable access to a GP or other health care providers. This underscores the importance of the RPWP and RPMA working together to ensure that there are future cohorts of pharmacists interested in working in rural pharmacy, that those pharmacists currently working in rural pharmacies are able to access professional education and that rural pharmacies remain open. Combined, these programmes enabled access to consumers living in rural and remote areas. The revision of the PhARIA categories throughout the life of the 5CPA has enabled funding to be more appropriately targeted in enabling this access.

## 7.5 Aboriginal and Torres Strait Islander Initiatives

### Combined Thematic Review summary findings Access Consumer Experience QUM

- Access, consumer experience and QUM focussed components
- While not attributable to the Aboriginal and Torres Strait Islander Pharmacy Workforce Programmes directly, there was substantial growth in numbers of Aboriginal and Torres Strait Islander pharmacy workforce between 2006 and 2011.
- There is a lack of information on effectiveness or outcomes from the QUMAX programme. This lack of data about medication compliance or health outcomes more generally for clients meant that the benefits and efficiency of this programme could not be quantified.
- There is scope for better integration of the three initiatives that affect access to and quality use of medicines by Aboriginal and Torres Strait Islander people—S100 RAAHS, CtG scripts and QUMAX. This scope increased with the replacement of the previous QUMAX waiver of PBS co-payments with CtG scripts, thereby disconnecting management and operational policy for these two initiatives.

The 5CPA funds two streams of programmes that are intended to improve the quality of pharmacy services for Aboriginal and Torres Strait Islander patients:

Programmes focused on the Aboriginal and Torres Strait Islander pharmacy workforce; and

Programmes that focus on quality use of medicines.

The Aboriginal and Torres Strait Islander Pharmacy Workforce Programmes comprise:

The Aboriginal and Torres Strait Islander Pharmacy Assistant Traineeship Scheme; and

The Aboriginal and Torres Strait Islander Pharmacy Scholarship Scheme.

The former encourages Aboriginal and Torres Strait Islander people to enter pharmacy assistant roles by subsidising community pharmacies to employ and train Indigenous Pharmacy Assistant Trainees. The latter provides annual scholarships to encourage and support Aboriginal and Torres Strait Islander students to undertake undergraduate or graduate studies in pharmacy at university.

Overall, the workforce programmes are relevant to both access to pharmacy services by Aboriginal and Torres Strait Islander people and to the associated consumer experience. They

<sup>120</sup> PwC Consumer Needs Final Report op. cit.

address the latter by considering cultural issues that affect Aboriginal and Torres Strait Islander people's experiences in the community pharmacy setting. In particular, these programmes aim to provide members of the Aboriginal and Torres Strait Islander community with suitable qualifications to work in community pharmacies.

There are many factors which can impair access to, and appropriate use of, medicines by Aboriginal and Torres Strait Islander people. They include financial, geographic and cultural barriers. The Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples (QUMAX) and the S100 Pharmacy Support Allowance programmes are intended to improve both access to and quality use of medicines by Aboriginal and Torres Strait Islander people.

QUMAX funds a range of support services, which are provided by participating Aboriginal Community Controlled Health Services (ACCHSs) and community pharmacies in rural and urban Australia. The Programme provides seven categories of support that help patients to better understand and more effectively use their medications.

The S100 Pharmacy Support Allowance is paid to approved community pharmacies for the provision of a range of QUM and other medication management services to approved remote area Aboriginal Health Services (AHS) participating in the S100 supply arrangements.<sup>121</sup> The programme provides approved applicants an annual allowance for the delivery of QUM support services to the AHS by a participating pharmacy.

These programmes are discussed in more detail in the following sections.

### 7.5.1 Aboriginal and Torres Strait Islander Pharmacy Workforce Programme

The 5CPA *Consumer Needs Report*<sup>122</sup> identified a number of issues affecting Aboriginal and Torres Strait Islander people's access to community pharmacy services, their experiences and their safe and effective use of medicines. Among those issues were:

Cultural competency—a need for cultural competency or employment of Aboriginal and Torres Strait Islander staff within community pharmacies, to actively and appropriately address the health needs and education of this population cohort;

Demographics of the pharmacist and other staff—Aboriginal and Torres Strait Islander people will have a more positive experience if they are served by an Aboriginal or Torres Strait Islander pharmacist, Health Worker or pharmacy assistant.

Some of these issues were echoed in the views of people with a chronic disease, as reported by Griffith University.<sup>123</sup> In this report, one of the top priorities for Aboriginal and Torres Strait Islander people with a chronic condition was patient centred care, with a focus on culturally appropriate care (such as “awareness of CtG” and “absence of discrimination/racism”).

<sup>121</sup> The S100 RAAHS Programme is a special supply arrangement administered under Section 100 of the National Health Act 1953. It began in 1999 and addresses geographical, cultural and financial barriers that Aboriginal and Torres Strait Islander peoples living in remote areas face in accessing PBS medicines. Under these arrangements, clients of approved remote area AHS can receive PBS medicines directly from the AHS at the point of consultation, without the need for a normal prescription form, and without charge. These arrangements are supported by community pharmacies, with a participating community pharmacy commonly being the supplier of approved medications to the AHS.

<sup>122</sup> PwC Consumer Needs Final Report op. cit.

<sup>123</sup> Griffith University (2014). op. cit.

Aboriginal and Torres Strait Islander stakeholders also were concerned with cultural appropriateness of community pharmacy services generally, ranging from improved awareness of individual needs through to culturally specific services such as liaising with Aboriginal Health Workers. Aboriginal and Torres Strait Islander participants advocated for more pharmacists and other staff of a similar cultural background. This was seen as particularly important in relation to the provision of information and education regarding services and medicines.

The Griffith University report proposed these issues be addressed through active recruitment of a workforce that addresses patient centred priorities. In particular, it proposed to “Promote or review existing programmes that promote a culturally diverse workforce”, with a view to increasing the Aboriginal and Torres Strait Islander pharmacy workforce.

The Aboriginal and Torres Strait Islander Pharmacy Workforce Programme is intended to support Aboriginal and Torres Strait Islander participation in the pharmacy workforce. As suggested above, it does this with the aim of providing improved, culturally appropriate pharmacy services to better meet the needs of Indigenous communities and patients. The origins of this programme were in the Aboriginal and Torres Strait Islander scholarship programme of the 3CPA and it is a continuing programme under 5CPA.

A budget of \$3.5 million is available for this programme over the life of the 5CPA.<sup>124</sup> To March 2014, actual expenditure was \$2.55 million and the programme was on track to meet or slightly underspend its full budget by June 2015.

#### **7.5.1.1 *Aboriginal and Torres Strait Islander Pharmacy Assistant Traineeship Scheme***

The Aboriginal and Torres Strait Islander Pharmacy Assistant Traineeship Scheme aims to support the community pharmacy workforce by encouraging Aboriginal and Torres Strait Islander people to enter pharmacy assistant roles. The scheme aims to increase the number of Aboriginal and Torres Strait Islander pharmacy assistants in community pharmacies and establish alternative pathways for Indigenous students to enter into pharmacy. Incentive allowances of \$10,000 are available to community pharmacies to employ and train an Indigenous Pharmacy Assistant Trainee.

The objectives of the Traineeship Scheme are:

- To improve quality use of PBS medicines by Indigenous Australians through the community pharmacy network in rural and urban Australia;
- To encourage and support Aboriginal and Torres Strait Islander people to become trained as pharmacy assistants and pharmacy technicians; and
- To increase the Indigenous health workforce in community pharmacies thereby assisting in meeting the needs of their communities.

The Traineeship Scheme was originally implemented as an initiative of the Indigenous Access Programme under the 4CPA. As such, it was part of an integrated approach to improve access to community pharmacy services by Aboriginal and Torres Strait Islander people, taking account of cultural issues in meeting their health needs.

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<sup>124</sup> Data provided by Department of Health.

The programme is based on 16 traineeship offers per year and by March 2014, 92 offers had been made and accepted, with 85 placements having commenced. These numbers are consistent with the target of 16 per year.

Retention data is not available to determine the extent to which Aboriginal and Torres Strait Islander trainees have remained within the community pharmacy sector following their traineeships. It is known that the number of Aboriginal and Torres Strait Islander people who were working in the pharmaceutical retail sector increased substantially between the 2006 Census and 2011 Census—from 294 to 493.<sup>125</sup> While the increase may or may not be due in part to the Traineeship Scheme, it could have raised the awareness of community pharmacy as a career option for young Aboriginal and Torres Strait Islander people. This hypothesis is supported by participants' feedback, which showed that 57 per cent of trainees would not have undertaken training in the pharmacy area if the Scheme had not been available.

### 7.5.1.2 *Aboriginal and Torres Strait Islander Pharmacy Scholarship Scheme*

The Aboriginal and Torres Strait Islander Pharmacy Scholarship Scheme aims to encourage Aboriginal and Torres Strait Islander students to undertake undergraduate or graduate studies in pharmacy at university. The objectives of the Scholarship Scheme are:

- To encourage and enable Aboriginal and Torres Strait Islander students to undertake undergraduate and graduate studies at an Australian university leading to a registrable qualification as a pharmacist; and
- To increase the number of Aboriginal and Torres Strait Islander pharmacists, particularly in rural and remote practice, through offering appropriate incentives and enhancing the attractions of pharmacy practice.

As a result of the Scholarship Scheme, in the long term it is expected that there will be an increase in the number of practising Aboriginal and Torres Strait Islander pharmacists and an increase in the number of Aboriginal and Torres Strait Islander communities with access to culturally appropriate pharmacy services.

The Scholarship Scheme was originally implemented as part of the Rural Workforce Programme within the 3CPA. It continued under the 4CPA but was integrated with the broader Indigenous Access programme under that agreement.

The programme is based on there being three scholarships offered per year. However, the actual number granted in any one year has varied above and below this figure, depending on the number and quality of applications received. Overall 34 applicants have received scholarships, of which:

- 16 completed pharmacy and 11 are currently registered pharmacists. Five are unknown;
- 10 applicants withdrew; and
- 8 are current scholarship holders.<sup>126</sup>

It is known that the number of Aboriginal and Torres Strait Islander people who stated their occupation as “pharmacist” almost tripled between the 2006 Census and 2011 Census—from 11

<sup>125</sup> Australian Bureau of Statistics 10 December 2014 (website). Census, Table Builder Basic. <https://www.censusdata.abs.gov.au/webapi/jsf/tableView/customiseTable.xhtml>. Accessed 10 December 2014.

<sup>126</sup> Information supplied by the Pharmacy Guild of Australia. Includes scholarship information prior to 5CPA.

to 30.<sup>127</sup> Within this, the number of Aboriginal and Torres Strait Islander pharmacists in remote or very remote Australia grew from zero to four. Given the timing and size of the increase, it cannot be directly attributed to the scheme. Although, as mentioned above, there are 11 currently registered pharmacists that received a scholarship. Nonetheless, it is possible that the scheme had raised awareness of pharmacy as a professional choice for young Aboriginal and Torres Strait Islander people.

There have been proposals to expand the Scholarship Scheme.<sup>128</sup> Any consideration of expansion should include investigation of the workforce participation outcomes of the eight scholarship recipients to have completed their courses. As stated above, there are currently no data on whether those recipients have obtained employment as pharmacists, in the community pharmacy sector or elsewhere.

### 7.5.2 QUMAX – Quality Use of Medicines Maximised for Aboriginal & Torres Strait Islander People

The QUMAX programme aims to reduce and remove barriers to QUM by Aboriginal and Torres Strait Islander people. It does so through funding a range of support services, which are provided by participating ACCHSs and pharmacies in rural and urban Australia. The Programme provides seven categories of support:

Dose Administration Aids (DAAs) support—to reduce financial barriers to access a comprehensive DAA service and to improve medication adherence and medication management for ACCHS clients;

QUM pharmacy support—to facilitate additional community pharmacy involvement and support in areas such as QUM planning, policies, protocol development, medicine quality assurance and appropriate Safety Net utilisation;

HMR models of support—to reduce the cultural and logistical barriers to access HMRs by ACCHS clients;

QUM devices—to reduce the financial barriers of access to QUM devices (such as asthma spacers and glucose monitors) to improve overall delivery of medicines and management of chronic conditions;

QUM education—to reduce financial barriers of access to QUM education and health promotion for ACCHS employees and their clients (consumers);

Cultural Awareness—to improve access and delivery of cultural awareness resources and training for community pharmacy to promote a culturally aware pharmacy environment; and

Transport—to reduce barriers to accessing medicines and community pharmacy services by providing transport support.

Underuse and quality use of medicines specifically by Aboriginal and Torres Strait Islander people were issues identified in the National Medicines Policy. The approach of the Programme is therefore consistent with the aims and objectives of the National Strategy for Quality Use of Medicines.

<sup>127</sup> Ibid.

<sup>128</sup> Pharmaceutical Society of Australia (October 2014), Better health outcomes through improved primary care: Optimising pharmacy's contribution. PSA: Canberra.

QUMAX was implemented in 2008 as part of the 4CPA and is relevant to the QUM theme for this Review. The Programme has continued through the 5CPA but with one major change. Under the 4CPA, QUMAX provided a conditional waiver of the PBS co-payments for eligible clients of AHSs. The waiver of PBS co-payments through QUMAX was discontinued under the 5CPA in recognition of the Subsidising PBS Co-Payments Measure implemented as part of the Australian Government's Indigenous Chronic Disease Package<sup>129</sup> (ICDP). Under that measure, implemented from July 2010, eligible Aboriginal and Torres Strait Islander people are entitled to subsidised access to PBS medicines through a mechanism called Closing the Gap (CtG) scripts. Eligible people comprise Aboriginal and Torres Strait Islander people with or at risk of a chronic disease who have been registered for CtG scripts by a prescriber at a suitable accredited general practice or AHS.

While CtG scripts are not a part of the 5CPA, to the extent they have increased PBS dispensing to eligible consumers,<sup>130</sup> increased opportunities for those consumers to interact with community pharmacies have been enabled. That means there have been increased opportunities for QUM services to be provided to this subgroup of Aboriginal and Torres Strait Islander people with or at risk of chronic disease. This is a subgroup for whom the benefit from such QUM services is expected to be high.

The total funding allocation for QUMAX in the 5CPA originally was \$11 million and this was supplemented with \$1.857 million of additional funds from other 5CPA programmes and the ICDP.<sup>131</sup> Actual expenditure for 2011-12 and 2012-13 was in line with budget allocations (see Table 10). Due to staff recruitment issues, expenditure to March 2014 was somewhat less than expected though the programme is still expected to reach budget by the end of the 5CPA. This reflects the fact that the programme itself is designed to ensure full expenditure of allocated funds each year.

No funds were allocated to QUMAX for 2010-11 (the first year of the 5CPA) but a transitional budget amount of approximately \$4 million was set aside to ensure that QUMAX consumers were not disadvantaged in the transition to CtG scripts and to enable continued support to established QUM improvements in participating ACCHSs.

A feature of the QUMAX Programme is the need for each participating ACCHS to develop a formal work plan of QUM services to be provided to consumers and specifies the associated agreed budget. The work plan then needs to be approved by the Guild, NACCHO and the Department and becomes part of the funding agreement between the Guild and the ACCHS. Some of the QUM services themselves are provided by local community pharmacists who enter into service agreements with the ACCHS.

The need to work within a fixed budget means that not all patients of a specific AHS may be able to be supported fully through QUMAX. This means that the ACCHS needs to establish and apply local protocols and procedures for determining who receives QUMAX services, what services they receive and what level of service they receive. Such protocols are usually based on

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<sup>129</sup> Australian Government (November 2009). National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan—Jurisdiction: Commonwealth.

<sup>130</sup> "The evaluation found some emerging evidence that in 2010-11 the PBS Co-payment measure was reducing financial barriers for Aboriginal and Torres Strait Islander people, and there were initial indications that the measure is having a positive impact on patient access to medicines". KPMG (2013). National Monitoring and Evaluation of the Indigenous Chronic Disease Package First Monitoring Report 2010-11. Commonwealth of Australia: Canberra.

<sup>131</sup> Data provided by Department of Health.

assessments of risk of medication misadventure and likely benefit from the QUMAX services. The Programme's design intentionally allows for this local flexibility.

Table 11 summarises key statistics for the QUMAX Programme during the period of the 5CPA. Note that the table also includes statistics from the transitional year of 2010-11, during which the previous QUMAX waivers of PBS co-payments were replaced by CtG scripts. This explains the large fall in number of participating pharmacies from 2010-11 to 2011-12.

In March 2011 the Australian Senate referred the effectiveness of the S100 RAAHS to the Senate Community Affairs References Committee for inquiry and report. Among its terms of reference, the inquiry examined access and QUM aspects and outcomes of S100 RAAHS. In doing so, the Committee also examined and commented on other programmes aimed at improving access to PBS medicines and quality use of those medicines for Aboriginal and Torres Strait Islander people more generally.

In its report, the Senate Inquiry was critical of the lack of integration among the three initiatives affecting access to and quality use of medicines by Aboriginal and Torres Strait Islander people—S100 RAAHS itself, CtG scripts and QUMAX.<sup>132</sup>

One potential issue related to this is that in replacing the previous QUMAX waiver of PBS co-payments with CtG, the link between quality use of medicines activities and improved access to medicines for Aboriginal and Torres Strait Islander consumers, however tenuous, was effectively broken. This disconnect was identified by the Senate inquiry and alluded to in the early findings of the evaluation of the Indigenous Chronic Disease Package.<sup>133</sup> Together with the above observation regarding CtG potentially increasing opportunities for community pharmacy to provide QUM services to Aboriginal and Torres Strait Islander people with or at risk of a chronic disease, this suggests there is scope to improve access to QUM for this subgroup.

Table 11 shows the number of pharmacies with DAA service agreements in place as 170 in 2012-13, the most recent full year of data available. This represents around 3.2 per cent of all community pharmacies.<sup>134</sup> The 2014 survey of pharmacists showed the overall participation rate in QUMAX generally as around 15 per cent of all pharmacists.<sup>135</sup> The data in Table 11 suggest ACCHSs engage with an average of two to three pharmacies each.

Several stakeholders consulted for this review raised the lack of information on effectiveness or outcomes from the QUMAX program. They cited that anecdotal evidence suggested it worked well but that the lack of information about medication compliance or health outcomes more generally for clients meant these views could not be quantified.

The data available from operational reporting for QUMAX is limited to numbers of patients receiving DAAs and the number of DAAs issued, on a weekly basis. Additional data on total

<sup>132</sup> The Senate Community Affairs References Committee (October 2011). *op. cit.*

<sup>133</sup> "Some pharmacists consulted highlighted the limitations of the PBS Co-payment measure in supporting medications compliance; which they suggested could be improved through patient education, greater access to Domiciliary Medications Management Reviews or inclusion of Dose Administration Aid services". KPMG (2013), *op.cit.*

<sup>134</sup> At 30 June 2013, there were 5,351 community pharmacies approved as PBS suppliers. Australian Department of Human Services (2014). Commonwealth of Australia: Canberra.

<sup>135</sup> 53 per cent of survey respondents said that QUMAX was not relevant to their pharmacy practice and another 31 per cent had not heard of QUMAX. The remaining 16 per cent responded that they were either participating in or planning to deliver services under QUMAX. Survey data provided by the Pharmaceutical Society of Australia and analysed by KPMG for this review.

numbers of QUMAX eligible patients registered with each participating ACCHS is available from annual work plans.

A potential area for development is the scope for collection of specific health outcome data for QUMAX registered clients, using existing patient management systems within ACCHSs. Addition of a 'QUMAX registration flag' to client details may enable extraction of data on conditions for which these clients are being treated. For those with chronic conditions it may also allow measurement of health care or outcome indicators. For example, frequency of HbA1c tests and whether those tests lie within or outside of clinically important ranges. Such information would be of significant help in understanding the targeting of QUMAX programs and their impacts. NACCHO intends undertaking a specific evaluation of QUMAX in 2015. This may offer an opportunity to investigate capacity for collection of such data as part of that evaluation.

Limited stakeholder input suggested some ACCHSs have tested the boundaries for QUMAX funding. An example is application for funding under QUM devices for weighing machines (scales). That application was rejected on the grounds that the QUM devices category was intended for devices to enhance the delivery of medicines. The guidelines for QUMAX state the aim of the QUM devices category as to "reduce the financial barriers of access to QUM devices to improve overall delivery of medicines and management of chronic diseases i.e. asthma and diabetes".<sup>136</sup> This Review notes that, while not the intent, this wording can be interpreted as allowing support for devices related to chronic disease management independently of medicine delivery.

Nonetheless, some unusual requests for devices have been approved within the work plan approval process. When this has occurred, it has been based on devices having a direct health benefit for an individual consumer, rather than for devices that might be used to benefit multiple consumers.

This serves to raise the question of whether the guidelines need to be modified to make explicit the limitation to devices enhancing medicine delivery or individual health outcomes, or alternatively whether there is an opportunity to provide support for other devices. The latter would require consideration of health needs and benefits for such devices (and for what patients), the means for determining need and the role of community pharmacy in (supporting) their provision. Answering these questions was beyond the scope of this review.

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<sup>136</sup> Department of Health and The Pharmacy Guild of Australia (May 2014). Programme Specific Guidelines: Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People (QUMAX).

Table 10. Funding allocation and actual expenditure for QUMAX, 2011-12 to 2014-15<sup>137</sup>

	2011-12	2012-13	2013-14	2014-15	Total
<b>Allocation*</b>	\$3.943m	\$2.683m	\$3.111m	\$3.120m	\$12.857m
<b>Expenditure</b>	\$3.943m	\$2.683m	\$0.746m**	-	\$7.372m

\* Original QUMAX funding allocation plus additional funds from other 5CPA programmes and ICDF

\*\* Actual expenditure to 31 March 2014

Table 11. Participating Aboriginal Community Controlled Health Services, community pharmacies and numbers of Dose Administration Aids and recipients, 2010-11 to 2014-15<sup>138</sup>

	2010-11*	2011-12	2012-13	2013-14**	2014-15***
<b>ACCHSs</b>	69	71	74	67	48
<b>Pharmacies with DAA service agreements</b>	333	221	170	164	141
<b>Consumers receiving DAAs</b>	Not available	4,141	7,127	3,416	1,886
<b>DAAs issued</b>	156,887	Not available	65,169	27,156	18,417

\* Transitional year between previous (4CPA) QUMAX arrangements and CtG subsidy.

\*\* Data available only for 8 months of this financial year.

\*\*\* Data available only for 3 months of this financial year.

### 7.5.3 S100 Pharmacy Support Allowance Programme

The S100 Pharmacy Support Allowance (Allowance) is paid to Section 90 approved pharmacies and Section 94 approved hospital authorities for the provision of a range of QUM and other medication management services to approved remote area AHS participating in the S100 supply arrangements. The programme provides approved applicants an annual allowance for the delivery of QUM support services and those services are delivered according to a formal work plan, agreed between the participating pharmacy and the AHS. The Allowance is clearly relevant to the QUM theme of this review and is consistent with the National Strategy for QUM.

The objectives of the S100 Support Allowance are:

to improve QUM for clients of remote area AHS;

to provide advice and support on a suite of pharmacy services relating to QUM management and staff training;

<sup>137</sup>Source: Department of Health internal document supplied to KPMG

<sup>138</sup>Source: Department of Health internal document supplied to KPMG

To improve access to the services and expertise that pharmacists can provide to AHS and its clients, by increasing awareness and understanding of medicines; and

To address cultural and other issues that may affect the effectiveness and acceptability of pharmacy services and to develop cooperative arrangements with the Indigenous communities being serviced, to optimise the health benefits to community members.

The Programme began in 2002, under the 3CPA and complements the S100 RAAHS introduced in 1999. The S100 Pharmacy Support Allowance has been continued through the subsequent 4CPA and now in the 5CPA.

There are 173 AHSs approved under the S100 RAAHS, of which 159 were supplied with PBS items in 2013-14 (see Figure 5).<sup>139</sup> Of these services, approximately 138 were receiving services under the S100 Pharmacy Support Allowance Programme at the time of this review. These support services were being provided through 24 community pharmacies and 2 approved hospital authorities. Annual payments for each supplier in 2013-14 ranged from around \$6,000 to \$350,000.

The programme has a budgeted expenditure of \$14.4 million over the 5CPA and as at March 2014, that budget was significantly underspent (see Table 12). Indications are that the programme will be underspent by as much as \$4 million by the end of the 5CPA in June 2015.

Allowance payments include the following variable components:

An amount based on the volume of PBS medicines supplied to an approved remote area AHS in the preceding calendar year;

A loading for outstation clinics attached to the AHS;

A loading based on round trip travel to AHS locations and the method of travel; and

A loading based on round trip travel to outstation locations and the method of travel.

Pharmacists providing the support services are required to visit the AHS a minimum of twice per 12 month period.<sup>140</sup> The community pharmacy (or hospital authority) that supplies an AHS through S100 RAAHS has first 'right of refusal' for provision of support services under the S100 Pharmacy Support Allowance Programme.<sup>141</sup>

The guidelines for the Programme require a supporting pharmacy (or hospital authority) to provide a range of support services that aim to deliver the QUM objectives of the programme. However, there is no requirement for the pharmacy to provide face to face engagement with consumers receiving medicines through the S100 RAAHS arrangements for the AHS. This has been cited as a weakness of the Programme, with the S100 RAAHS Senate Inquiry report advising "more direct access to a pharmacist is required by both AHSs and their patients in order to support

<sup>139</sup> Of the 173 AHS approved to participate, some are no longer participating due to one of the following reasons:

- the AHS closed because of cyclone damage;
- the AHS became an outstation; or
- the AHS was part of a pilot program that did not progress beyond the pilot.

<sup>140</sup> Department of Health, Pharmacy Guild of Australia (February 2014). Programme Specific Guidelines: Section 100 Allowance for Support Services to Remote Area Aboriginal Health Services, Effective from 1 March 2014.

<sup>141</sup> Ibid.

better use of PBS medicines".<sup>142</sup> The current minimum of two visits per year does not provide sufficient time for pharmacists to engage directly with consumers, in light of the other support services required to be delivered. This observation is given further weight when it is noted that some pharmacies are providing support to as many as 20 AHSs through the Programme.<sup>143</sup>

Current guidelines do not prevent a supporting pharmacy from directly engaging consumers in QUM activities, such as providing specific advice on appropriate medication use. The Senate Inquiry into the S100 RAAHS found that some supporting pharmacies do undertake such consumer engagement but that these were few in number.<sup>144</sup> Stakeholder input to this review suggests such consumer engagement may be more common now than at the time of the Senate Inquiry but the extent could not be quantified. In light of this, it may be worth considering whether the value of QUM activities delivered under the S100 Pharmacy Support Allowance Programme might be enhanced by explicit inclusion of a consumer engagement service component.

Stakeholders interviewed for this review raised some concerns over the quality of support services provided to AHS through the Programme. Pharmacists develop an annual work plan with the AHS and are required to report on outcomes against that work plan twice per year. Nonetheless, there have been issues with late reporting and instances where AHSs have exercised insufficient influence over the work plan to ensure the support services best suit their circumstances and needs. In some cases, this has caused concerns that some AHSs are not receiving enough visits to meet their support needs.

Accordingly, consideration should be given to strengthening the reporting requirements under the Programme. Such consideration should particularly focus on the timeliness of reporting and on the numbers of visits undertaken per annum. Consideration also should be given to enhancing the participation of AHS in the development of work plans that best meet their local requirements. This could be partially achieved by providing information resources to aid AHS in their approach to developing such work plans. For example, provision of sample work plan(s) or guidance on issues to consider when developing an S100 Pharmacy Support work plan.

The eligibility criteria in the current Programme guidelines effectively give a supplying pharmacy the first right of refusal for provision of the S100 support services to an AHS.<sup>145</sup> However, the guidelines also give the AHS the right to transfer those support services to another (eligible) pharmacy. In practice, this has meant that the AHS, while required to first approach or engage its supplying pharmacy, can change provider should it wish to do so.

Maintaining this flexibility of choice is important to ensure the quality of the support services received by AHSs and to deliver the intended QUM outcomes. An option may be to consider increasing the choice by removing the requirement for the AHS to first approach the current S100 supplier. However, to date there has been only one instance where an AHS has chosen to change its S100 RAAHS support service provider.<sup>146</sup> In the absence of other evidence to the contrary, this supports the view that the current guidelines are sufficient in this respect.

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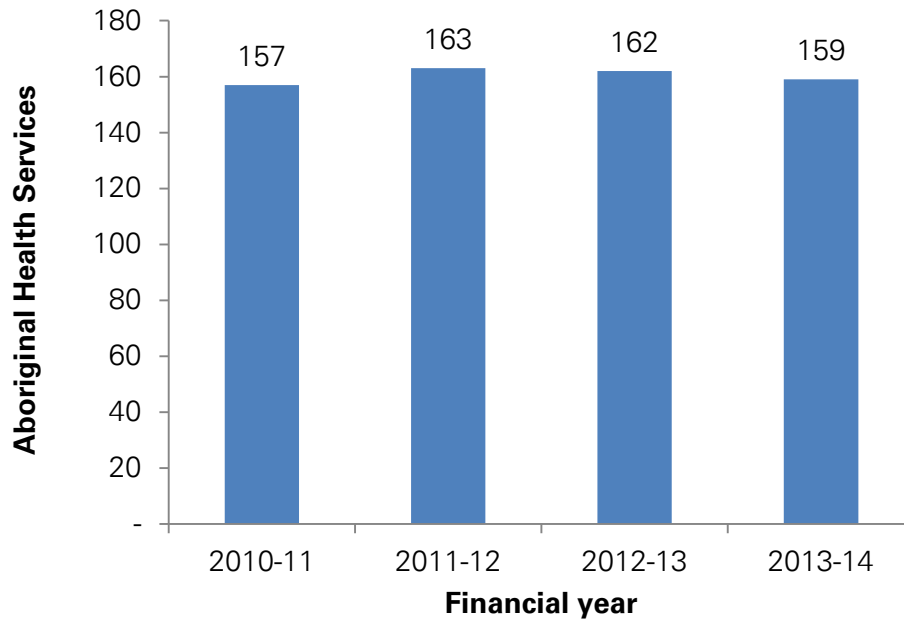
<sup>142</sup> The Senate Community Affairs References Committee (October 2011). The effectiveness of special arrangements for the supply of Pharmaceutical Benefits Scheme (PBS) medicines to remote area Aboriginal Health Services. Parliament of Australia: Canberra.

<sup>143</sup> Ibid.

<sup>144</sup> Ibid.

<sup>145</sup> Department of Health, Pharmacy Guild of Australia (February 2014). op. cit.

<sup>146</sup> Unpublished data provided by Department of Health.



■ AHSs supplied under S100 RAAHS

Figure 5. Number of AHSs supplied through the S100 Remote Area Aboriginal Health Services Programme, Australia, 2010-11 to 2013-14<sup>147</sup>

Table 12. S100 Pharmacy Support Allowance Programme funding, 2010-11 to 2014-15<sup>148</sup>

	2010-11	2011-12	2012-13	2013-14	2014-15	Total
<b>Allocation</b>	\$2.540m	\$2.670m	\$2.800m	\$3.000m	\$3.390m	\$14.400m
<b>Expenditure</b>	\$2.006m	\$1.830m	\$1.526m	\$0.897m*	-	\$6.259m

\* Expenditure to 31 March 2014.

<sup>147</sup> Source: S100 RAAHS data supplied by the Department of Health.

<sup>148</sup> Source: Department of Health internal document supplied to KPMG

## 7.6 Other programs to support patient services

### Combined Thematic Review summary findings Access Consumer Experience QUM

- Access and QUM focussed components
- The ERRCD has potential to support QUM but its delayed release and national implementation has limited its potential impact
- The NRMC pilot in a small number of RACFs showed promising QUM results but it is not possible to compare
- CD has enabled access to medicines for a small number of consumers. Despite objections from some bodies, namely the AMA, there may be opportunity for expansion of CD to other medicines.

### 7.6.1 Electronic Recording and Reporting of Controlled Drugs initiative

The Electronic Recording and Reporting of Controlled Drugs (ERRCD) initiative under the 5CPA aims to develop a nationally consistent system to collect and report data relating to dispensing Controlled Drugs. This system will complement and support the current controls mandated by the states and territories in their role as regulators. The initiative aims to improve appropriate access to the prescribing and dispensing of Controlled Drugs (Schedule 8 drugs) i.e. it is a QUM focussed initiative. Ultimately though it may enable easier access to these controlled drugs for patients that legitimately require them.

Significant stakeholder consultation was undertaken before the design and operation of each of these initiatives could commence. The ERRCD arrangements were more complex than initially envisaged. In view of the above, full implementation and programme spending were delayed some years.

Access and testing of the upgraded system by jurisdictions is contingent upon each jurisdiction signing a Software License Agreement (SLA). The Commonwealth sent out the SLA to jurisdictions for consideration in January 2013. The SLA has been signed by all jurisdictions except the Northern Territory and Victoria. The subsequent release of the ERRCD system in each state and territory is reliant on the timing of any required jurisdictional legislative changes and jurisdictions undertaking the necessary work to migrate their existing data and process to a central system. This will see some variation of the date that the system becomes available for use between jurisdictions. The ERRCD system is currently installed on a Commonwealth funded secure host server and is awaiting utilisation by states and territories.

There has been recent media coverage of the ERRCD, its delayed uptake by the States and Territories and alternative solutions that are available.<sup>149</sup> The limit of these alternative solutions, which are not part of the 5CPA, is that they are generally only available to prescribers (e.g. Medisecure's Doctor Shop), for the eligible medicines or are not "real time" solutions (e.g. Prescription Shopping Program (PSP)). These inherent limitations in alternative options reinforce the case for one national system, like ERRCD, with the privacy and governance controlled and

<sup>149</sup> [http://www.pulseitmagazine.com.au/index.php?option=com\\_content&view=article&id=2196:medisecure-set-to-launch-real-time-prescription-monitoring-system&catid=16:australian-ehealth&Itemid=328](http://www.pulseitmagazine.com.au/index.php?option=com_content&view=article&id=2196:medisecure-set-to-launch-real-time-prescription-monitoring-system&catid=16:australian-ehealth&Itemid=328), accessed 8 December 2014

maintained by government. A national system, accessible to prescribers and dispensers, will aid in the appropriate access and quality use of controlled drugs.

### 7.6.2 National Residential Medication Chart initiative

The Australian Commission on Safety and Quality in Healthcare worked closely with key stakeholders over an 18 month period to develop the National Residential Medication Chart (NRMC) for use in Residential Aged Care Facilities (RACF). The chart is to be the primary medication communication tool between prescribers, dispensers, administrators, and reconcilers meaning that the resident has only one chart.

The NRMC has defined areas for regular medications, variable dosed medication, as required, and nurse initiated medication. There is also a weight graph that clearly shows changes in the resident's weight to help initiate early intervention.

The trial of this new chart took place in 22 RACF's over an 8 month period within 2013. This resulted in 4,674 NRMCs being used by care staff, general practitioners and pharmacies.

The key findings from this initiative directly link to improvements in the quality use of medicines. There was a reduction in medication errors from 5.2 to 1.7 per 1000 prescriptions and also a reduction seen in number of medications prescribed from 13.8 to 5.7 per resident.<sup>150</sup> Secondary to these findings there were positive benefits also seen in improved decision making, reduced time spent on prescription writing and chasing scripts, reduced stress from staff and better information management as a result of a more streamlined process.

Due to the variable IT capacity within the aged care sector the first iteration of the NRMC is paper based. Stakeholders have expressed concern around cost and time needed for printing which may be a potential barrier. It was also noted by stakeholders that there were limited change management practices in place for the successful implementation of this new process and limited transition planning on getting residents over from the old to new charting process. Moving forward, programme improvements could include easy on-line access and the four month validity for use.

### 7.6.3 Continued Dispensing initiative

Continued dispensing (CD) was introduced during the 5CPA. This initiative allows the dispensing of eligible medicines without a prescription and subject to specific prerequisites. These prerequisites require a pharmacist to be satisfied that:

- There is an immediate need for the medicine;
- It is not practicable to obtain a prescription for the medicine;
- The medicine has been previously prescribed;
- Therapy is stable;

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<sup>150</sup> Australian Commission on Safety and Quality in Health Care (ACSQHC) 2014. Phased implementation of the National Residential Medication Chart in NSW residential aged care facilities: Summary of evaluation June 2014. ACSQHC.

- There has been prior clinical review by the prescriber that supports continuation of the therapy;
- The medicine is safe and appropriate;
- The consumer has not received the medicine via continued dispensing in the previous 12 months; and
- Dispensing the medicine is permitted under relevant State or Territory law.

This measure was introduced as an access measure, specifically aimed at improving the timely access to medication in circumstances that might otherwise lead to reduced adherence to medication. As such, it is consistent with the National Medicines Policy. The nature of the prerequisites for its use and the process undertaken by community pharmacists when deciding to dispense under this initiative, are also consistent with the National Strategy for the Quality Use of Medicines.

At present, two types of medicine are eligible for CD —oral contraceptives and statins.<sup>151</sup> At the time of writing, CD is available in all States and Territories except Queensland, where legislation to permit continued dispensing is yet to be passed.

CD commenced in September 2013 in all other States and Territories except the Australian Capital Territory and Northern Territory, where the timing of empowering legislation delayed its start until November 2013 and May 2014, respectively. In the subsequent period to June 2014, 2,390 items have been dispensed under these arrangements, through 532 community pharmacies (see Table 13). Of these transactions, 72 were either invalid (11) or beyond power<sup>152</sup> (61).

Invalid transactions were for medicines not eligible under CD arrangements. In response to these invalid transactions, dispensing software for community pharmacies has been updated to prevent their recurrence in the future.

Based on Table 13 below, between September 2013 and June 2014, up to 2,300 consumers have benefited from CD arrangements, avoiding interruptions to their regular medication regimes. This equates to around 250 people per month benefiting from the initiative, since its inception.

There is strong support for CD from the community pharmacy sector and from consumers. In their report on the role of community pharmacy in chronic illness management,<sup>153</sup> Griffith University researchers identified continued medication supply as a priority for people with chronic conditions. Such people expressed a strong preference for pharmacists to supply regular medications for a predefined period. This strong preference extended further to the supply of medications previously used to relieve symptom exacerbations. The recommended exploration of ways to extend CD arrangements to include other medicines for people with chronic conditions, subject to the same controls and prerequisite conditions as currently apply.

This recommendation is consistent with the outcome of the Inquiry into Community Pharmacy in Victoria. That inquiry found that the initiative “could be expanded to include further medications,

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<sup>151</sup> Australian Government, 10 August 2013. National Health (Continued Dispensing) Determination 2012. Office of Parliamentary Counsel: Canberra.

<sup>152</sup> ‘Beyond power’ refers to CD transactions made without empowering legislation in place. All of the 61 identified beyond power transactions took place in Queensland.

<sup>153</sup> Griffith University (2014). Exploring the health consumers’ perspective on the burden of chronic illness and the role of community pharmacy in chronic illness management. Fifth Community Pharmacy Agreement Research and Development Program, managed by The Pharmacy Guild of Australia and funded by the Department of Health.

and that these repeat prescriptions could cover a longer period of time”.<sup>154</sup> That inquiry went on to recommend that the Victorian and Commonwealth governments work together to expand continued dispensing. Importantly, the inquiry noted a need to require “communications between prescribers and pharmacists” as a necessary precursor to any such expansion.

This view is consistent with concerns raised by the Australian Medical Association, which opposed the introduction of CD and can be expected to oppose any moves to expand its operation. The AMA raised these matters both during consultation over the approach to continued dispensing<sup>155</sup> and following its commencement.<sup>156</sup> It expressed concerns over a lack of collaboration between pharmacists and patients’ usual general practitioners, as well as potential for increased risk, in some clinical situations, through continuing medication relative to skipping a few days’ medication.<sup>155</sup>

The design of the CD initiative has sought to address some of these concerns through guidelines requiring identification and communication with the consumer’s most recent prescriber, within 24 hours of the CD transaction. That communication is also required to be substantive, providing full details of the transaction. The guidelines are also designed to ensure CD is a last resort option.

This review did not find evidence of adverse outcomes for consumers due to continued dispensing of medicines under this initiative. The frequency with which CD has been used to date suggests it is not being overused (see Table 14 below). In particular, it is relatively rare CD to be used for supply of an eligible statin, when compared with overall use of statins through PBS. This finding is consistent with effective use of the guidelines by community pharmacists, reducing the likelihood of adverse outcomes.

Overall, CD has been a successful complement to other mechanisms providing emergency access to PBS medicines. CD provides that access with the advantage of providing access to the eligible medicines under PBS benefit arrangements. Analysis of the average PBS benefits per prescription for the eligible medicines indicates that any financial benefits from this source are minimal. In all cases, the average Government contribution was less than \$1.00.<sup>157</sup>

Nonetheless, the successful implementation of CD for oral contraceptives and for statins provides a model for exploring additional medicines that may be appropriately included in the continued dispensing arrangements. Any decisions regarding potential expansion should first consider the effectiveness of communication mechanisms put in place for the current initiative. This review found no evidence to suggest those mechanisms are either effective or ineffective. In particular, the review did not find information on the extent of compliance with the mechanisms by community pharmacists.

The review notes that the CD initiative was budgeted for a total of \$1 million over the period of the 5CPA. By March 2014, \$570,000 of that budget had been expended and the measure was expected to come in under budget by the end of the Agreement. This expenditure was associated

<sup>154</sup> Legislative Council Legal and Social Issues Legislation Committee, October 2014. Inquiry into Community Pharmacy in Victoria, Report No. 3. Parliament of Victoria: Melbourne.

<sup>155</sup> AMA, 13 April 2011. Continued Dispensing of Pharmaceutical Benefits Scheme Medicines in Defined Circumstances. Submission to the Continued Dispensing Consultation. Available at <https://ama.com.au/system/files/node/6691/AMA%20submission%20to%20continued%20dispensing%20consultation.pdf>.

<sup>156</sup> AMA, 21 January 2014. Continued dispensing – facts for AMA members. Australian Medicine, Issue 26.01, 21 January 2014, p44.

<sup>157</sup> Based on analysis of PBS Date of Supply data for eligible medicines dispensed between September 2013 and June 2014, inclusive. Available at <http://www.pbs.gov.au/statistics/dos-and-dop/files/dos-jul-2008-to-apr-2014.xlsx>.

with the establishment of the initiative and communication strategies. Less than \$70,000 of the costs were incurred after the initiative's commencement.

Table 13. Continued dispensing transactions and participating pharmacy numbers, by jurisdiction, to June 2014<sup>158</sup>

Jurisdiction	ACT	NSW	SA	TAS	VIC	WA	Total
Transactions	154	586	183	192	908	367	2,390
Per cent	6.4%	24.5%	7.7%	8.0%	38.0%	15.4%	100.0%
Pharmacies	16	131	44	38	204	99	532

Table 14. Continued dispensing relative to total PBS dispensing, September 2013 to April 2014<sup>159</sup>

Item type	Continued dispensing items*	Total PBS items*	Ratio CD:PBS
Oral contraceptives	992	2,222,770	1:2,241
Statins	1,398	20,745,637	1:14,840
Total	2,390	22,968,407	1:9,610

\* Continued dispensing items exclude Queensland but total PBS items include Queensland.

<sup>158</sup> Source: Department of Health (December 2014). Report to Parliament on the operation of s 89A of the National Health Act 1953 ('Continued Dispensing'). Australian Government: Canberra.

<sup>159</sup> Source: Department of Health (December 2014). op. cit. and PBS Date of Processing Statistics 2013-14, available at <http://www.pbs.gov.au/statistics/dos-and-dop/files/dop-2013-2014.xlsx>.

## 8 Part 5: Other Matters

### Combined Thematic Review summary findings



Access

Consumer  
Experience

QUM

- Access focussed components
- Ratio of pharmacies to population has remained steady through 5CPA and new pharmacies have been approved, which suggests the Location Rules are enabling access
- Under-copayment scripts support the NMP in relation to QUM and access, through an improved information base.

### 8.1 Location Rules

The Australian Community Pharmacy Authority (ACPA) considers applications by pharmacists seeking approval to relocate an existing pharmacy or to establish a new pharmacy. The ACPA assesses applications against the requirements of the Pharmacy Location Rules (Rules), which have an objective of ensuring community access to PBS medicines through a network of viable community pharmacies throughout Australia i.e. the Rules are an Access related measure.

There are 14 Rules, three (3) of which require that applications were made before 16 April 2012. Each of the Rules is applicable to certain circumstances but in general the rules cover relocation of existing pharmacies (Rule 121 to 124) or applications for new pharmacies (Rule 130 to 136). Applicants choose to apply under the Rule which best suits their circumstances. For example an applicant may choose to apply under Rule 136: New pharmacy in a facility (large medical centre). A handbook is available to applicants to assist in the application process.<sup>160</sup>

New rules came into effect during the 5CPA on the 18 October 2011. Under the pre-18 October 2011 Rules a total of 730 applications were considered for the period 1 July 2010 up to 20 April 2012. Of these 437 (59.9 per cent) were recommended for approval. Common themes in the 293 (40.1 per cent) applications that were not recommended included issues such as not meeting the distance requirements. The most common rule for which applications were considered were Rule 104: Short distance relocation. There were 241 applications considered (33.0 per cent) under Rule 104. There were 110 applications for new pharmacies recommended for approval during this period.

A total of 963 applications have been considered under the post 18 October 2011 Rules (up to and including 31 March 2014). Of these 592 (61.5 per cent) were recommended for approval. Common themes in the 371 (38.5 per cent) applications that were not recommended included issues such as not meeting the distance. There were 241 applications for new pharmacies recommended for approval during this period.

When a pharmacist's application for approval to supply pharmaceutical benefits, under section 90 of the Act, has been rejected by the Secretary's delegate (an officer in the Department of Human Services) because it failed to satisfy the requirements of the Pharmacy Location Rules, the pharmacist may make a request to the Minister to exercise of their discretionary power to approve a pharmacist to supply PBS medicines. As at 31 March 2014 there have been 51 valid

<sup>160</sup>[http://www.health.gov.au/internet/main/publishing.nsf/Content/DDB409EBB18FCE8FCA257BF0001D3C0C/\\$File/pharmacy-location-rules-handbook-v1.1-march-2014.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/DDB409EBB18FCE8FCA257BF0001D3C0C/$File/pharmacy-location-rules-handbook-v1.1-march-2014.pdf), accessed 9 December 2014

requests for ministerial discretion under 5CPA. The Minister's discretionary power was exercised for 15 of these requests.

Access to PBS medicines is primarily governed by the distribution of pharmacies. Across Australia, there were 3,963 people per pharmacy in urban areas and 3,771 people per pharmacy in rural areas at 30 June 2014.<sup>161</sup> This ratio in both urban and rural areas has fluctuated slightly over the period 2010 to 2014 (see Table 15 below) but broadly suggests that the number of pharmacies is keeping track with population growth. The number of pharmacies in rural areas has increased by 119<sup>162</sup> between 2010 and 2014, which equates to an increase of 15.7 per cent. This is a greater percentage increase than urban pharmacies, which increased by 8.7 per cent for the same period. Many of these 119 rural pharmacies are in locations that previously did not have a community pharmacy.

The fact that the ratio of people per pharmacy is relatively even across Australia, in conjunction with the fact that new pharmacies continue to be assessed and recommended for approval by the ACPA suggests that the Rules are enabling consumer access to a network of community pharmacies in areas of need.

*Table 15. Pharmacies and people per pharmacy by urban and rural status for 2010 to 2014*<sup>163 164</sup>

<b>Year</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
<b>People per urban pharmacy</b>	3,814	3,777	4,082	4,034	3,963
<b>Urban pharmacies</b>	4,212	4,258	4,286	4,500	4,580
<b>People per rural pharmacy</b>	4,277	4,108	4,148	3,887	3,771
<b>Rural pharmacies</b>	876	908	955	851*	877

\*As a result of updates to the PhARIA classification, 118 pharmacies were reclassified from rural to urban in 2013. This does not represent a decline in the number of rural pharmacies.

<sup>161</sup> [http://www.pc.gov.au/data/assets/pdf\\_file/0019/132346/rogs-2014-volume-health.pdf](http://www.pc.gov.au/data/assets/pdf_file/0019/132346/rogs-2014-volume-health.pdf), viewed 9 December 2014

<sup>162</sup> Based on the following calculation 877 - (876-118 reclassified)=119 new rural pharmacies.

<sup>163</sup> Source: SCRGSP (Steering Committee for the Review of Government Service Provision) 2014, Report on Government Services 2014, vol. E, Health, Productivity Commission, Canberra.

<sup>164</sup> Notes on this table: ,Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PhARIA 1. Rural = PhARIA 2–6. The ACT has no rural PhARIA areas. b Excludes RPBS and doctor's bag. c Care should be taken in using data for the NT, as 43.9 per cent of the population live in remote and very remote areas and data exclude Aboriginal Medical Services that supply medications in these areas under s.100 of the National Health Act 1953 (Cwlth)

## 8.2 Recording of PBS Prescriptions priced below the General Patient Co-Payment

The 5CPA contains a clause requiring community pharmacies to provide data to the Commonwealth on each PBS prescription dispensed at a price below the general patient co-payment. The collection of these under co-payment prescription data began on 1 April 2012.

The purpose of collecting this data is to improve the information available on use of PBS medicines by the Australian population. A high proportion of medicines listed on the PBS are priced below the general patient co-payment. This meant that historically there were large gaps in information about the use of these medicines by the Australian population. Given that such medicines include many commonly prescribed antibiotics as well as medicines and other items associated with management and treatment of chronic diseases, this information gap was significant.

This initiative also supports aspects of the NMP with respect to access to medicines and their quality use. The additional information made available through collection of under co-payment scripts' data improves the capacity to measure and assess overuse and inappropriate use of medicines. These are areas specifically targeted through the NMP as helping to implement the principles of quality use and thereby reduce pressure on the costs of PBS and thus ensure good access in the longer term.

Since collection began, good quality data has been provided by 99 per cent of community pharmacies. The additional data has been used to improve the accuracy of information available to the Pharmaceutical Benefits Advisory Committee (PBAC), among other decision makers, policy developers and researchers.

As indicated above, this initiative supports but does not directly affect access to and quality use of medicines. Its successful implementation and use of the resulting data to better inform policy and decisions affecting listing of medicines may lead to indirect effects on access to medicines. This could happen through future listing and delisting of medicines on the PBS but at the time of this review there was no evidence found for such a link, even indirectly.

In addition, the use of the data to inform research into medicines' use and overuse also may indirectly affect future policy or initiatives in the quality use of medicines. However, again this review did not find evidence of this happening to date. Given the timelines involved in building of research evidence and subsequent development of new policy, it is unlikely such evidence yet exists.

This Review did find that this initiative supports the NMP in relation to QUM and access, through an improved information base.

Table 16. Population, scripts dispensed and scripts dispensed per capita for 2010-11 to 2014-15<sup>165</sup>

Statistic	2012-13	2013-14	2014-15 (Forecast)
Population as at 30 June	22,728,254	23,135,281	23,559,362

<sup>165</sup> Source: Australian Bureau of Statistics (ABS) 2014. Population Projections, Australia, 2012-2101. Cat. No. 3222 ABS, Canberra and Australian Bureau of Statistics (ABS) 2014. Regional Population Growth, Australia. Cat. No.

<b>Statistic</b>	<b>2012-13</b>	<b>2013-14</b>	<b>2014-15 (Forecast)</b>
<b>Scripts dispensed including under co-payment</b>	275,371,805	283,960,108	Not available
<b>Scripts per capita</b>	12.1	12.3	Not available

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3218. ABS, Canberra and PBS Date of Supply data supplied by the Department of Health. includes Under Co-payment scripts

## 9 Appendix

### 9.1 Review questions

Table 17. List of review questions/activities being explored in this review<sup>166</sup>

Theme	Questions/Activities	Priority
Access	How does distribution impact on access and where are potential gaps of service across the network of community pharmacies?	
Access	In what way are access-related components of 5CPA investments integrated so as to deliver consistency in outcomes (e.g. QUMAX, CSO, and MedsCheck)? (Investments are defined as any service or programme remunerated under the Agreement including Dispensing.)	
Access	Look at the impact of and reasons for pharmacies providing 5CPA programmes. For example, why pharmacies registered to provide Dose Administration Aids and Clinical Interventions (as part of the PPI Programme).	
Access	What is the current level of awareness by consumers of 5CPA programmes and services offered through community pharmacy? How does this impact on access?	Lower priority
Access	How could this awareness be improved and information best presented to consumers to improve access?	
Access	Analyse number and type of complaints to the Australian Health Practitioner Regulation Agency and State and Territory Health Complaints Commission concerning access to Commonwealth funded services through community pharmacy.	Lower priority
Access	Undertake a sample audit of the uptake of, and use of, the Community Pharmacy Service Charter and examine impacts of the Charter on access to, and increased consumer awareness of, 5CPA programmes and services and medicines?	
Access	What enablers and barriers have been experienced in supporting access to medicines through 5CPA programmes, services, and initiatives?	

<sup>166</sup> Source: Department of Health

Theme	Questions/Activities	Priority
Access	How do community pharmacies supply a medicine specifically for a consumer (as opposed to stock replenishment) if it cannot be sourced within 24 hours? What is the extent and nature of this and what can be done to collect this information in the future?	Lower priority
Access	What could improve access to PBS medicines while still maintaining Quality Use of Medicines principles?	
Access	What are the benefits and risks of discounting in relation to timely and affordable access to medicines? (Note: discounting refers to the Government enabling Community Pharmacy to discount PBS medicine prices to consumers below the current co-payment amounts – currently not possible)	
Consumer Experience	Examine stakeholder awareness of 5CPA programmes and services offered through community pharmacy	
Consumer Experience	What is the current level of awareness by consumers (and other stakeholders) of 5CPA programmes and services offered through community pharmacy?	Lower priority
Consumer Experience	Determine what evidence there is that services funded under the 5CPA are delivered to consumers. For example, have services been delivered as intended?	
Consumer Experience	Determine what evidence there is that services funded under the 5CPA are delivered to consumers. For example, have services been delivered as targeted?	
Consumer Experience	What consumer health benefits can be identified from <del>investments</del> in 5CPA programmes and services?	Note: investments in deleted.
Consumer Experience	What other benefits to consumers if any have there been from 5CPA investments?	Lower priority
Consumer Experience	Have any unintended consequences in the delivery of 5CPA investments that impact directly on consumer experience emerged, and if so how have these been addressed?	
Consumer Experience	How are consumer interests reflected in the development and operation of 5CPA programmes, services, and activities?	

<b>Theme</b>	<b>Questions/Activities</b>	<b>Priority</b>
Consumer Experience	Are any improvements needed to increase or target more appropriately, consumer awareness of, and participation in 5CPA programmes, services and activities? (Including strategies to assist with sustainability of programmes and services i.e. better targeting and more appropriate use of services?)	
Consumer Experience	What evidence is there of consumer satisfaction with 5CPA services?	
Consumer Experience	What are the health and demographic determinants of satisfaction with community pharmacy services?	Lower priority
Consumer Experience	How are 5CPA programmes, services and activities publicised to consumers?	
Consumer Experience	How effective has the 5CPA Communication Strategy been in raising awareness and targeting of 5CPA programmes, services and activities?	
Consumer Experience	What evidence is there that consumer information is adequate, timely, appropriate and available?	Lower priority
Consumer Experience	What is the contribution of the 5CPA Residential Medication Management Programme to the health literacy of staff in Residential Aged Care Facilities?	
Consumer Experience	What is the level of awareness among consumers of the Charter?	
Consumer Experience	How have consumers used the Charter? For example, are the complaints mechanisms adequate?	
Consumer Experience	Does the Customer Service Statement element of the Charter contribute to raised awareness amongst consumers of services funded under the 5CPA?	

Theme	Questions/Activities	Priority
QUM	To what extent do the 5CPA Programmes reflect QUM principles as outlined in the National Medicines Policy (NMP) and the National Strategy for Quality Use of Medicines (QUM)? Specific programmes designed to support/enhance QUM include: the Pharmacy Practice Incentives Programme, Medicine Use Review programmes, Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander peoples, Medication Charts, Continued Dispensing, and Electronic Recording and Reporting of Controlled Drugs.	
QUM	What evidence is there that 5CPA investments support the NMP and the National Strategy for QUM? For example, how are medicines being used safely and effectively? and how has QUM by healthcare consumers been improved?	
QUM	What were the barriers/enablers to achieving QUM outcomes of 5CPA programmes/initiatives?	
QUM	In the context of promotional campaigns, to what extent has knowledge of 5CPA programmes/initiatives for QUM among healthcare teams/stakeholders increased? and Has this contributed to an increase in healthcare team collaboration to achieve QUM?	

The lower priority review Access questions “*Analyse number and type of complaints to the Australian Health Practitioner Regulation Agency and State and Territory Health Complaints Commission concerning access to Commonwealth funded services through community pharmacy,*” is addressed below. It is addressed here due to the fact that it does not fall neatly within the other sections of the report.

On 30 June 2014, there were 28,282 registered pharmacists across Australia. There were 514 notifications received in 2013-14, which was an increase of 20% over the 429 received in 2012-13. For notifications received in 2013-14, 322 were lodged outside NSW. The overall rate of notifications per registrant nationally was 1.7%.<sup>167</sup>

Table 18. Notifications received by state or territory<sup>168</sup>

Jurisdiction	2011-12	2012-13	2013-14
NSW	171	183	192
VIC	88	93	142
QLD	57	82	87

<sup>167</sup> Australian Health Practitioner Regulation Agency (AHPRA) 2014. Annual Report 2013-14. AHPRA, Victoria.

<sup>168</sup> Ibid

<b>Jurisdiction</b>	<b>2011-12</b>	<b>2012-13</b>	<b>2013-14</b>
SA	16	21	26
WA	32	31	39
TAS	9	9	14
NT	1	5	10
ACT	13	5	4
Total	387	429	514

## 9.2 Stakeholders consulted

Table 19. List of stakeholders consulted in undertaking this review<sup>169</sup>

<b>Stakeholder organisation</b>	<b>Mechanism</b>
The Pharmacy Guild of Australia	Face to face and telephone consults
Department of Health	Face to face and telephone consults
The Pharmaceutical Society of Australia	Telephone consult
The Society of Hospital Pharmacists Australia	Telephone consult
Council of Pharmacy Schools	Telephone consult
Australian Consumer's Association (Choice)	Declined consult
Consumers Health Forum of Australia	Contacted but did provide response
Carers Australia	Contacted but did provide response
Monash University (John Jackson)	Telephone consult
National Rural Health Alliance	Telephone consult

<sup>169</sup> Source: KPMG

Stakeholder organisation	Mechanism
Australian Medical Association	Telephone consult
Royal Australian College of General Practitioners	Provided written response
Rural Doctors Association of Australia	Declined consult
National Aboriginal Community Controlled Health Organisation (NACCHO)	Telephone consult
Department of Veterans' Affairs	Telephone consult
The National Prescribing Service	Telephone consult
Leading Aged Care Services Australia	Telephone consult
University of Tasmania	Telephone consult – only to discuss availability of pharmacy survey
University of Technology Sydney	Sourced Community Pharmacy Barometer Survey

### 9.3 Reference information

Table 20. ABS PES proportion of population receiving a prescription for medication and the proportion that experienced a financial barrier.<sup>170</sup>

Statistic	2010-11	2011-12	2012-13	2013-14
<b>Received a prescription for medication</b>	68.9%	68.0%	67.9%	68.9%
<b>Proportion of population that experienced a financial barrier to prescription medication</b>	9.2%	9.0%	Not available	7.6%

<sup>170</sup> Source: Australian Bureau of Statistics (ABS) 2014. ABS Patient Experience Survey. ABS Cat. No. 4839., Canberra.

Table 21. Scripts per capita by remoteness areas for 2010-11 and 2013-14, including under co-payment scripts in square brackets<sup>171</sup>

Scripts per capita	2010-11	2011-12	2012-13	2013-14
<b>0 - Major Cities of Australia</b>	8.9	8.9	8.7 [11.6]	8.6 [11.7]
<b>1 - Inner Regional Australia</b>	11.2	11.3	11.3 [14.2]	11.4 [14.5]
<b>2 - Outer Regional Australia</b>	10.2	10.4	10.3 [13.3]	10.4 [13.6]
<b>3 - Remote Australia</b>	6.3	6.4	6.3 [8.9]	6.3 [9.1]
<b>4 - Very Remote Australia</b>	3.5	3.6	3.5 [5.4]	3.4 [5.4]

Table 22. Scripts per capita by age groups for 2010-11 and 2013-14, including under co-payment scripts in square brackets<sup>172</sup>

Scripts per capita	2010-11	2011-12	2012-13	2013-14
<b>00-09 YEARS</b>	1.1	1.1	1.0 [2.1]	1.0 [2.1]
<b>10-19 YEARS</b>	1.2	1.2	1.2 [2.3]	1.2 [2.3]
<b>20-29 YEARS</b>	1.5	1.5	1.5 [3.2]	1.5 [3.2]
<b>30-39 YEARS</b>	2.7	2.6	2.5 [4.8]	2.5 [4.9]
<b>40-49 YEARS</b>	4.6	4.5	4.4 [7.9]	4.3 [8.0]
<b>50-59 YEARS</b>	8.9	8.6	8.2 [14.2]	7.9 [14.3]
<b>60-69 YEARS</b>	22.6	22.3	21.6 [27.0]	20.9 [27.0]
<b>70-79 YEARS</b>	41.9	42.1	41.6 [43.3]	41.7 [43.6]
<b>80-89 YEARS</b>	54.7	54.8	54.5 [56.2]	54.6 [56.5]
<b>90-99 YEARS</b>	59.9	61.8	61.9 [63.8]	62.7 [64.8]
<b>OVER 100 YEARS</b>	49.6	51.1	51.7 [53.7]	53.4 [55.7]

<sup>171</sup> Source: PBS Date of Supply data from the Department of Health and Australian Bureau of Statistics (ABS) 2014. Regional Population Growth. ABS Cat. No. 3218., Canberra.

<sup>172</sup> Ibid

Table 23. Scripts dispensed under ATC Categories N05 (Psycholeptics) and N06 (Psychoanaleptics) 2010-11 to 2013-14 including under co-payment scripts in square brackets<sup>173</sup>

Statistic	2010-11	2011-12	2012-13	2013-14
Scripts dispensed <sup>174</sup>	23,355,228	24,062,602	24,298,252 [31,953,314]	24,432,309 [33,361,284]

Some key summary statistics for each of the focus groups are outlined in the table below

Table 24. Summary statistics on focus population groups

Population group	Population estimates
Aged care recipients and residential aged care facilities (RACFs)	As at 30 June 2013 there were 2,718 residential aged care facilities (services) providing 186,278 places. <sup>175</sup>
Aboriginal and Torres Strait Islander people	As at 30 June 2011 the estimated Aboriginal and Torres Strait Islander population of Australia was 669,900 people, or 3% of the total Australian population.
Carers	In 2012 the ABS estimated there were 1.5 million female carers, and of these 536,700 were primary carers, compared to 1.2 million male carers and 233,100 male primary carers. <sup>176</sup>
Rural and remote populations	As at 30 June 2013 the estimated resident population of Australia was 23,135,281 persons. Of these <ul style="list-style-type: none"> <li>• 71 per cent or 16,319,144 persons lived in Major Cities</li> <li>• 18 per cent or 4,217,079 persons lived in Inner Regional Australia</li> <li>• 9 per cent or 2,066,961 persons lived in Outer Regional Australia</li> <li>• 1 per cent or 322,749 persons lived in Remote Australia</li> <li>• 1 per cent or 209,348 persons lived in Very Remote Australia<sup>177</sup></li> </ul>

<sup>173</sup> Source: PBS Date of Supply data supplied by the Department of Health

<sup>174</sup> PBS Date of Supply data supplied by the Department of Health.

<sup>175</sup> <http://www.aihw.gov.au/aged-care/residential-and-community-2012-13/services-and-places/>, viewed November 2014

<sup>176</sup> Australian Bureau of Statistics (ABS) 2014. Caring in the Community, Australia, 2012. ABS Cat. No. 4436., Canberra.

<sup>177</sup> Australian Bureau of Statistics (ABS) 2014. Regional Population Growth. ABS Cat. No. 3218., Canberra. ABS.

<p>Culturally and Linguistically Diverse populations</p>	<p>Australia has a culturally and linguistically diverse population, with many residents born overseas and originating from non-English speaking countries. Australia is also home to refugees, who have a unique and often traumatic experience of migration. Considering relapse prevention within a multicultural context requires understanding the differences that arise through cultural and linguistic diversity.</p> <p>There is no official “CALD” definition but it is often described in terms of whether residents were born in English speaking countries. The 2011 Census of Population and Housing reported that of Australia's 21.5 million people, about one quarter were born overseas, with a further 20% of residents having at least one parent born overseas. Over half (53%) of the population are third-plus generation Australians; those having one or more of their grandparents who may have been born overseas or who may have several generations of ancestors born in Australia.<sup>178</sup></p>
<p>Consumers with a mental illness</p>	<p>The 2007 National Survey of Mental Health and Wellbeing provides information on the 12-month and lifetime prevalence of mental disorders in the Australian population, focusing on anxiety, affective and substance use disorders. The National Survey of Mental Health and Wellbeing includes 3 main components—a population-based survey of adults, a service-based survey of people with low-prevalence psychotic disorders, and a population survey of children.</p> <p>The survey estimated that almost half (45.5%) of Australians aged 16–85 (7.3 million people) experienced a mental disorder over their lifetime. Each year, 1 in 5 Australians (20%) in this age range, or 3 million Australians, are estimated to experience symptoms of a mental disorder<sup>179</sup>. Anxiety, affective and substance use disorders were experienced by 14.4%, 6.2% and 5.1% of the population respectively over the 12 months. See the full report for further information.<sup>180</sup></p>

<sup>178</sup> Australian Bureau of Statistics (ABS) 2013. Perspectives on migrants. ABS Cat. No. 3416., Canberra. ABS.

<sup>179</sup> Australian Bureau of Statistics (ABS) 2008. National survey of mental health and wellbeing: summary of results, Australia, 2007. ABS cat. no. 4326.0. Canberra: ABS.

<sup>180</sup> Department of Health and Ageing (DoHA) 2009. The mental health of Australians 2: report on the 2007 national survey of mental health and wellbeing. Canberra: Commonwealth of Australia

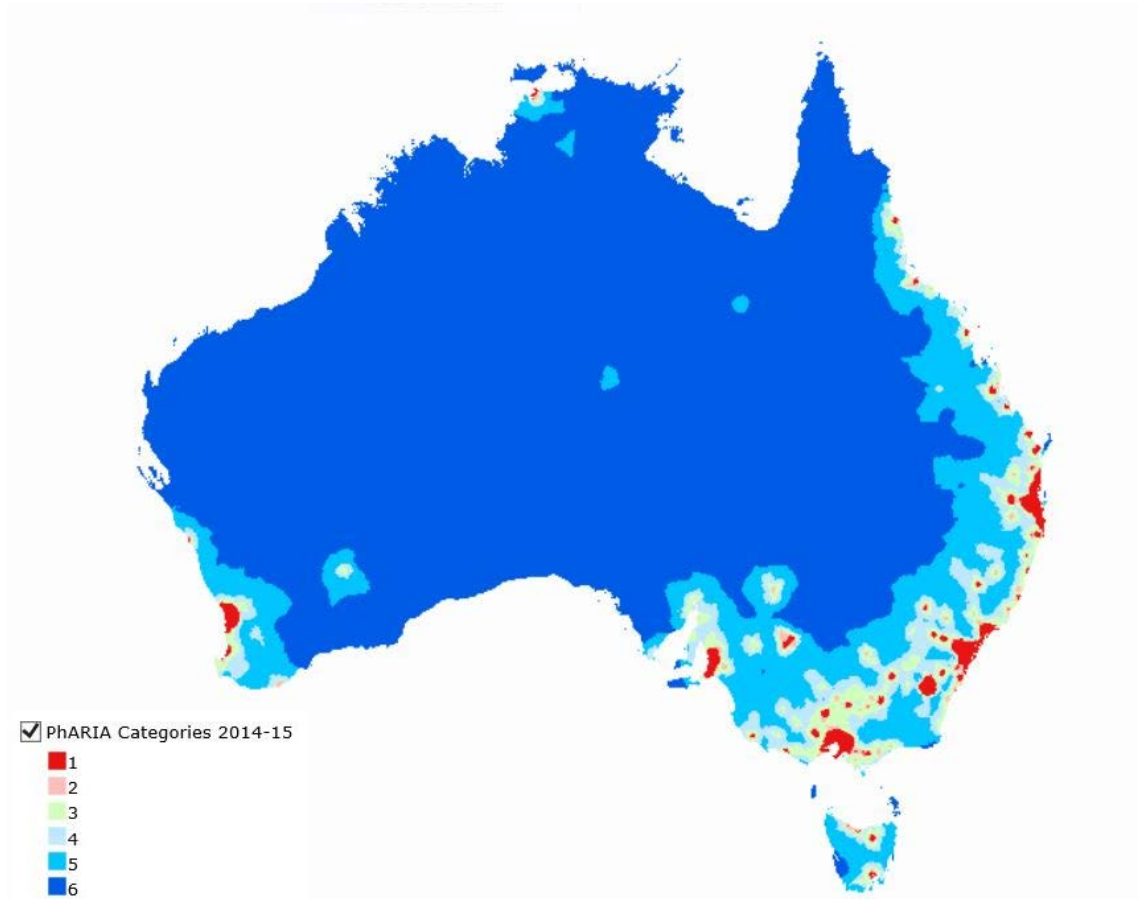


Figure 6. Map of Australia by PhARIA categories 2014-15<sup>181</sup>

<sup>181</sup> [http://www.spatialonline.com.au/pharmpub\\_2014to15/default.aspx](http://www.spatialonline.com.au/pharmpub_2014to15/default.aspx), Accessed 9 December 2014

Table 25. RPMA Payment matrix 2013-14<sup>182</sup>

Prescription volume range	PhARIA Category				
	2	3	4	5	6
<b>0 – 16,925</b>	\$12,029	\$15,036	\$22,964	\$34,447	\$45,930
<b>16,926 – 33,851</b>	\$10,935	\$13,669	\$20,777	\$31,166	\$41,555
<b>33,852 - 42,314</b>	\$9,842	\$12,302	\$18,590	\$27,885	\$37,180
<b>42,315 – 50,776</b>	\$8,748	\$10,935	\$16,403	\$24,605	\$32,806
<b>50,777 – 59,239</b>	\$7,655	\$9,568	\$14,216	\$21,324	\$28,432
<b>59,240 – 67,702</b>	\$6,561	\$8,202	\$12,029	\$18,043	\$24,058
<b>67,703 – 76,165</b>	\$5,468	\$6,835	\$9,842	\$14,763	\$19,684

<sup>182</sup> Source: Department of Health