From: Sharlene Wellard [mailto:swellard@meridianlawyers.com.au]
Sent: Wednesday, 18 April 2018 5:18 PM
To: AMOD
Cc: Jacki Baulch; Kate Thomson; Jessica Light; Scott Harris
Subject: AM2014/209 Pharmacy Industry Award 2010 - Work value

Dear Amod Team

AM2014/209 Pharmacy Industry Award 2010
Work value case

We act for the Pharmacy Guild of Australia (PGA).

In accordance with the directions made on 11 April 2018 please find attached:

1) Draft confidentiality orders (not opposed by APESMA)
2) Further Submissions of the Pharmacy Guild of Australia
3) Redacted Affidavit of a witness, employer based in Western Australia
4) Redacted Affidavit of a witness, employer based in Victoria

We have been unable to contact the proposed third witness for the PGA, an employer based in Queensland, today. As soon as we have heard from him we will file his affidavit.

Un-redacted affidavits (not for publication on the website) will be filed and served upon the making of the confidentiality orders or at the further direction of the Commission.

Regards

Sharlene Wellard | Principal

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DRAFT ORDER

s.156 - 4 yearly review of modern awards

4 yearly review of modern awards

(AM2016/28)

PHARMACY INDUSTRY AWARD 2010

[MA000012]

COMMISSION MEMBER PLACE, DATE 2018

Confidentiality Order – Lay Evidence – Pharmacy Guild of Australia

A. Pursuant to s.594 of the Fair Work Act 2009 (Cth) (the Act), it is ordered that:

1. The three lay witness statements filed by the Pharmacy Guild of Australia on 18 April 2018 are not published on the Fair Work Commission website or otherwise, save and except in the redacted form here attached.

2. Access to the unredacted form of the Pharmacy Guild of Australia lay witness statements is granted to the following persons for the sole purpose of AM2016/28 in the 4 yearly review of modern awards:

    a. Employees of the Fair Work Commission who need to deal with the material in the ordinary course of their duties;

    b. APESMA, Australian Business Industrial and NSW Business Chamber, including their representatives and counsel, but not including their members.

3. Any other persons or party who wish to view the unredacted form of the Pharmacy Guild of Australia law witness statements may apply to the Fair Work Commission and the application shall be determined following a hearing involving affected parties.

B. Liberty to apply generally on these matters is granted.

COMMISSION MEMBER

IN THE FAIR WORK COMMISSION

Title:	**s 156 of the *Fair Work Act* 2009 - 4 yearly review of modern awards**
Award:	**Pharmacy Industry Award 2010**
Matter No.:	**AM2014/209**
Subject:	**Work value claim for pharmacists**

Further Submissions of the Pharmacy Guild of Australia

Introduction

1. On 13 June 2017, the Pharmacy Guild of Australia (**Guild**) filed an Outline of Submissions (**Original Outline**) in relation to the claim by the Association of Professional Engineers, Scientists and Managers, Australia (**APESMA**) for increases to the minimum rates of pay for pharmacist classifications covered by the *Pharmacy Industry Award 2010* (**Pharmacy Award**), and the creation of a new classification of Accredited Pharmacist.
2. The APESMA claim arises in the context of the Commission's 4 yearly review of modern awards in accordance with s 156 of the *Fair Work Act 2009* (**FW Act**) and is reliant on "*work value reasons*" (ss 156(3) and (4)).
3. On 21 December 2017, APESMA filed and served:
   a. A submission that is in essence an Outline of the findings it seeks from the Commission based on its lay evidence and additional expert evidence;
   b. Lay evidence consisting of statements from 9 witnesses;

c. Additional expert evidence, in the form of the second part of a report from the Faculty of Pharmacy at the University of Sydney, titled "*The Work Value of a Community Pharmacist – Part II: Semi Structure Interviews*" (**APESMA Report – Part II**), by Dr Vivien Tong and Professors Parisa Aslani and Ines Krass.

4. On 3 November 2016, APESMA filed an Outline of Submissions and a document titled "Submissions and an Outline of findings APESMA Submit should be made based on Expert Evidence" on 5 April 2017. The latter document includes what is understood to be Part I of APESMA's expert evidence, being at Annexure F a document titled "*Work value of a community pharmacist*", a report by Professors Aslani and Krass (**APESMA Report – Part I**).
5. There are also various documents produced by Dr Lance Emerson and the PSA in accordance with orders of the Commission, and upon which in its Submissions of 5 April 2017 APESMA submits the Commission should also make certain findings.
6. In its submission of 21 December 2017, APESMA further states at [12] that it will "*provide a submission outlining how our application meets all of the various requirements of the Act in order for it to be successful when all evidence has been admitted and we have had the opportunity to peruse the submissions and evidence filed by [the Guild] and any other interested party opposing our application*". The Guild understands this statement to mean nothing other than any relevant outline of submission in reply and ultimately a closing address at hearing. The Guild otherwise proceeds on the basis that APESMA will advance its case and that APESMA has already filed all material on which it intends to reply, save for any reply material.
7. On the above understanding, the Guild relies upon its Original Outline, which it supplements by this further outline following service of the APESMA material described in paragraph 3 above.

8. The Guild submits that APESMA's evidence will not be able to make out that there has been the requisite "significant net addition" to the work of pharmacists to warrant an increase in minimum wages for work value reasons.
9. In relation to the proposed new classification of Accredited Pharmacist, that claim is not properly explained by APESMA, but in any event is a contrived classification and not justified on work value reasons.
10. The Guild acknowledges and respects the work of community pharmacists, as well as their commitment to their profession and professional obligations. The Guild's submission reflects an objective position in the circumstances of the APESMA claim and an assessment against the requirements of the FW Act.

Commission approach

11. As the APESMA claim arises in the context of the 4 yearly review of the Pharmacy Award, the Commission must under s 134(2)(b) of the FW Act take into account the modern award objective in s 134(1), and also apply under s 284(2) the minimum wages objective.
12. Section 135 of the FW Act also limits the circumstances in which modern award minimum wages can be varied, including relevantly:
    a. in the context of a 4 yearly review, s 156(3) of the FW Act confers a discretion on the Commission to vary modern award minimum wages but only where the Commission is satisfied that the variation is justified by "work value reasons" as provided for in s 156(4); and
    b. the Commission must take into account the rate of the national minimum wage (s 135(2); currently $694.90 per week or $18.29 per hour with a casual loading of 25%), and the minimum wages objective.
13. Under s 154(4) of the FW Act, work value reasons are reasons related to:

a. The nature of work; or

b. The level of skill or responsibility involved in doing the work; or

c. The conditions under which the work is done.

14. The factors which may justify an increase in wages on work value grounds can be discerned from previous decisions of the Commission and its predecessors. Those decisions are identified in the APESMA submissions of 3 November 2016 and the Guild's Original Outline and are not repeated in detail. However, the Guild submits the following is a correct summary of the relevant test:

> *"The strict test for an alteration in wage rates is that the change in the nature of the work should constitute such a significant net addition to work requirements as to warrant the creation of a new classification or upgrading to a higher classification".*

15. Consistent with that approach, other principles which have generally applied in work value matters, and relevant to the current proceedings are that:

a. Where new or changed work is only performed from time to time or only by some persons in a classification, an allowance may be appropriate; and

b. Caution should be exercised to avoid "*contrived classifications and over classifications of jobs*",

(*Child Care Industry Australian Capital Territory Award 1998* PR 954938 at [186]).

16. The datum point for the assessment of change in work value is the date that the Commission or its predecessors last reviewed the relevant classifications for work value purposes. In the case of community pharmacists this was the decision of Commissioner Hingley on 29 June 1998 (Print Q2258) in making the *Community Pharmacy Award 1998* (**Federal Pre-reform Award**), which adopted classifications arising from a decision of Commissioner O'Shea on 6 March 1996 (Print M9831) which had led to the making of

the *Community Pharmacy Award 1996.* There is no dispute in this matter about the applicable datum point.

17. Relevant historic award coverage of community pharmacists and classification relativities is set out at [21] - [31] of the Original Outline.

18. The APESMA claim also includes the creation of a new classification of Accredited Pharmacist and a proposed rate for that classification. An issue potentially arises as to whether APESMA is seeking to have a new modern award minimum wage set (in which case s156(3) and (4)) may not apply), or whether the proposal can properly be characterised as a variation of the existing minimum wage for certain pharmacists with higher qualifications. This requires clarification by APESMA, although the obiter at [46] in *4 yearly review of modern awards – Pastoral Award 2010* [2015] FWCFB 8810 suggests work value considerations would still be relevant. The Guild reserves its position on this point.

19. The *Pastoral Award case* is also relevant to consideration of the modern award objective and the minimum wages objective. In that case the Full Bench at [65] – [67] endorsed the approach to ss 134 and 284 of the FW Act taken in the *Annual Wage Review 2014-15 decision* ([2015] FWCFB 3500) at [89] to:

> *"…take into account the effect of its decisions on national economic prosperity and in so doing give particular emphasis to the economic indicators specifically mentioned in the relevant statutory provisions. Such an approach is supported by the object of the Act".*

20. In this matter, APESMA must adduce specific and probative evidence properly directed to demonstrate the facts supporting the claimed increases in award minimum wages.

The APESMA claim

21. In summary. APESMA claims:

a. increases to the minimum rates of pay for Pharmacist classifications covered by the Pharmacy Award i.e. Pharmacy Interns, Pharmacist, Experienced Pharmacist, Pharmacist in Charge and Pharmacist Manager; and

b. as identified above, the creation of a new classification of Accredited Pharmacist with a proposed wage rate for that classification equivalent to that of Pharmacist Manager.

22. The wage rates reflecting the APESMA claim were originally identified at [2] of the APESMA submissions of 5 November 2016. Those proposed rates will presumably be updated and re-presented by APESMA before the hearing.

23. The APESMA claims are premised on there having been "*such significant changes in the work done by pharmacists in community pharmacies since* [the datum point] *that an increase in the award minimum rates of pay is warranted*" (APESMA submissions 3 November 2016 at [5]).

24. In the APESMA Submissions of 5 April 2017, the Commission is asked to make various findings in relation to:

a. The APESMA Report – Part I - see 10.4 of the Submissions;

b. The documents produced by the PSA – see 11.4 of the Submissions; and

c. A report by Professor Phillip Clarke – see 12.4 of the Submissions.

25. From its evidence filed on 21 December 2017, the APESMA submission of the same date seeks that the Commission make further findings, i.e:

a. 10 findings identified at 5.1-5.10 of its Outline based on the lay evidence of Dr March, Ms McCallum, Ms Madden, Mr Yap, APESMA Witness A.5, APESMA Witness A.6, APESMA Witness A.7 and Ms Malakozis, and which in broad terms deal with work load and type (including claimed new work) and education and registration requirements;

b. 5 findings identified at 6.1-6.5 of its Outline based on the evidence of Mr Crowther dealing with a range of issues relating to the rates of pay of community pharmacists; and

c. 7 findings identified at 9.1-9.7 of its Outline based on the APESMA Report – Part II dealing with the provision by pharmacists of what are described as "cognitive professional services" (**CPS**) and aspects of training to be able to provide such services.

26. In this Further Submission, the specifics of each of the various findings sought by APESMA are not individually addressed. There is considerable overlap across the material upon which APESMA relies and the various findings it seeks.

27. Volume of material and repetition of itself does not make the case for APESMA, nor does it enhance. The Commission must be satisfied that the relevant material disclosed over the relevant period is sufficiently probative to support a "significant net addition" to work requirements for each classification.

28. In this latter respect, APESMA at [7] of its Outline of 3 November 2016 distilled the matters relied on for its claim into 5 main categories:

a. An increase in various educational and registration requirements which are indicative of the increase in the skills, knowledge and responsibility required to perform the role of a pharmacist;

b. The introduction of additional training so a pharmacist can become and retain registration under the legislative requirements for registration of a pharmacist;

c. The introduction of new work that requires additional skills, knowledge and training;

d. The introduction of new work that has resulted in an increase in responsibility and accountability; and

e. An increase in workload and an increase in pressure and on skills and the speed with which vital decisions need to be made.

29. Notwithstanding the findings sought by APESMA, the 5 categories are an appropriate way for the Guild (and the Commission) to address the APESMA claim. The Guild's position on these categories is addressed further below.

30. To the extent the APESMA claim includes a new classification of Accredited Pharmacist, it has not sufficiently defined the proposed role, including importantly what would qualify a pharmacist to be so classified. This again is an issue on which the Guild reserves its rights.

The Guild's position

31. The Guild maintains that APESMA will not be able to make out that there has been the requisite "significant net addition" to the work of Pharmacists to warrant the increases claimed.

32. The Guild's position in terms of the 5 main categories on which the APESMA claim is based is addressed in the following paragraphs.

An increase in various educational and registration requirements which are indicative of the increase in the skills, knowledge and responsibility required to perform the role of a pharmacist

33. The most significant changes to the content of the Bachelor of Pharmacy qualification were already in place before the datum point. For example, the University of Sydney began transition to a 4 year degree in 1996, and courses in pharmacy practice had been introduced from the early 1990s.

34. To the extent the work of pharmacists may have changed or evolved to better reflect their education and training, the evidence does not support this claim.

Registration requirements have not increased or varied since the datum point in a way that supports the APESMA claim. The key elements of such registration continue to be a Bachelor of Pharmacy and satisfactory completion of an intern year.

The introduction of additional training so a pharmacist can become and retain registration under the legislative requirements for registration of a pharmacist;

35. The Guild relies upon its submission at [33]-[34] above.
36. Furthermore, better regulation of registration standards does not mean additional training is required. Continuing professional development, although perhaps not as now formalised or in some states previously mandatory, has always been a feature of pharmacy practice. Assessment against competency standards for registration purposes has been in place since 1994, being before the datum point. Revised competency standards since 1994 reflect the evolution of changes in health care services.
37. The Commission and its predecessors have long accepted a requirement to keep abreast of changes and developments in a profession is simply a requirement of such a role, "*and generally only some basic changes in the educational requirements can be regarded, of itself, as constituting a change in work value*" (*ARTBIU v Rail Commissioner* [2014] FWC 53 at [38]).

The introduction of new work that requires additional skills, knowledge and training

38. The Guild acknowledges that there have been changes in the health care services provided by pharmacists but affirms its position that these changes are evolutionary in nature and do not represent a "significant net addition" for work value purposes.
39. However, APESMA's claim that various items constitutes new work should not be accepted, other than perhaps the inoculations, clozapine clinics and provision of absence

from work certificates. Most of the claimed new tasks are well within, and always have been, the skill set of pharmacists achieved in their bachelor degree.

40. In this latter respect:
    a. Patient interactions and clinical intervention has always been part of the role of a pharmacist;
    b. Irrespective of down-scheduling or up-scheduling of medicines, the pharmacist has always needed to understand the nature, purpose and effect of those medicines, and advise on managing conditions;
    c. Working to quality standards is simply good practice (such as should ideally have always been in place).
41. Where training has been required (e.g. inoculations) it is not extensive and relies on the core clinical skills sets already held by a pharmacist.
42. Where accreditation may be required (Home Medicine Reviews (**HMR's**) and Residential Medication Management Review (**RMMR's**)) the actual function is (and always has been) within the core clinical skill set of a pharmacist, including the need to adhere to standard documentation. What is required is the pharmacist to be certified to that effect. This represents credentialing as opposed to further qualification.
43. Further, not all the claimed new tasks are applicable at all pharmacies and/or to all pharmacists, and nor are they undertaken at all times. Indeed, a number of the claimed new tasks will arise at only a limited number of pharmacies (e.g. sleep apnoea services and clozapine clinics), or at irregular intervals (e.g. emergency contraception).
44. In the case of HMR's and RMMR's only accreditation has been available since 1997, yet only approximately 10% of pharmacists are accredited[1].

[1] Australian Association of Consultation Pharmacy (AACP)

45. The work that might conceivably be categorised as new work (e.g. inoculations and absence from work certificates), is not sufficient to justify a significant net addition for work value purposes.

46. In considering the APESMA claim, the evidence also establishes that certain tasks are no longer done or done in more limited circumstances (e.g. compounding), and that technology has simplified a number of tasks (e.g. PBS claiming processes, scanning of prescriptions, stock administration, dose administration and availability of patient information).

47. Also of relevance is that since 1998 there are more community pharmacies (in 2017[2], 5665 compared with 4952) with almost the same service to person ratio as previously (3884 as opposed to 3782). Across this period of time there has also been a substantial increase (in 2017[3], 30360 compared with 16391) in the number of registered pharmacists, most of whom will be working in community pharmacies.

The introduction of new work that has resulted in an increase in responsibility and accountability

48. The Guild relies on its submission at [38] to [47] above.

An increase in workload and an increase in pressure and on skills and the speed with which vital decisions need to be made

49. The evidence of the APESMA witnesses does not support this claim.

50. Whilst the work of pharmacists has evolved, a number of factors have assisted in simplifying process, including in particular automated dispensing and scanning, automated reporting systems and greater use of computers for recording information and

[2] Department of Human Services, approved s90 pharmacies
[3] http://www.ahpra.gov.au/annualreport/2017/downloads.html#data

communication purposes. The work of technicians and pharmacy assistants has also extended to things previously done by pharmacists.

51. The statistics at [47] also support a conclusion that the workload of pharmacists is now shared across a substantially greater number of pharmacists. Where in an individual pharmacy workload may have increased that should be viewed as a staffing issue rather than an industry work value issue.

Additional considerations

52. In relation to the APESMA evidence, the APESMA Report – Part II cannot be accepted as expert evidence. With great respect to the authors, it reports on a survey of a small number (25) of unidentified pharmacists expressing views on aspects of their qualifications, training, the work they perform and issues for community pharmacists. There is no specialised knowledge required (or demonstrated) by the authors of such a survey. The sample size is also inadequate to enable the authors to reach statistically safe conclusions.
53. The survey presents as a contrived attempt to lend weight to the views of the APESMA "lay witnesses", but in circumstances where the Guild will have no opportunity to cross-examine participants in the survey, let alone knowing details of their actual role, background, where they work etc. Their evidence is therefore unreliable and ought not to be accepted.
54. At its highest, the APESMA Report – Part II records hearsay of anonymous participants, although much of it confirms the Guild's position, i.e:
    a. Not all identified tasks are performed by all pharmacists, or at all times – there are in particular, differences in work undertaken by pharmacists at smaller compared with larger pharmacies, or those in rural compared to metropolitan pharmacies;

b. The incidence of non-6CPA cognitive pharmacy services is not uniform, nor necessarily extensive (see p29);

c. The core 6 CPA tasks are neither new, nor require skills beyond the bachelor degree. For example, clinical interventions have always been required, with the change being in the documentation.

d. There has been an evolution in the work done by pharmacists to take into account changes in technology, medicine and market conditions.

55. The Crowther evidence and the findings APESMA seeks the Commission to make in relation to their evidence (see 6.1 – 6.5 of Outline of 21 December 2017, and in particular the matters at 6.1 -6.4 i.e. lower mean hourly rates in 2016 compared with 2011; lower growth in hourly rates; declining real value of wages and the difference in wages paid by discount pharmacies compared with non-discount banner groups) are simply not relevant to work value considerations.

    With respect the Crowther evidence is also of little if any relevance to either the modern award objective or the minimum wages objective. Community pharmacists are not low paid (as that term is used in the Act).

56. The Commission will be cautious to ensure that APESMA is not in fact pursuing an industry wage campaign in lieu of enterprise bargaining. The APESMA claim if granted will significantly increase employment costs for community pharmacies in circumstances where their viability from traditional services is reduced. This could arise not just from the wage rise sought, but by over-classification of employees disrupting workplace flexibility and productivity.

57. APESMA relies on the same block of evidence to support its claim for increases to all pharmacist classifications, as well as the creation of the new classification.

58. Without making any concession to the APESMA position, even if its position was to in part be accepted, a number of the matters relied on must be limited to those classified as Experienced Pharmacist or higher. The Federal Pre-reform Award introduced the classification of Experience Pharmacist in all states except Western Australia, the claim for such a classification having been rejected in 1996 by Commissioner O'Shea. There must be no double counting of matters considered at that time.
59. Whilst previous decisions dealing with classifications for community pharmacists are with respect somewhat brief, it is apparent that from the early-mid 1990s the work of pharmacists was understood to include methadone and needle exchange programmes, increased prescriptions, and the development of medication counselling (Decision of Drake DP 30 May 1995 *re an interim award*; Print M2399).

Conclusion

60. On the evidence, the Commission will not be satisfied that the APESMA claim and its supporting evidence is sufficient to support a variation to award minimum wages for Community Pharmacists in the Pharmacy Award is justified for "work value reasons." The proper view is that the work of Community Pharmacists has been subject to "*evolutionary*" change, but this has not resulted in a significant net addition for work value purposes.

Michael Seck
Counsel for the Pharmacy Guild of Australia
6 St James
18 April 2018

IN THE FAIR WORK COMMISSION

Review of the *Pharmacy Industry Award 2010*

APESMA WORK VALUE CLAIM

Matter No: AM2016/28

Applicant: Pharmacy Guild of Australia

I, [redacted] Pharmacist say on oath/affirm:

1. I make this affidavit in relation to the Association of Professional Engineers, Scientists and Managers Australia (**APESMA**) work value claim to vary minimum wages in the *Pharmacy Industry Award 2010* (**the Award**).

2. This affidavit by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Fair Work Commission. This affidavit is true and correct to the best of my knowledge and belief.

Background

3. I qualified with a Bachelor of Pharmacy from Curtin University in 1994. In 1995 I completed my intern year. I began practicing as a Pharmacist in 1996 and have practiced since this time.

4. I became a Pharmacist because the course description appealed to my strengths and I liked the idea of being able to assist the community with their healthcare needs, specifically through understanding medicines and their impact on disease processes.

5. From 1996 until 1998, I was engaged as a locum Pharmacist at a variety of locations.

6. In 1999 I became a proprietor of [redacted] Pharmacy in a partnership one other Pharmacist. In 2006 I became the sole Proprietor of [redacted] Pharmacy. I am still the sole proprietor of [redacted] Pharmacy. I am in the pharmacy on average three days per week, performing a variety of clinical and administrative tasks.

7. In 2010 I also became a proprietor of [redacted] Pharmacy in a partnership with one other Pharmacist. I do not work in this pharmacy but do perform all the administrative tasks including payroll and accounts.

8. [redacted] **Pharmacy**

9. [redacted] Pharmacy is located in [redacted], Perth, Western Australia.

10. The opening hours of the Pharmacy are as follows:

    a. Sunday:10am - 2pm;

    b. Monday:8am - 7pm;

    c. Tuesday:8am - 7pm;

    d. Wednesday:8am - 7pm;

e. Thursday:8am - 8pm;

f. Friday:8am - 7pm; and

g. Saturday: 8am - 6pm.

11. We employ

a. 3 Pharmacists;

b. 2 pharmacy assistants

c. 1 naturopath; and

d. 2 interns.

12. [redacted] **Pharmacy**

13. [redacted] Pharmacy in located in [redacted] Western Australia.

14. At [redacted] Pharmacy, we employ 1 pharmacist and 1 pharmacy assistant.

15. The opening hours of the pharmacy are as follows:

a. Sunday: CLOSED;

b. Monday:8:00am - 7pm;

c. Tuesday:8:00am - 7pm;

d. Wednesday:8:00am - 7pm;

e. Thursday:8:00am - 7pm;

f. Friday:8:00am - 7pm; and

g. Saturday: 8:00am - 5pm.

Pharmacist Rates of Pay

16. I pay all of my qualified Pharmacists above the minimum wage prescribed by the *Retail Pharmacists' Award 2004.*

17. I pay my employees above award as this is the market rate for good pharmacists.

Accredited Pharmacists

18. I do not employ any accredited pharmacists.

19. If I was to employ an accredited pharmacist I would not pay them more for their work in the pharmacy. I would pay them a separate allowance for any Home Medicine Review ("**HMR**") they conducted.

20. All of my pharmacists are accredited to provide influenza vaccinations but they are not paid more because of this accreditation.

Pharmacist Duties since 1998

21. Pharmacists have been responsible and accountable for the safe and judicious use of medicines since the inception of community pharmacy. In today's litigious society there is a greater need to record, document and be able to justify the actions of a pharmacist both to receive Government payments and in case of misadventure, but this is a situation occurring across the board in most industries.

22. Since 1998, there has been an increase in the level of funding offered by the Federal Government for services offered in community pharmacy. The Federal Government has recognised that pharmacists have a skill set that enables them to perform these professional services which enhance community health outcomes and has developed a payment mechanism for some of these services, including home medicines reviews, Medschecks, staged supply, clinical interventions and dose administration aids, by way of government funding. Most pharmacies were performing the majority of these services prior to Government funding streams; the funding is more a recognition of the contribution of pharmacists to community health, and to get pharmacists to record these activities, not really to encourage more pharmacies to do them.

23. The tasks which are now funded by government were performed in pharmacy in 1998; it's just that they were either offered free to consumers or were available on a fee for service basis. The services may not have required the same level of documentation previously, as there was no claim for government funding as there is now.

24. Pharmacists now routinely perform services outside of dispensing and counselling that were still performed but were less commonplace 20 years ago, such as point of care testing and formal Medschecks, but these are duties that a Pharmacist was always educated and qualified to perform. The increased prevalence of these duties is also offset by a greater number of dispensary staff, including dispensary technicians and multiple pharmacists, who share the load. You could argue that this means the pharmacist-in-charge has more responsibility in managing personnel, but this is not the role of the Pharmacist in Charge in all stores. Ultimately the pharmacist is legally responsible for themselves and their own work as they've always been.

25. Pharmacists can now administer influenza vaccines, plus other vaccines in some jurisdictions. A pharmacist always dispensed the vaccination, however now they are able to also administer the injection itself.

26. Improvements in technology such as automated dispensing and scanning has improved dispensary speed, efficiency and accuracy.

27. Developments in dispensing software have made it easier to assess the suitability of a medicine for a patient with script history, allergies and interactions with other medication more readily apparent. Similarly, reporting systems have advanced to improve ordering efficiency. This has also streamlined Government reporting and PBS claiming.

28. I am aware that automated systems exist for packing dosage administration aids but our pharmacies do not use one. We use a computer to record medication profiles and track a virtual pill count for patients. Pharmacies used to dispense the medication and

quarantine the medicines for each patient in a separate box or basket as a means of keeping track of what tablets they have left. Now the dispensed medicines are stored together in a mini dispensary and the number of tablets belonging to each patient is tracked via a virtual pill count. This is much more efficient and saves considerably on space.

29. Computers are used in a greater capacity to record information and communicate with patients, including script management and ordering via smartphone apps.

APESMA claim concerning work value changes

30. I am aware that APESMA says there has been a significant amount of new work under taken by pharmacists.

31. I have reviewed the list of "new work" APESMA claims is being undertaken in their submission dated 5 April 2017 and the administration of vaccine injections is the only "new work" identified by APESMA that has required me to undertake additional training over and above my degree.

32. Everything else listed (aside from HMR's and Residential Medication Management Review's (**RMMR**) which I am qualified to do but not accredited to do) I have performed in one way, shape or form since graduating. Some services are performed as formal consultations with a recording process whilst others are done ad hoc and perhaps more informally as part of counselling, but they certainly haven't required further education. Instruction on how to conduct a sleep study, set up a compounding lab or record a clinical intervention is a process issue, not an education or qualification one. All pharmacists are capable of doing these things regardless of when they completed their degree. This is aside from continuing professional development which I have always seen as just part of my professional responsibility.

33. My pharmacists perform the majority of these tasks in one way or another on a daily basis and have done since 1998. I couldn't possibly assign a portion of time as they are seamlessly integrated into our workflows and are viewed as part of our pharmacist toolkit with which we can assist and improve the health outcomes of our patients, depending on their individual needs.

34. HMR's and RMMR's are medication reviews performed in the patient's home or residential facility from which recommendations are made and reported back to the doctor. They are not dissimilar to a Medscheck however they do allow the pharmacist to make observations regarding the storage or medicines, hoarding of medicines, medication adherence and complementary medicines. Accreditation to perform these reviews requires the pharmacist to prove clinical skills and adherence to a standardised documentation process. It does not require any special skills over and above those possessed by an average Pharmacist; it just requires them to undertake a process to gain a certificate.

35. Asthma and diabetes management programs are highly variable. In some instances they may involve making sure the patient has an asthma action plan or understands how to use their blood glucose meter correctly. In other instances the service may be restricted to making sure the patient takes their medicines appropriately. Counselling

and providing advice on these conditions is part of being a pharmacist and has been since I commenced practice. There are very few pharmacies providing specialised services in these areas where they have undertaken advanced training to provide a niche service. If and when the Government decides to fund a more formalised service most of the training will be process driven or refresher in nature as pharmacists already have the necessary clinical skills.

36. Clinical interventions involve the everyday work of a pharmacist in identifying actual or potential problems with medicines or medication regimes and making recommendations to avoid future harms or to improve outcomes. We've always done clinical interventions; the only difference is that now we record them.

37. Dose administration aids involve repacking medications into a blister or sachet form whereby all medicines that are taken at a particular time of the day are packaged together and clearly marked. I was doing dose administration aids using the same system I use now in my intern year in 1995. The only thing that's changed about dose administration aids since 1998 is that now we use a virtual pill count system instead of a separate box of medicines for each patient. This service is usually outsourced by pharmacies that do a lot of them.

38. Sleep apnoea services involve wiring up a patient to conduct a sleep study in their own home to identify the presence of sleep apnoea. All pharmacists understand sleep apnoea; this is a part of the university course requirement. The provision of sleep apnoea services has become possible due to advances in technology such as portable testing units with improved sensitivity and less false positives. Conducting a sleep study and sleep trial is largely a process driven task with minimal clinical training necessary. A sleep physician provides the actual diagnosis and the pharmacist has a support role in communicating with the patient as well as fitting and setting up machines.

39. Compounding services involve manually preparing a medication dosage form that does not currently exist as a proprietary product. All pharmacists have done compounding in their degree since the dawn of time. Setting up a compounding service is just doing it on a grander scale and usually with the assistance machines.

40. Weight management services in pharmacy are usually confined to meal replacements and weigh ins, often conducted by non-pharmacists. All pharmacists can give advice on healthy eating.

41. Blood pressure level tests and blood glucose level tests involve testing the blood pressure or blood glucose levels of a patient at that moment in time then interpreting the results. Point of care testing has been occurring since the machines were invented which was before I graduated.

42. Smoking cessation services involve providing advice on the most effective use of nicotine replacement therapies. Occasionally it also involves carbon monoxide testing. Rarely it involves a consultative service. In pharmacy smoking cessation services are largely limited to providing advice on nicotine replacement products. Only a handful of pharmacies provide any formalised service involving counselling and cognitive

behavioural therapy. I'm not aware of any pharmacies providing these services in my region.

43. Diagnosis and treatment of minor ailments such as colds and flu, minor aches and pains, hayfever, minor skin irritations and wounds, and if necessary referral of patients to their treating medical practitioner, is not new in any way, shape or form.

44. Down-scheduling is changing the class of a medicine from prescription only to over the counter. With the down scheduling of a large number of previously prescription only medicines pharmacists may now diagnose and treat conditions such as bacterial conjunctivitis, nausea related to migraine, medicated weight loss treatments, provision of pump inhibitors for treatment of gastro-oesophageal reflux disease, nasal decongestants, providing emergency contraception, oral antiviral treatments for cold sores, oral treatments for vaginal thrush and the provision of Naloxone for the emergency treatment of acute opioid overdose. A pharmacist had to learn about these drugs when they were on prescription, not much changes when they are down scheduled. Pharmacists are already fully conversant in these medications and the conditions they are used to treat, regardless of their scheduling.

45. Quality Care Pharmacy Program is a quality assurance program for community pharmacy that provides support and guidance on professional health services and pharmacy business operations. This is not a new form of work, just working under a set of standards to ensure quality outcomes. This isn't a change to the duties or work of a pharmacist it's just a means of ensuring good practice.

46. The introduction of clozapine clinics involves moving clozapine maintenance prescribing and supply out of the hospital setting into the community. Pharmacists simply have to follow a process for recording pathology results into a database prior to supply. This only affects a small number of pharmacists and basically amounts to making sure patients have had the necessary blood tests prior to supply of medication.

47. Pharmacists have been able to issue absence from work certificates since 2009. Providing absence of work certificates and the skills needed to assess the patient before issuing them are not new skills, these are skills routinely used by a Pharmacist. The only training required was how to fill out a form.

Aspects of work no longer performed

48. Most pharmacies weren't doing any significant compounding in 1998, and certainly nothing terribly complex, but comparatively now compounding pharmacies are doing more and regular pharmacies are doing less.

49. In 1998 more things were manual including PBS claims, scheduled medicine recording and reporting, ordering and stocktaking, to name a few. The main thing we don't do now that we did in 1998 is make a viable profit from dispensing.

50. PBS data will tell you that prescription volumes have increased by less than 25% in the last 15 years, but this increase has not been proportionally distributed amongst all pharmacies. Some pharmacies have become very busy whilst others are less so.

51. In the main, any increase in pressure has originated from the unrealistic expectations of owners and managers who, in a quest to meet KPIs and cost ratios, are not employing adequate numbers of staff. This is a management issue, not a question of the pharmacist being universally expected to do more. In contrast, many other pharmacies have employed additional pharmacists and technicians to share the workload so pharmacists in these environments usually feel less pressure and more supported than in the common single pharmacist enterprises of 1998. On average, in my experience a typical pharmacist is dispensing less prescriptions and performing more patient services than 20 years ago, a situation that most pharmacists find both engaging and professionally rewarding.

52. Technology has vastly streamlined the dispensing and reporting processes, assisting the pharmacist to be faster and more accurate. Increased levels of support staff have also created time for the pharmacist to spend with the patient.

53. The ageing population and increasing disease burden has created opportunities for the pharmacist to employ their full training and skill set to screen, manage and mitigate chronic disease in the community. Far from increasing work pressures most pharmacists embrace this opportunity and the satisfaction they derive from having meaningful interactions with their patients to have a positive impact on their health.

54. Whilst the increased recording and reporting requirements have meant changes to the workflow of pharmacies and a shift in the mindset of pharmacists, this burden is generally offset by the increase in staffing levels and technological support.

55. The workload pressures that some pharmacists feel from being in an environment where there is insufficient staffing and excessive expectations to meet KPIs should not be confused with an overall increase in the scope and value of the work of a pharmacist.

Pharmacy Accessibility

56. The removal of the step up dispensary and the addition of pharmacy technicians and automated dispensing have allowed pharmacists to have greater interaction with their patients, however this can be controlled to a level the pharmacist is comfortable with. Pharmacies that don't prioritise pharmacists consulting with patients will put their dispensary behind the serving counter, thus creating a physical barrier. Those that value the interaction will welcome patients being able to approach the dispensary and design their pharmacies accordingly.

57. In my experience the expectation of patients that they will be able to speak directly to a pharmacist is largely matched by the expectation of pharmacists that they will have sufficient time to spend with their patients to adequately meet their needs. Pharmacists that don't embrace patient contact will become more like a dispensary technician and those that do, put themselves front and centre to patients. It is still largely a choice, although on the whole pharmacy is moving toward being a personal service industry. Most pharmacists are happy with this evolution. It hasn't increased the workload of pharmacists, merely changed the dynamic.

58. There has not been a significant net addition to the work or responsibility of pharmacists since 1998. Over the 22 years of my career my role as a pharmacist has evolved into one that more befits the education and training I received with my degree. The pharmacist of today more closely resembles the expectation I had of what my career would look like and I am using the skills I learned at university more frequently now. All the roles of a modern pharmacist as described by APESMA, with the exception of vaccinations, I have been able to perform without the need to undertake additional training that is not of a procedural or conceptual nature. To suggest that all the tasks outlined by APESMA are new roles not previously performed by a pharmacist would be to suggest that my degree does not qualify me to be a pharmacist in 2018, which is clearly not the case.

59. As the needs of the community and the Government has changed, so the role of the pharmacist has adapted to meet these needs but there has not been a paradigm shift in the practice of pharmacy. Rather there has been a gradual evolution of the role to embrace different aspects of a pharmacist's knowledge and expertise, to meet evolving patient expectations and for the betterment of community health.

#SWORN #AFFIRMED
At [place]
On [date]
Signature of deponent
Name of witness
On [date]
Address of witness
Capacity of witness

[redacted]

And as a witness, I certify the following matters concerning the person who made this affidavit (the **deponent**):

1 #I saw the face of the deponent. [OR, delete whichever option is inapplicable]
~~#I did not see the face of the deponent because the deponent was wearing a face covering, but I am satisfied that the deponent had a special justification for not removing the covering.[1].~~

2 #I have known the deponent for at least 12 months. [OR, delete whichever option is inapplicable]
~~#I have confirmed the deponent's identity using the following identification document:~~

Identification document relied on (may be original or certified copy)[2]

Signature of witness [redacted]

[1] The only "special justification" for not removing a face covering is a legitimate medical reason.]

[2] "Identification documents" include current driver licence, proof of age card, Medicare card, credit card, Centrelink pension card, Veterans Affairs entitlement card, student identity card, citizenship certificate, birth certificate, passport or see Oaths Regulation 2011 or refer to the guidelines in the NSW Department of Attorney General and Justice's "Justices of the Peace Handbook" section 2.3 "Witnessing an affidavit" at the following address: http://www.jp.nsw.gov.au/Documents/jp%20handbook%202014.pdf]

IN THE FAIR WORK COMMISSION

Review of the *Pharmacy Industry Award 2010*

APESMA WORK VALUE CLAIM

Matter No: AM2016/28

Applicant: Pharmacy Guild of Australia

I, [redacted], Pharmacist ~~say on oath~~/affirm:

1. I make this affidavit in relation to the APESMA work value claim to vary minimum wages in the *Pharmacy Industry Award 2010* (**the Award**).

2. This affidavit by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Fair Work Commission. This affidavit is true and correct to the best of my knowledge and belief.

Background

3. I am a Pharmacist and a Partner of [redacted]

4. I have worked at [redacted] since around 1997.

5. I obtained a Bachelor of Pharmacy in 1986 and registered as a pharmacist in 1987 after a year of training in hospital pharmacy

6. I have always had a strong interest in science and healthcare which is why I felt a calling to pharmacy.

7. Operating a pharmacy business is an opportunity for me to have a direct influence on a patient's life and the health of my community, and I feel a sense of responsibility to ensure I am providing the highest quality services at all times.

[redacted] Pharmacy

8. [redacted] Pharmacy is open from 8am until midnight every day.

9. We diagnose, treat and care for patients and have never shut early in 25 years. That reliability is a combination of us discharging our duty of care to the public, but also a result of the ownership of the business by me and not a corporate entity with a focus on profitability at the expense of providing a community service.

10. We employ 22 staff consisting of:

    a. Two full time Pharmacist Managers;

    b. Ten part time Pharmacists

    c. One Pharmacy Intern;

    d. Three Pharmacy students (one second year and two third year);

e. One Level 2 Pharmacy Assistant;

f. Two Level 3 Pharmacy Assistants; and

g. Three Level 4 Pharmacy Assistants.

11. All staff is covered by the Award.

Pharmacist Rates of Pay

12. I pay every pharmacist I employ above the Award rate. I understand that the Award rate is the minimum rate for duties performed at a certain level. The Award rate does not reflect how well those duties are performed. I pay my pharmacists more to reward good work and to secure good staff.

Changes in work from 1998 to now

13. Work has evolved for pharmacists over the last 20 years but essentially the core tasks have stayed the same. We supply to patients medicine on prescription, check it is safe and appropriate, and also recommend to them additional measures and products if required.

14. Over the years the drugs change somewhat, and so do the directions for their use sometimes but this has always been the case and is why continuing professional development remains essential.

15. The way pharmacists have performed their work has evolved. When I started in community pharmacy the pharmacist stood on a raised step behind the counter and would come down to the counter to talk to patients. The step isn't there in many pharmacies now. My employed pharmacists and I will still often speak to patients at the counter, but we will also often speak to them on the floor of the store. It's not a change or addition in duties, skill level or responsibility it's just more friendly, caring and makes good business sense. However, the need to talk to patients, understand their health issues and relevant medicines and their effects has been part of the role of the pharmacist since I started practice.

16. Technology has impacted every job I can think of, including community pharmacy. Computers have changed everything and so have printers, which are so quiet and smaller compared to the old dot matrix printers. Information is often more readily available now and hence current, but it is important to choose reliable sources.

17. When I started out in pharmacy you had to remember and almost know off the top of your head a lot of information about various drugs and medications. Now, although there are more drugs and medications available, you can quickly and easily look up information on Mims about them on the computer in the store.

18. The level of responsibility and accountability of employed pharmacists has not in my experience changed since 1998.

19. We made up lots more extemporaneous medicines in 1998 compared to now. Although I am not a 'compounding pharmacist' I see far fewer scripts that need to be

[redacted]

compounded. This is partially because I am not a compounding pharmacist but also because fewer doctors write scripts that require this service.

Other Services

20. [redacted] Pharmacy provides a range of community health services to its patients. Just one example is wound dressings – if people can have that done at the local pharmacy they do not have to wait long hours to see a doctor or a nurse at medical centre. It is a relatively straightforward task and is performed by a pharmacist or trained pharmacy assistant under the supervision and direction of the pharmacist. We have been offering this service for some time. It can increase the workload of the pharmacist on duty but does not require additional responsibility or accountability.

21. In about 2008 we started issuing medical certificates for patients, which has been an extremely popular service for them. People can walk in and see a pharmacist straight away rather than waiting hours to see a doctor in the medical clinic next door. There is also the possibility that the medical clinic will not be open. The issuing of the certificate is a relatively straightforward task drawing on the existing skills of the pharmacist to talk to a patient and understand their health issues.

APESMAs list of new work

22. I am aware that APESMA says that there is a significant amount of new work undertaken by pharmacists. I disagree.

23. Most pharmacists do not do home medicine reviews or residential management reviews. None of my employed pharmacists perform that work. To some extent it was done informally in the past. In my opinion it is and always was within the capability of pharmacists, it's simply now that formal training is required to claim it via the PBS.

24. Pharmacists have always dispensed inoculation drugs. In dispensing the vaccine the pharmacist has always had a discussion with the patient about the medication, the potential side effects and what to expect. Now some pharmacists, who have specific training, can inject some inoculation drugs, like the flu shot. It is a small additional component added onto what pharmacists already do, but consistent with the health care services pharmacists have always provided.

25. Asthma and diabetes management programs are also not new to pharmacy, although the medical treatment has changed. I recall when I started out in pharmacy providing advice and information about the use of Ventolin inhalers. A script was required for Ventolin then. A script is no longer required for Ventolin and I regularly provide advice about the use of spacers to inhale the medication. There are other preventative medications for asthma now too that I dispense. That is no more complicated than dispensing any other drug, and within the basic skill of a qualified pharmacist.

26. A pharmacist has always performed clinical interventions although they are now recorded more formally to document how often they happen and the pharmacy can be remunerated for them now.

27. Dose Administration aids are not new. The old plastic pill containers with each day labelled on a flip lid are now largely replaced by blister packs. This is a good example

of an evolutionary technological development that has not increased responsibility just because it goes into a different container.

28. Sleep apnoea services are not provided in my pharmacies, or to my knowledge in many pharmacies generally due to commercial considerations.

29. Compounding services are of course not new, and in fact they are significantly reduced. We all learnt compounding when I did my undergraduate degree, and it is still part of the program. Now, because it isn't required as much is treated as if it was a specialist task.

30. Weight management services require talking to patients, understanding their needs and providing them with appropriate advice and products to meet that need. It's exactly the same thing we do with all medication and treatments. It is not an additional skill or level of accountability.

31. Many pharmacists but not all perform blood pressure level tests. We have always had the capacity and knowledge to check and counsel on blood pressure levels. The newer devices have just made the task easier and quicker. Most GPs also now use the newer automated blood pressure machines. Conducting the test is simple. It has In fact become significantly easier. Now a button is pressed after the cuff is applied and the technology shows the result. There is no longer manual pumping required or the need to read a dial. However, the important part has always been understanding the reading and what to do with the result. This is the pharmacist's role and that has not changed, it's just that taking the measurement is easier.

32. The same goes for blood glucose tests. Technology has made them simpler. The pharmacist's role in providing advice has not changed.

33. Smoking cessation services are not new. Gum was first available in Australia in about 1987 and required a prescription. It was crazy that you needed a prescription to buy nicotine gum but not cigarettes. As an example of the evolutionary and inevitable change the gum is now available over the counter. Our role has not changed being to help people to quit smoking, and provide appropriate advice and recommend appropriate medication.

34. Pharmacists have always assisted patients by diagnosing and treating minor ailments such as colds and flu, minor aches and pains, hay fever, minor skin irritations and wounds. It's again really just that the products have developed and changed.

35. Down scheduling of drugs that previously required a prescription has not affected the job of a pharmacist, in terms of skill, overall workload or responsibility. Just like nicotine gum becoming available without a prescription and now available over the counter, it is still the job of a pharmacist to talk to the patient about the drug.

36. It is not very common for a person to request emergency contraception in most pharmacies (the morning after pill). On the occasions it does occur the pharmacist is simply responsible for ensuring that the medication is appropriate and safe. That is the case with all medications and it is part of being a pharmacist.

[redacted]

37. The introduction of quality standards, with QCCP, has formalised what we have all aspired to but not in itself added to workload or the responsibility/accountability of a pharmacist.

38. Many patients get their clozapine prescribed at the GP clinic. Treatment with most drugs is dynamic and changes as ideas change, research is done and experience is gathered.

39. To undertake recording and providing absence of work certificates, a pharmacist does need to assess the patient before issuing them. These are not new skills. Pharmacists have always assessed how sick or how well people are, now we can formally do it, which saves the patient taking GP time.

40. I am sure that in 1998 I felt just as responsible and accountable as a pharmacist as I do today. That's because people's health is important and always has been. We are just as accountable and responsible; largely the use of technology has hastened outcomes.

41. I do not believe that there has been an increase in the workload and an increase in pressure and speed in which vital decisions are made. For me it can feel like there is some increased pressure when I work on a busy day and I am dealing with telephone calls, customers and staff all needing my attention. However that is not new, and was the same when I was working 20 years ago. Prioritising tasks and managing workflow has always been part of the job.

42. In my experience patient accessibility to the pharmacist varies with the pharmacy and the pharmacist. It needs to be managed with the workflow of the business; this has always been the case. Twenty years ago, and still today, I can't spend enough time with some people in some situations.

43. In my view, overall, there has not been a significant net addition to the work, accountability or responsibility of a pharmacist. In some cases pharmacists are spending more time talking to patients, however technology has meant they now spend less time in other areas, for example with a tap of a keyboard I can quickly retrieve and print patient history or provide a receipt for private health insurance or a consumer medicine information leaflet.

[redacted]

#SWORN ~~#AFFIRMED~~

At [place] BRUNSWICK

On [date] 18/4/2018

Signature of deponent [redacted]

Name of witness **AMY YU**

On [date] 18/4/2018

Address of witness 70 Sydney Road, Brunswick, Victoria 3056
An Australian Legal Practitioner within the meaning of the Legal Profession Uniform Law (Victoria)

Capacity of witness [~~#Justice of the peace~~ #Solicitor ~~#Barrister #Commissioner for affidavits #Notary public~~]

And as a witness, I certify the following matters concerning the person who made this affidavit (the **deponent**):

1 #I saw the face of the deponent. [OR, delete whichever option is inapplicable]

~~#I did not see the face of the deponent because the deponent was wearing a face covering, but I am satisfied that the deponent had a special justification for not removing the covering.~~[1]

2 ~~#I have known the deponent for at least 12 months.~~ [OR, delete whichever option is inapplicable]

#I have confirmed the deponent's identity using the following identification document:

DRIVERS LICENSE

Identification document relied on (may be original or certified copy)[2]

Signature of witness

AMY YU
70 Sydney Road, Brunswick, Victoria 3056
An Australian Legal Practitioner within the meaning of the Legal Profession Uniform Law (Victoria)

[1] The only "special justification" for not removing a face covering is a legitimate medical reason.]

[2] "Identification documents" include current driver licence, proof of age card, Medicare card, credit card, Centrelink pension card, Veterans Affairs entitlement card, student identity card, citizenship certificate, birth certificate, passport or see Oaths Regulation 2011 or refer to the guidelines in the NSW Department of Attorney General and Justice's "Justices of the Peace Handbook" section 2.3 "Witnessing an affidavit" at the following address: http://www.jp.nsw.gov.au/Documents/jp%20handbook%202014.pdf]