FAIR WORK COMMISSION

Attachment AC-14 of Alex Crowther's Statement (A.9) has been amended - pages 3 to 20 were previously missing. Updated 3 May 2018.

4 Yearly Review of Modern Awards

Matter No.: AM2016/28

Pharmacy Industry Award 2010

Submissions and Lay Evidence

Outline of findings APESMA Submit should be made based on Lay Evidence

Association of Professional Engineers, Scientists and Managers, Australia (APESMA)

DATE: 21 December 2017

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INTRODUCTION

1. This submission is filed by the Association of Professional Engineers, Scientists and Managers Australia ***(APESMA)*** in accordance with the Directions issued by Vice President Hatcher on 28 August 2017.[1]

2. These Directions require APESMA to file its lay evidence, any other documentary material upon which it intends to rely and an outline of submissions.

LAY EVIDENCE

3. Attached at Appendix 1 are the Statements of:

   3.1. Dr. Geoffrey March (Marked as A.1)

   3.2. Ms Carmel Mac Callum (Marked as A.2)

   3.3. Ms Jennifer Madden (Marked as A.3)

   3.4. Mr Leon Yap (Marked as A.4)

   3.5. [redacted] (Marked as A.5) (Please Note: this Witnesses Statement is the subject of an application for a Confidentiality Order. Please respect this witness's confidentiality)

   3.6. [redacted] (Marked as A.6) (Please Note: this Witnesses Statement is the subject of an application for a Confidentiality Order. Please respect this witness's confidentiality)

   3.7. [redacted] (Marked as A.7) (Please Note: this Witnesses Statement is the subject of an application for a Confidentiality Order. Please respect this witness's confidentiality)

   3.8. Ms Katerina Malakozis (Marked as A.8)

[1] https://www.fwc.gov.au/documents/sites/awardsmodernfouryr/am201628-dir-280817.pdf

3.9. Mr Alex Crowther (Marked as A.9)

4. Attached at Annexure 'A.10', is the second part of the Report from the Faculty of Pharmacy at the University of Sydney as foreshadowed in the Addendum to the Outline of submission and Expert Evidence filed by APESMA on 5 April 2017[2].

4.1. This Report is titled 'The Work Value of a Community Pharmacist - Part II: Semi Structured Interviews'. It was conducted by Professors Aslani and Krass along with Dr. Vivien Tong from the Faculty of Pharmacy at the University of Sydney. (The Curriculum Vitaes for Professors Krass and Aslani were attached to the submission filed by APESMA on 5 April 2017. They can be found at Annexures 'A' and 'B' of that submission.)

4.2. This Report contains the findings from interviews of 25 pharmacists who undertake 'professional services'.

FINDINGS SOUGHT TO BE MADE FROM THE LAY EVIDENCE

5. APESMA seeks that the Commission make the following findings from the evidence provided in the Statements Annexed and Marked as A.1 to A.9 inclusive.

5.1. That there have been significant net increases in the work requirements for all of the Pharmacy Intern, Pharmacist, Experienced Pharmacist, Pharmacist in Charge and Pharmacist Manager classifications currently contained in the Pharmacy Industry Award 2010 (PIA).

5.2. That there has been 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.

5.3. The introduction of the Quality Use of Medicines (QUM) into the National Medicines Policy in 1999 resulted in significant changes to both the philosophy of

[2] https://www.fwc.gov.au/documents/sites/awardsmodernfouryr/am201628-sub-apesma-050417.pdf

pharmacy practice and the actual practice itself. It led to significant changes and increases in the skill and qualification requirements for pharmacists. This is outlined in the Statement of Dr. March (A.1).

5.4. The changes include an increase in the undergraduate course requirements including an increase in the minimum number of years required to undertake the qualifications from three to four. This is evidenced by the difference between the Statement of Mr. Yap (A.4) and Ms. Thomson (A.5).

5.5. There has also been an increase in the breadth and complexity of undergraduate course requirements:

5.5.1. particularly the inclusion of topics such as pharmacists' roles and responsibilities; communication theory and skills development; cultural sensitivity; behavioral theory and application; problem solving skills including the basis of the pharmaceutical care model. This is evidenced by the Statement of Dr. March (A.1);

5.5.2. these increases in the undergraduate course requirements are also evidenced by a comparison between the undergraduate degree undertaken by Mr. Yap (A.4) and that of Ms. Thomson (A.5). This comparison shows that Ms. Thomson undertook additional topics, particularly those relating to social pharmacy, forensics, pharmacy legislation, pharmacotherapeutics, integrated dispensing and novel therapeutics, and that the course requirements were much more onerous than those undertaken by M. Yap, including by having a third year curriculum which was required to be completed by studying full-time.

5.6. That there has been an introduction of additional registration requirements in order to become registered as a pharmacist and to remain registered as a pharmacist. The additional requirements for a graduate pharmacist to gain full registration as a pharmacist is evidenced by a comparison between the Statements

of Mr. Yap (A.4) and Ms. Thomson (A.5). In Ms. Thomson's Statement she details the current requirements for a graduate pharmacist to gain full registration as a pharmacist. Mr. Yap in his Statement (A.4) outlines the requirements for a 1998 graduate to gain full registration as a pharmacist. The comparison between these two statements shows that the current requirements are much more stringent with there being requirements to undergo significantly more rigorous on the job training; attend training and study with a registered training provider and to sit two formal examinations (one written and one oral).

5.7. There has been an introduction of a significant amount of new work that requires additional skills, knowledge and training. These changes are outlined in all of the Statements of Dr. March (A.1); Ms McCallum (A.2); Ms Madden (A.3); Mr. Yap (A.4); [redacted] (A.6); [redacted] (A.7); and Ms. Malakozis (A.8). The new work requiring additional skills outlined in these statements includes:

5.7.1. Home Medicine reviews (HMR)

5.7.2. Residential Medication Management reviews ((RMMR)

5.7.3. Medschecks

5.7.4. Inoculations

5.7.5. Asthma and Diabetes Management Programs

5.7.6. Clinical Interventions

5.7.7. Dose Administration Aids (DAA)

5.7.8. Sleep apnoea services

5.7.9. Compounding services

5.7.10. Weight management services

5.7.11. Blood Pressure Level tests

5.7.12. Blood Glucose Level checks

5.7.13. Smoking cessation service

5.7.14. Diagnose and treat minor ailments such as colds and flu, minor aches and pain, hay fever, minor skin irritations and wounds and, if necessary, refer the patient to a medical practitioner.

5.7.15. With the 'down-scheduling' of a large number of medicines (i.e. those that previously were only able to be dispensed with a prescription from a registered prescriber) pharmacists must now diagnose and treat if appropriate or refer a patient to a doctor conditions such as Bacterial conjunctivitis (Chloramphenicol), Nausea related to migraine (Metoclopramide and Prochlorperazine), medicated weight loss treatments (Orlistat), provision of Proton pump inhibitors (PPI's) for the treatment of Gastroesophageal Reflux Disease (GORD), nasal decongestants (facilitated with the use of Project Stop), providing Emergency Contraception (the morning after pill), oral antiviral treatments for cold sores (Famciclovir), oral treatments for vaginal thrush (fluconazole), and the provision of Naloxone for the emergency treatment of acute opioid overdose.

5.7.16. The provision of Emergency Contraception (known as the 'morning after pill') requires pharmacists to be able to determine not only that the product will be appropriate, safe and effective for the particular patient, but also to be able to asses and assist in cases where the patient may be underage and/or there is the possibility that a sexual assault has taken place. This requires specialist communication skills and knowledge of local sexual health clinics, sexual assault services, as well as the requirements for mandatory reporting of suspected cases of child sexual abuse.

5.7.17. The introduction of Quality Standards into the workplace with the introduction of the Quality Care Pharmacy Program (QCPP). (Pharmacies

who wish to receive funding under the Community Pharmacy Agreement (6CPA) for provision of what is known as 'professional services' must be registered as QCPP pharmacies.)

5.7.18. The introduction of Clozapine clinics. (Clozapine is an antipsychotic drug that requires regular blood monitoring and other special monitoring in order to treat a patient safely.)

5.7.19. Recording and Provision of Absence from work certificates and the skills needed to assess of the patient before issuing them.

5.8. There has been an introduction of new work that has resulted in an increase in responsibility and accountability. This is outlined in the Statements of Dr. March (A.1); Ms McCallum (A.2); Ms Madden (A.3); Mr. Yap (A.4); [redacted] (A.6); [redacted] (A.7); and Ms. Malakozis (A.8). The new work requiring an increase in responsibility and accountability outlined in these statements includes:

5.8.1. Increased opioid treatment programs and regulation requirements associated with this program have resulted in pharmacists having additional regulatory requirements and responsibilities.

5.8.2. The introduction of Inoculations has resulted in pharmacists having responsibility for adverse reactions etc. from the inoculations they give.

5.8.3. The introduction of Asthma and Diabetes Management Programs have resulted in pharmacists having responsibility for adverse health outcomes from the advice and treatment they give.

5.8.4. The introduction of Blood Pressure Level tests has resulted in pharmacists having responsibility for adverse outcomes if they have not properly advised and treated a patient they have tested

5.8.5. Blood Glucose Level checks has resulted in pharmacists having responsibility for adverse outcomes if they have not properly advised and treated a patient they have tested.

5.8.6. The increased and new requirement for pharmacists to diagnose and treat minor ailments such as colds and flu, minor aches and pain, hay fever, minor skin irritations and wounds etc., rather than simply serving patients with these symptoms, which has resulted in pharmacists having responsibility for adverse health outcome if they have not properly advised and treated the patient.

5.8.7. With the 'down-scheduling' of a large number of medicines (i.e. those that previously were only able to be dispensed with a prescription from a registered prescriber) pharmacists having responsibility for adverse health outcomes if they have not properly advised and treated the patient.

5.8.8. The introduction of Emergency Contraception (known as the 'morning after pill') has placed a new and additional responsibility on pharmacists to asses and assist patients may be underage and/or there is the possibility that a sexual assault has taken place to be referred to the appropriate service providers and to report any suspected cases of child sexual abuse.

5.8.9. The introduction of Quality Standards into the workplace with the introduction of the Quality Care Pharmacy Program (QCPP) has placed an additional level of responsibility on Pharmacists in Charge and Pharmacist Managers to ensure their pharmacy complies with all of the requirements of this program.

5.8.10. The introduction of Clozapine clinics has introduced an increased responsibility on pharmacists to ensure that patients receive blood monitoring and that they are being treated safely.

5.8.11. The introduction of Absence from Work Certificates that can be signed by a pharmacist has introduced a new responsibility of diagnosing a patient's illness and assessing whether the patient is not fit to attend work before signing these certificates.

5.9. There has been an increase in workload and an increase in pressure and the speed with which vital decisions need to be made. These increases are outlined in all of the Statements of Ms McCallum (A.2); Ms Madden (A.3); Mr. Yap (A.4); [redacted] (A.6); [redacted] (A.7); and Ms. Malakozis (A.8). The increases in workload and pressure outlined in these statements include:

5.9.1. An increase in the number of prescriptions being prescribed.

5.9.2. An increase in co-morbidity which makes dispensing of medicines more complex and difficult.

5.9.3. An increase in the different types of new functions performed by pharmacists (outlined above) has resulted in making additional demands on their time and the need to prioritize the work they are doing in an already complex environment.

5.9.4. An increase in the regulatory and legislative requirements for dispensing and providing treatment to patients.

5.10. That the introduction of the Accredited Pharmacist qualification requires those who obtain it to undertake significant additional training and that they have additional ongoing registration requirements to that of a registered pharmacist. (It should be noted that only pharmacists who have obtained this qualification are authorized to conduct HMRs and RMMRs.) These additional educational requirements are outlined in the Statements of Mr. Yap (A.4) and Ms. Madden (A.3). These additional qualification requirements include:

5.10.1. Undertaking a course accredited by the Australian Pharmacy Council which involves a communication module which must be passed by the student before attempting the rest of the course. The remainder of the course involves conducting ten case studies where the student was required to successfully develop an appropriate medication profile; recommended changes to the patient's medication profile and then write a

letter to a 'doctor' which identified issues that needed changes for ten patients.

5.10.2. That this program is of one year's duration.

5.10.3. That in order to maintain registration as an Accredited Pharmacist an additional 20 CPD points must be undertaken each year.

5.10.4. That the Accredited pharmacist must be reaccredited every three years by sitting an open book examination on 40 scenarios and they must achieve at least an 80% pass rate in order to maintain this accreditation.

6. The evidence provided by Mr. Crowhter (A.9) in respect of the Community Pharmacists' Employment and Remuneration Report series conducted by APESMA supports findings that:

6.1. Mean hourly rates of pay reported by community pharmacists were lower in 2016 than they were for community pharmacists surveyed in 2011, with decreases of 5.49% for Pharmacists, 3.73% for Experienced Pharmacists, 7.94% for Pharmacists-in-Charge, and 1.86% for Pharmacist Managers. Prior to 2011 community pharmacists' mean hourly rates of pay increased steadily.

6.2. Growth in the hourly rates of pay for community pharmacists has also fallen behind growth in the Australian wage, as measured by the Wage Price Index (WPI), and the cost of living, as measured by the Consumer Price Index (CPI) for each of the classifications above that of Pharmacy Intern.

6.3. Pharmacists have experienced a decline in the real value of their wages of 11.59%, Pharmacists-in-Charge of 7.35%, and Pharmacist Managers of 3.52%. Pharmacists have also experienced wage growth 21.47% below that of the average Australian, 17.69% for Pharmacists-in-Charge, and 14.29% for Pharmacist Managers. The underperformance of Pharmacist wage growth relative to both CPI and WPI is largely due to stagnant and declining hourly rates of pay

since 2011. Prior to 2011, Pharmacists tended to outperform both CPI and WPI year on year.

6.4. Recent survey data on what 'discount pharmacies' (eg Chemist Warehouse, Discount Drug Stores and My Chemist) pay compared to 'banner' groups (eg Amcal/Amcal Max, Chemmart, Chemplus, Guardian, Priceline Pharmacy, Soul Pattinson, Terry White, National Pharmacies) shows that at the Pharmacist classification and above there is a clear difference between the mean hourly rate of pay for community pharmacists employed at discount pharmacies, as opposed to those employed at non-discount banner groups. Discount pharmacies tend to pay much closer to the minimums set out in the Pharmacy Industry Award 2010.

6.5. Survey data on whether pharmacists were undertaking 'professional services' in recent years and whether they were paid additional money for undertaking those services shows that the majority of community pharmacists are providing these services and the majority receive no additional remuneration for undertaking these services.

FINDINGS SOUGHT TO BE MADE FROM THE ADDITIONAL EXPERT EVIDENCE

7. Attached at Annexure 'A.10', as foreshadowed in the Addendum to the Outline of submission and Expert Evidence filed by APESMA on 5 April 2017[3], is the second part of the Report from the Faculty of Pharmacy at the University of Sydney.

8. This Report is titled 'The Work Value of a Community Pharmacist - Part II: Semi Structured Interviews' and it contains the findings of interviews of 25 pharmacists who undertake 'cognitive professional services' (CPS). (Also known as professional services.).

9. APESMA seeks that the Commission make the following findings from the evidence provided in this report:

[3] https://www.fwc.gov.au/documents/sites/awardsmodernfouryr/am201628-sub-apesma-050417.pdf

9.1. Pharmacists are offering a broad range of CPS within the community pharmacy setting, both via 6CPA-funded initiatives as well as non-6CPA initiatives.

9.2. Almost all pharmacies provide 6CPA-funded initiatives such as DAAs, clinical interventions, MedsChecks/Diabetes MedsChecks, and HMRs. User-pay services being offered include pharmacist-led flu vaccinations, OST, diagnostic testing for sleep apnoea, and absence from work certificates, among other services.

9.3. That CPS provision has positive impacts at both patient and health care system levels. Pharmacists have enabled timely and convenient access to health care for patients in the community pharmacy setting, and facilitated QUM, which then in turn had some positive impact on the community pharmacy business.

9.4. That despite the increasing provision of services and integration of CPS delivery within the community pharmacist's role, in most cases there was no additional reimbursement received by the pharmacist to deliver services specifically, other than the level of wages received.

9.5. In respect of training, that:

9.5.1. Training varies significantly between undergraduate training, self-directed learning and completion of accredited training courses.

9.5.2. Of the service-specific training completed, accreditation courses are more likely completed for pharmacist-led immunisation, HMRs, and compounding.

9.5.3. Non-specific training for the services typically includes training received from company representatives and/or self-directed learning.

9.5.4. Financial support received for training undertaken by pharmacists varies; the most common course that is financially covered by employers is pharmacist-led immunisation training. However, training opportunities received by staff potentially varies depending on their role within the pharmacy.

9.6. Pharmacists' roles and responsibilities have changed, where there are now increased opportunities for clinical involvement and inter-professional collaboration in the provision of patient health care.

9.7. Reforms such as accelerated price disclosure and emergence of discount pharmacy models of pharmacy have impacted the sector, and created an impetus for the industry to evolve.

CONCLUSION

10. APESMA submits that the evidence filed confirms that there have been significant changes in the work done by pharmacists covered by the Pharmacy Industry Award 2010 since the work value of these people was last assessed by the Commission.

11. APESMA submits that this evidence demonstrates that:

11.1. There have been significant changes to the educational requirements for pharmacists, including an increase from a three year degree to a four year degree with greater breadth and complexity.

11.2. There have been significant additional registration requirements for pharmacists introduced.

11.3. A significant amount of new work has been introduced which requires pharmacists to obtain additional skills, and a higher level of skill, and to undertake additional training.

11.4. The new work attracts a higher level of responsibility and accountability for pharmacists.

11.5. The work done by pharmacists has become more complex requiring compliance with an increasing amount of legislative and regulatory requirements.

12. APESMA 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 PGA and any other interested party opposing our application.

Jacki Baulch

Senior Industrial Officer, National Office

APESMA

Appendix 1

The attachments can be viewed via the following links:

1. **Attachment A.1** – statement of Dr Geoffrey March – 10 December 2017
2. **Attachment A.2** – statement of Carmel Mary McCallum – 18 December 2017
3. **Attachment A.3** – statement of Jennifer Ruth Madden – 14 December 2017
4. **Attachment A.4** – statement of Leon Wai Hon Yap – 18 December 2017
5. **Attachment A.5** – statement of anonymous witness – 10 December 2017
6. **Attachment A.6** – statement of anonymous witness – 15 December 2017
7. **Attachment A.7** – statement of anonymous witness – 13 December 2017
8. **Attachment A.8** – statement of Katerina Malakozis – 20 December 2017
9. **Attachment A.9** – statement of Alex Crowther – 13 December 2017
10. **Attachment A.10** – Work value of a community pharmacist – University of Sydney report – part II: semi-structured interviews

Annexure 'A1'

IN THE FAIR WORK COMMISSION

Fair Work Act 2009

s. 156 – 4 yearly review of modern awards

AM2016/28 - Pharmacy Industry Award 2010

STATEMENT OF DR GEOFFREY MARCH

I, Geoffrey March, of 79 Willyaroo Rd, Willyaroo, 5255 in the state of South Australia, say as follows:

1. I make this statement from my own knowledge, save where otherwise indicated. Where I refer to matters within this statement on the basis of information and belief, I identify the source of that information and believe those matters to be true.

2. I completed a Bachelor of Pharmacy at South Australian Institute of Technology in 1975. I also have completed the requirements of a Doctor of Philosophy from the University of South Australia.

3. I gained Intern Registration with the Pharmacy Board of the Australian Health Practitioner Regulation Authority (AHPRA) in 1976.

4. I gained full registration as a Pharmacist with the Pharmacy Board of AHPRA in 1977.

5. I do not hold current registration to practice as a pharmacist by the Pharmacy Board of AHPRA and I retired from the profession in 2016.

6. Prior to retirement I held a number of positions within the School of Pharmacy and Medical Sciences at the University of South Australia and a number of pharmacies in South Australia.

   Annexed to this statement and marked "**GM-1**" is a true and correct copy of my curriculum vitae

My position

7. I currently hold the position of President of Professional Pharmacists Australia, a Division of the Association of Professional Engineers, Scientists and Managers Australia (APESMA), and have held that position for a number of years. I am also a National Assembly member of APESMA and have also held that position for a number of years.

8. The National Assembly is the APESMA's governing body, comprising of representatives elected by members from each division of the union.

Academic positions

9. From 2007 to 2016 I was a Lecturer (Level B) at the School of Pharmacy and Medical Sciences, University of South Australia. This was a tenured position. From 1998 – 2006 I held the same role in a contract position. I worked for 20 years as a research fellow in the Quality Use of Medicines and Pharmacy Research Centre (QUMPRC) which is part of the School of Pharmacy and Medical Sciences, and Lecturer in Pharmacy Practice at the School of Pharmacy and Medical Sciences, University of South Australia.

10. At the University of South Australia, I undertook my PhD which is titled *"From Medicines Supplier to Patient Care Practitioner: Implementation and Evaluation of Two Practice Models in Australian Community Pharmacies"*. The objective of my PhD was to dissect the practice of pharmacy and test a patient centred approach for pharmacists in caring for the public.

11. At the University of South Australia, I was part of a research team led by Emeritus Professor Andrew Gilbert AO that identified shortcomings in the practice of pharmacy, developed strategies to address those shortcomings, and tested those strategies in the practice setting.

12. My research was also applied to the teaching of pharmacy students. My team introduced a new approach to teaching students by including "social pharmacy" in the curriculum. Social pharmacy involved teaching students how to apply their didactic pharmacy knowledge to the practice setting.

My positions as a community Pharmacist

13. From 1977 to 1997, I practised as a Pharmacist for National Pharmacies in Adelaide. My roles included Professional Practice Pharmacist, Pharmacist-in-Charge, and Pharmacist, Pharmacist reliever, Manager and ultimately a Specialist Pharmacist. National Pharmacies is a national retail pharmacy chain. In 1976, I was a Trainee Pharmacist at the Queen Elizabeth Hospital/Whyalla Hospital.

Working as a Pharmacist at the commencement of my Career

14. In 1976, when I commenced practice within the pharmacy profession I was ethically prevented from discussing or describing medication to patients. I was required to label medicine as "The Tablets" or "The Mixture".

15. My training and practice as a pharmacist involved a focus on the drug itself, how it works, dosages, formulation to ensure the drug gets into the body.

16. At the start of my career, between 1976 and 1979 I worked in some pharmacies where the pharmacist dispensed prescriptions in a separate room and passed the completed prescriptions through a hole in the wall for the shop staff to give to the consumer.

17. When I entered the profession, in 1976, I was not trained to appreciate consumer wants, desires or needs. The dynamic between myself and my patients was one of the "health professional knows best" and I expected that the consumer would accept my directions.

18. When I commenced my career as a community pharmacist, pharmacists were less easily accessible by members of the public than now . However, even then, there were few other health professionals that were as accessible as Pharmacists to the public.

Policy reform

19. During my career a number of policies have influenced my practice, research and teaching. In the 1980s, I became aware of a number of studies that reported harm associated with the use of medications.

20. I recall that in 1987 the World Health Organisation (WHO) issued a resolution calling upon all member countries to develop national medicinal drug policy. The 41st World

Health Assembly subsequently adopted this recommendation in the document "Guidelines for Developing National Drug Policies". Annexed to this statement and marked "**GM-2**" is a true and correct copy of the WHO Guidelines for Developing National Drug Policies.

21. I recall that the Australian Government's response to this recommendation was outlined in the report "Health for All Australians" (1988) where the Government announced a commitment to formulate a comprehensive policy pursuant to the WHO (1987) recommendations.

22. I recall that the Australian government subsequently established two advisory committees that reported to the Australian Minister for Health. The first, the Australian Pharmaceutical Advisory Council (APAC) was responsible for the development of the National Medicines Policy. It was established as a multi-disciplinary representative committee with members drawn from the health professions, consumer organisations, the pharmaceutical industry and Australian Governments. APAC published Australia's National Medicines Policy. Annexed to this statement and marked "**GM-3**" is a true and correct copy of the Australian Government National Medicines Policy 2000

23. I recall that as part of the introduction of the new National Medicines Policy in 2000 the Quality Use of Medicines (QUM) strategy was also introduced. Annexed to this statement and marked "**GM-4**" is a true and correct copy of the Australian Government National Strategy for the Quality Use of Medicines

24. The second committee which the Government established in 2002 was the Pharmaceutical Health and Rational Use of Medicines (PHARM) committee; a multi-disciplinary expert committee that provides advice to the Minister for Health and Ageing and the Department of Health and Ageing on strategies for achieving the quality use of medicines in Australia

25. In line with the principles of the National Medicines Policy, the development and implementation of Australia's strategy for achieving quality use of medicines was based on a partnership approach. This concept refers to a local "medication team" made up of consumers, doctors, pharmacists and nurses with each having a role to play in ensuring that medicines are used wisely in an environment that develops behaviours that both supports and is conducive to the quality use of medicines.

26. Through-out my career, I observed that in addition to a multi-strategic approach, there was a range of settings in which these strategies had to be implemented by practitioners. These settings include the individual and interpersonal (eg health practitioner-patient interaction), the group and community (eg self-help groups, local health services), and organisations (eg professional organisations, aged-care facilities and hospitals). Further there are structures and systems such as Commonwealth, State and local governments (eg health policies, legislative change), and international systems (WHO policies and programs). Thus, in developing, implementing and evaluating initiatives to improve the use of medicines, individual, community and public health perspectives had to be addressed.

27. I observed that the policy framework provided a range of opportunities for the development of health professional practices that met consumers' demands for medicines issues to be addressed. The principal question for me as a practising pharmacist and then a researcher and teacher revolved around what changes in practice professional roles and responsibilities were necessary to achieve the expectations placed upon Pharmacists by the National Medicines Policy.

28. I was part of the research team that investigated the development and implementation of a pharmacy practice based on the philosophy of pharmaceutical care and as part of the Quality Use of Medicines (QUM) strategy where pharmacists in collaboration with the consumer and the consumer's medical practitioner worked to identify and resolve medication related problems for both prescribed and over-the-counter medicines. One outcome of this research was the implementation of the home medicines review program firstly in aged care facilities and eventually in the community.

What changed in educating future pharmacists?

29. The changes in policy and philosophy outlined above had and still have ramifications for the education of pharmacists for future practice. The practice paradigm was flipped from one that focussed on giving medication(s) for a medication condition(s) a person may have to one that focused on the person first, who has a medical condition(s) and who may or may not take a medication(s) for that condition.

30. Consequently, it was no longer sufficient for Universities to produce students who were knowledgeable about all aspects of medications including their formulation and action in the body; the student needed knowledge and the ability to apply that knowledge in "soft" skills required for patient care activities, for example to be able to communicate effectively with consumers (and other relevant persons) at a level the consumer can understand selecting the most appropriate mode(s) of communication, understand and use a different set of skills when communicating with other health professionals, understanding the roles of other health professionals in the health team, developing team skills as a forerunner to being able to collaborate with other health professionals in team care.

31. In 1998, the QUMPRC team introduced a number of new courses into the pharmacy curriculum taught in third and fourth year that reflected the need to teach students the necessary skills to become patient care practitioners. This concept refers to putting the patient first, rather than the drug.

32. The "Applied Therapeutics" courses were taught in third year and the student placement program run in third and fourth years was redesigned to facilitate the practical exposure to patient care.

33. Topics covered in this new course stream included:

33.1. pharmacists' roles and responsibilities,

33.2. understanding the health system,

33.3. the role of standards, guidelines and ethics in practice,

33.4. communication theory and skills development,

33.5. cultural sensitivity,

33.6. behavioural theory and application,

33.7. problem solving skills including the basis of the pharmaceutical care model,

33.8. inter-professional learning and collaboration,

33.9. literature researching and critical evaluation skills to facilitate access to independent information (ie not relying on drug companies to provide medical information), and

33.10. understanding the roles and responsibilities of various professional bodies.

34. The importance of the pharmacy practice stream (alternatively known as social and administrative pharmacy in other quarters) was acknowledged by its integration into other pharmacy courses not directly related to pharmacy practice.

35. Prior to the changes, student practicals focussed on drug formulation, drug manufacture with some dispensing with minimal unsophisticated drug counselling. Following the change, while drug formulation and drug manufacture continued, the practicals around dispensing underwent significant reorganisation such that at the time of my retirement, we had first year students introduced to the fundamentals of consumer advice and education, visiting aged care facilities to have the opportunity to conduct a conversation with an older person (to develop communication skills suitable for older people), role playing scenarios in second, third years and fourth years (the intensity of which grew across the years allowing for greater complexity and knowledge) , and providing the opportunity for students to test their skills by requiring students to be involved in consumer commutation episodes during their student experiential placements held in fourth year.

36. By the time I retired in 2016, pharmacy practice was taught across all years and a satisfactory placement outcome was required for the student to graduate from the program. I was teaching students how pharmacists act to accept their responsibility for the outcomes of prescription and over the counter medicines they dispense by being able to communicate effectively with consumers, exploring behavioural strategies used and to be used to assist consumers change behaviours, to develop the skill to identify and resolve medication related problems, and to communicate effectively with other health professions.

37. As a consequence of the changes in the National Medicines Policy and the adoption of Pharmaceutical Care, students graduating from pharmacy schools have both the necessary knowledge required of a pharmacist and the skills necessary to apply that knowledge for the benefit of society at the graduate level.

38. The changes to the pharmacy curricula preceded changes in practice in the community setting. For example, by 2000, relatively few pharmacists had established a practice involving medication reviews and it was a challenge to find pharmacists who were either beginning to practice in a more patient centred manner or providing specific patient care services for our student placements.

39. In the year 2000 under provisions in the third Community Pharmacy Agreement (CPA), community pharmacies were remunerated by the Australian government for medication reviews undertaken in the home (Home Medication Reviews) and the provision of Consumer Medication Information. These were the first community based professional services funded under the CPAs between the Commonwealth of Australia and the Pharmacy Guild of Australia. The suite of remunerated professional services has expanded in subsequent CPAs.

40. Graduates implement the patient care services that over a number of CPA became available to the public including home medicines reviews, aged care medicines reviews, quality use of medicines initiatives in the aged care sector, provision of understandable, culturally sensitive consumer health information to the general population and to segments of the population such as people with English as their second (or third) language, over-the-counter medications (down scheduled from prescription only), chronic disease state management, and health promotion.

Introduction of Pharmacy Program Accreditation Requirements

41. Accreditation of pharmacy programs in Australia began in 1998 with the creation of the New Zealand and Australian Pharmacy Schools Accreditation Committee (NAPSAC) as a standing committee of the Association of Pharmacy Registering Authorities (APRA), the organisation which preceded the creation of Australian Pharmacy Council. As part of the latest Accreditation Standards for Pharmacy Programs (2014), APC provides a six learning domains to provide guidance for academics in developing their pharmacy curricula. Of note is that the very first domain (below) relates to the health consumer, indicating that APC acknowledges the supremacy of the consumer in practice. This learning domain now incorporates the various aspects of social pharmacy first described in police framework developed in the 1990s. Annexed to this statement and marked "**GM-5**" is a true and correct copy of

the Australian Pharmacy Council Accreditation Standards for Pharmacy Programs 2012.

41.1. Learning domain 1: The health care consumer. This learning domain can be described as follows:

41.1.1. The health care consumer is central to the degree course, reflecting the importance that a pharmacy graduate focuses on prevention and wellness in all people, as well as the needs of patients. The items grouped under this heading address the biological, environmental, psychological and some of the social foundations of treatment with medicines. The curriculum should address specific consumer needs in diverse multicultural populations, particularly Aboriginal and Torres Strait Islander people in Australia.

41.1.2. The indicative elements of learning domain 1 are:

41.1.2.1. The unique expertise of the pharmacist in ensuring that the consumer achieves optimal health outcomes from medicines and minimises the potential for harm.

41.1.2.2. Principles and methodologies of the social sciences relevant to pharmacy.

41.1.2.3. Cultural competence and cultural awareness.

41.1.2.4. Health and illness: definitions and perceptions.

41.1.2.5. Theory and practice of personal and inter-personal skills, including written and oral communication skills to proactively build trust, support, motivate and influence professional colleagues and consumers with varying levels of health literacy, as well as study skills.

41.1.2.6. The ideas and approaches of compliance or concordance in health care provision, including as they apply to medicines administration.

41.1.2.7. The pharmacist's contribution to the promotion of good health and disease prevention.

41.1.2.8. Normal and abnormal bodily function: anatomy, biochemistry, genetics, microbiology, nutrition, immunology, physiology, pathology, pathophysiology and infective processes.

41.1.2.9. Aetiology and epidemiology of major diseases and the principles of their treatment.

41.1.2.10. Symptoms recognition and management, the principles of differential diagnosis, important diagnostic methods and tests, and medical terminology.

41.1.2.11. Disease management and care planning, including application of clinical guidelines, prescribing guidelines, medication review and new models of care.

41.1.2.12. Clinical reasoning, collaborative decision making and documentation.

41.1.2.13. Complementary therapies.

41.1.2.14. Drug and substance misuse, and physiological and psychological dependence. Clinical toxicology associated with drug overdosage, drug or substance misuse or accidental exposure.

Geoffrey John March

10/12/2017

List of Annexures

The annexures can be viewed via the following links:

1. **Attachment 'GM-1'** – Curriculum vitae – Geoffrey John March

2. **Attachment 'GM -2'** – Guidelines for developing national drug policies

3. **Attachment 'GM-3'** – National Medicines Policy – Department of Health and Ageing – 2000

4. **Attachment 'GM-4'** – National Strategy for Quality Use of Medicines – 2002

5. **Attachment 'GM-5'** – Accreditation standards for pharmacy programs in Australia and New Zealand – effective from 1 January 2014

Annexure 'A2'

IN THE FAIR WORK COMMISSION

Fair Work Act 2009

s. 156 – 4 yearly review of modern awards

AM2016/28 - Pharmacy Industry Award 2010

STATEMENT OF CARMEL MARY McCALLUM

I, Carmel Mary McCallum, of 388D Main Road, Cambewarra, in the state of New South Wales, say as follows:

1. I make this statement from my own knowledge, save where otherwise indicated. Where I refer to matters within this statement on the basis of information and belief, I identify the source of that information and believe those matters to be true.

2. I completed a Bachelor of Pharmacy at the University of Sydney in 1977. I also have a Post Graduate Certificate in Counselling.

3. I gained full registration as a Pharmacist with the Pharmacy Board of NSW in September 1977.

4. I hold current registration to practise as a pharmacist by the Pharmacy Board of the Australian Health Practitioner Regulation Agency (AHPRA).

5. I am currently employed as a locum pharmacist at various pharmacies. In the main, I work as a locum pharmacist at Hope's Pharmacy, Vincentia, in the State of New South Wales. In my role as locum I am classified in the position of Pharmacist-in-Charge.

6. From 2003 – September 2015 I was the Pharmacist-in-Charge, part-time and casual, at East Blaxland Pharmacy. From January 2013 – December 2014 I was the Pharmacist-in-Charge, part-time, at North Nowra Pharmacy.

7. I am paid $40 per hour.

8. I have not entered into an Annualised Salary Agreement/Individual Flexibility Agreement with my employer.

9. My duties in my current position are:

9.1. Dispensing and checking prescriptions which are delivered from patients, via fax, or contacting prescribers for tourists who omit to carry prescriptions or prescription items. This may include checking of prescriptions dispensed on previous days by other pharmacists, but awaiting product from the wholesaler.

9.2. Dispensing and checking items for patients receiving Dose Administration Aids (DAAs, such as Webster packs). I also check and sign off the DAAs before they are delivered to the patient. These may or may not have been dispensed into the DAA by a dispensing technician.

9.3. Logging Schedule 8 [S8] drugs when arriving from wholesalers and again when they are dispensed. These are generally drugs of addiction and include opioids, fentanyl, central nervous system stimulants such as Ritalin, and alprazolam. Once dispensed, the repeats remain in the same pharmacy, in a special file, until out of date-six months- or completely dispensed. Anabolic steroid prescription repeats are also kept at the same pharmacy, in the same way S8 drugs are, but do not need to have a separate log book.

9.4. Counselling patients regarding new prescription medications, when adverse drug reactions occur or when interactions with other drugs may occur.

9.5. Counselling, diagnosing and recommending treatments for ailments as the first point of contact for patients, and referring to general practitioners when necessary.

9.6. Interpreting patient blood pressure readings and blood sugar levels of patients.

9.7. Pain management and alternative recommendations when drug dependence is suspected.

9.8. Dispensing and delivery of Methadone or buprenorphrine under the NSW Opioid Treatment Program [OTP] to approved Injection Drug Users, as an opioid substitute. This involves following the regulations which include ascertaining the identity of the patient, dispensing their prescribed dose, recording this in the daily log book and also at the end of the day recording the

total of all doses for that day in the day log book. The OTP can only be conducted with prescriptions which are in date as per the current prescription and according to the strict instructions of the prescriber, including the delivery of take-away doses when allowed.

9.9. Issuing medical certificates to patients.

9.10. Overseeing the general day-to-day performance of staff in relation to customer service and staff interaction.

9.11. Overseeing that adequate supplies of drugs are ordered and kept on the pharmacy premises according to the projected usage of items.

9.12. Ascertaining the entitlement of patients to receive prescriptions under the National Health Scheme [NHS], including their registration with Medicare, the various concession entitlements and their Safety Net Threshold when they reach it during a calendar year. For a patient on a concession or pension this is sixty NHS prescriptions, or for a full-paying patient, in 2017, it is $1,494.90. When patients have been receiving their medications from several different pharmacies, and have not kept a record on a Prescription Record Form, we have to contact the pharmacies and request documented evidence to prove and support the allocation of a Safety Net Card application.

Changes in the retail pharmacy industry

10. When I commenced work in 1977, as an unregistered graduate pharmacist, I worked in a small individually-owned pharmacy in Campbelltown NSW, where I was handwriting copies of prescriptions into a log book, handwriting repeats and typing labels on a non-electric typewriter. All my work was checked off by a more senior registered pharmacist. This process took several minutes- probably about thirty seconds for each step- and may have also involved recording of an S8 drug- about another minute- removal of drug from the shelf- about ten seconds- or count out or measure medication- could be up to two minutes. If a product needed to be prepared, such as creams, ointments or mixtures, it could have taken between ten minutes to over an hour, depending on the complexity of the item. The numbers of scripts prescribed were fewer, probably around seventy or eighty a day, in that particular pharmacy, as there

were not so many treatments available as at present, and co-morbidity was not as common.

11. I also used to count out and package medications which were cheaper to buy in bulk, than the pre-packaged proprietary items.

12. I recall spending time with patients of up to ten minutes per patient. As there were usually two other pharmacists present on the busiest days, I was able to give adequate time to the patient.

13. I recall that patients were respectful to me. As a pharmacist I gave them professional advice on minor ailments, such as bites, rashes, minor burns, injuries, allergies, upper respiratory tract infections, vomiting and diarrhea, difficulties with new-born babies, recommending the appropriate treatment which was available over the counter, or other non-drug related action, such as twenty-four hour fast for vomiting and diarrhea, or referring them to a GP if necessary.

14. I also used to make up proprietary products, in bulk, tailored to that pharmacy, which had been formulated by the previous owner who had compiled his own formulary, which was based on non-prescription formulae, labelled with custom-printed pharmacy labels. These would include such things as blackberry-flavoured child's cough medicine. This would have taken over an hour to make, but maybe another hour or two to pack and label.

15. My employer always paid me my full pay entitlements and loadings according to the requirements of the NSW Retail Employees Award, including meal allowances on days when I would work from 9am to 9pm.

16. In 1978 I moved to Nowra on the South Coast of New South Wales, where I worked as a Pharmacist-in-Charge.

17. After working there for a couple of years, I bought the pharmacy with another young woman. The same mode continued until, after owning a pharmacy for four years, in partnership, my partner and I, she being pregnant with her second child due in less than twelve months of her first, and my husband being posted to the United States on exchange with the US Navy, purchased a computerised dispensing system in Nowra,

and employed a pharmacist manager to look after our business. We contracted to AMFAC-Chemdata.

18. For the first time, access to patient histories was easily achievable through access to an electronic database rather than physical documentary records. The initial cost of the system we purchased was $16,000 in 1983, with ongoing charges for updates, which was very expensive for the times.

19. On my return in 1987, the business employed two shop assistants and a pharmacist manager. We paid our staff all their entitlements according to the award. My partner and I, now with three children each and my expecting a fourth, decided to put the business on the market as it was not profitable enough to continue without my partner and I working the business ourselves, which was not possible because of our family commitments.

20. Since I sold the business in 1988, I have continued to be employed as a Pharmacist-in-Charge, at more than fifty pharmacies in NSW.

Working as a pharmacist today

21. Over the years of my time in the profession I have observed additional expectations, regulations and increases in workloads for pharmacists. Workloads, especially the increases in numbers of prescriptions, have increased because of the increase in life expectancy, which is because of advancements in medical technology and availability of more, and greater in effectiveness, drugs. The increase in co-morbidity as a result of greater risk owing to longevity, and increases in disease states as a result of lifestyle choices, are the main contributors to this. This has led to pharmacists over-seeing the accuracy of dispensing of huge numbers of prescriptions, increasing the risk of error as a result of brain fatigue from not having breaks, not drinking enough fluid, going for long stretches without eating and not being able to attend to toileting needs. This is most likely when a pharmacist is the only pharmacist on duty, and works at least eight hours and sometimes up to twelve hours straight. Some pharmacists work late into the night, and some are working over-night, which, because there is currently more difficulty finding work in metropolitan areas, pharmacists are being forced to take on these positions. This is also because hospital emergency rooms are seeing people at all hours of the night and day and sending patients home with no medication, but a

prescription to be dispensed in the community, so twenty-four hour pharmacies are springing up near hospitals. There are many more restrictions on products than in the past, which largely occurred in the 1990s with the up-scheduling of many over-the-counter products to Schedule 3 and 3R [recordable], such as those containing codeine, pseudoephedrine and dihydrocodeine, where the pharmacist must ascertain need, usage, possible interactions, adverse drug reactions and possible addiction to, or misuse by the patient. With the up-scheduling of codeine-containing products to Schedule 4, prescription-only, about to occur on 1st February 2018, there will be many challenges as pharmacists have to appease those who may have addiction issues. The down-scheduling of products such as bronchodilators in the 1990s, also increased pharmacists' responsibilities when assessing if the patient was already attending a medical practice, had an Asthma Action Plan, and was taking adequate steps to manage their asthma appropriately with their prescribed medication. Initially, we had to complete forms and cards to collect information and keep a check on the regularity of purchase of the products by the patient. We now oversee blood pressure measurement which most pharmacies offer, and have the responsibility of referring patients to see their GP, sometimes calling an ambulance, when excessive pressure is prevalent. We also oversee glucose monitoring devices when patients are having difficulty using them, or when they are getting high readings and are unsure what to do. This can also lead to GP referrals. I completed the training for the Diabetes Medication Assistance Service in 2010, but as there was very little effort and even less success in rolling out the service, because there was not a dedicated attempt to bring GPs into the sphere by convincing them that we could produce evidence to affirm the benefits of the scheme to increase the efficacy of diabetes treatments, changes of lifestyle and better long-term outcomes for patients. There has also been an exponential increase in the prescribing of S8 drugs which is increasing by the year. These dispensings always require a much longer time to dispense, as the greatest care must be taken. As we are continually interrupted, and as I have mentioned earlier, there is a greater risk of error in dispensing these dangerous drugs, as they used to be called. In hospitals, nurses always have two qualified people signing off on every dosing, but in pharmacy, the onus is on the only pharmacist on the premises. We also have an increase in interventions, because of all the new drugs and increasing prescribing, and although a good pharmacist would counsel accordingly, the recording of these is not always simple, but involves paperwork which also takes a few

minutes to attend, as there may not be a computer available to digitally record the intervention, which needs to be done in order to attract payment for service.

22. I have worked with at least six different digital dispensing systems and their various stages of development over the last thirty-five years. These systems have varying interfaces and data requirements, as do the systems of the GPs. Not all pharmacies use the e-script barcode on the prescription as the doctors' software is not always compatible and can sometimes mean the dispensing process takes much longer. The e-script system is supposed to help eliminate errors, but it is not as useful as it should be. In fact, it slows down the system with some of the software systems I have used.

23. In my role as an emergency locum, I have arrived to fill an emergency position at a Pharmacy that has less staff than usually required, because of sickness. I am the single Pharmacist and I have no help in the dispensary. At opening time there will be methadone patients with whom I am not familiar, waiting to be attended as well, which makes the situation extremely stressful. In attending a new pharmacy at any time, it is considerably stressful, even if there are no methadone patients, as the pharmacist has to put their shoulder to the wheel, sometimes with no briefing, and sometimes with no assistance in the dispensary. Because there are several software packages, and a relieving pharmacist is not continuously using all of them, it can be a challenge to refamiliarise with systems quickly.

24. I have to oversee the sale, with direct personal intervention, of all Schedule 3 products [as described earlier] to customers, and this has involved the monitoring of prophylactic asthma treatments and the assessment of real need for codeine-combination products, along with many other medications which have a potential risk for misuse or drug interactions to people with co-morbidity, who would already be on other medications, or who may be 'doctor shopping'.

25. I regularly dispense S8/narcotic items, such as opioids, central nervous system stimulants, alprazolam and fentanyl, by local GPs and nurse practitioners, which I am required to verify by phone. This, along with recording in a register (mostly by hand, as not all pharmacies have a digital recording system yet), is sometimes difficult as the pharmacist is interrupted continuously in carrying out their normal lines of work,

overseeing the dispensing of all prescriptions, and all other activities being conducted in the pharmacy.

26. The responsibility of all process and activity in the pharmacy is my sole responsibility as the pharmacist. As a pharmacist I am required by law to be on the premises at all times, which is difficult when toilets are not in the same premises.

27. I recall having to sacrifice my own personal health with times when I have not been to the toilet all day, being unable to have liquid refreshment with hot drinks going cold, missing a lunch break, and feeling dehydrated because of the dispensing requirements, especially at the end of the calendar year, when customers are purchasing in bulk, their free NHS items, as a result of their reaching their safety net threshold as discussed earlier. In my experience, this includes being on one's feet for at least nine hours a day, and in some pharmacies, up to twelve or more hours a day which is not acceptable in a safe working environment.

28. Unlike most professions, pharmacists are not able to make appointments for enquiries off-the-street, as people have an expectation that we are freely available at all times, which has always been the situation, and we are required to be available at all times of the day during opening hours, while on the premises, but the pressure and the workloads have increased enormously since I first started in 1977.

29. If I was starting in pharmacy now, I would seriously consider changing my profession, and I don't feel that it is a profession that I can recommend to young people considering pharmacy as a career. We will lose our best pharmacists if they are not remunerated for their professional skills and knowledge.

CARMEL MARY M'CALLUM

18th DECEMBER, 2017.

Annexure 'A-3'

IN THE FAIR WORK COMMISSION

Fair Work Act 2009

s. 156 – 4 yearly review of modern awards

AM2016/28 - Pharmacy Industry Award 2010

STATEMENT OF JENNIFER RUTH MADDEN

I, Jennifer Ruth Madden, of 29 O'Connor Street, Uranquinty in the state/territory of NSW. say as follows:

- I make this statement from my own knowledge, save were otherwise indicated. Where I refer to matters within this statement on the basis of information and belief, I identify the source of that information and believe those matters to be true.

- I completed a Bachelor of Pharmacy at the Victorian College of Pharmacy in 1968. I have also gained the qualification of Accredited Pharmacist.

- I gained full registration as a Pharmacist with the Pharmacy Board of Victoria in 1970.

- I hold current registration to practice as a pharmacist by the Pharmacy Board of AHPRA.

- I am currently employed as a locum pharmacist with several pharmacies for whom I provide locum pharmacy work, Medication Reviews and/or Residential Medication Management Reviews. My most regular locum work is with Simon Horsfall of Thurgoona Pharmacy Thurgoona Plaza Thurgoona in New South Wales. In addition, I provide locum and medication review services to several more remote Riverina pharmacies such as Ardlethan, Adelong, Howlong and Finley.

- I held the following positions prior to commencing my current locum services

- I shared a pharmacist position at Latchford Barracks Vic, from 2005 - 2007

- Charles Sturt University Wagga Wagga, as a lecturer, demonstrator and examination marker in Pharmacy practice from 2001 – 2004.

- Tutor and Marker for PGTC and Facilitator for Ethics Workshop from 2002 – 2004.

- Relieving Pharmacist at Ashmont Pharmacy (since closed) from 2002 - 2003.

- Pharmacist in Charge (part-time) at Turvey Tops Pharmacy from 1994 - 2002.

- Locum Relieving Pharmacist in Charge or Assistant Pharmacist in several pharmacies and facilities in NSW, Queensland and Victoria from 1971 - 1994. Some of these were permanent part time positions.

- In my current position I am classified as a Pharmacist-in-Charge.

- I am paid $40 per hour as a PAYG employee. In my other work I contract a flat rate plus travel, where the round trip is greater than 100km, and pay my own tax.

- I have not entered into an Annualised Salary Agreement or Individual Flexibility Agreement with my employer.

- My duties in my current position are:

    - As a Pharmacist-in-Charge, I carry out the usual activities of dispensing, supervision of sales of Schedule 2 and Schedule 3 medicines; give advice as requested or as deemed suitable.

        - The Therapeutic Goods Administration (TGA) determines the

scheduling of medicines in Australia. They classify substances into schedules as follows:

- Not currently in use
- Pharmacy Medicine
- Pharmacist Only Medicine
- Prescription Only Medicine OR Prescription Animal Remedy
- Caution
- Poison
- Dangerous Poison
- Controlled Drug
- Prohibited Substance
- Substances of such danger to health as to warrant prohibition of sale, supply and use

- Under this scheme Schedule 2 medicines are medicines that can only be sold in a pharmacy and Schedule 3 medicines are medicines that can only be sold after a pharmacist has decided that they are appropriate for the patient's conditions.

- I am not required to pay wages or manage stock, other than ordering and packing in busy times. I also check Webster Packs and make corrections to packs when needed.

- As an Accredited Pharmacist, I manage the process from the time that the Home

Medicine Review (HMR) is either given to me by hand, faxed or mailed. With Residential Medication Management Reviews (RMMR), in addition to the work of performing the review, I also work with the nursing home to identify suitable residents and then request the review from the doctor.

- During my period of employment as a pharmacist over more than 45 years, I have always worked part-time. I have never owned a pharmacy or been a part-owner. My work has included the community, hospital, military, academic, (including tutoring, lecturing and demonstrating), research and consulting spheres. I am also involved with Professional Pharmacists Australia (PPA, a Division of the Association of Professional Engineers, Scientists and Managers, Australia (APESMA). I also undertake some mentoring of early career pharmacists and pharmacists who are seeking accreditation as Accredited Pharmacists.

- Over the years, since graduating, the practice of pharmacy has changed significantly.

- My intern (qualifying) year [1969] was spent under supervision, learning dispensing skills, developing the extemporaneous preparation skills learned at university, becoming familiar with the medicines, as prescribed by doctors, rather than the theoretical approach in text books, and the National Health Service (NHS), and becoming expert in Over the Counter Medicines (OTC) preparations and counter dispensing (e.g. coughs and colds, pain remedies, first aid). At that time, there were no scheduled medicines. None of these medicines were available, except in a pharmacy. At college we had learned pharmacology and physiology and drug scheduling, centered around Schedule 4 and Schedule 8 medicines, but very little about OTC medicines (mostly S2) and business skills, (that is how to run a business), which was the expectation of most pharmacists who graduated in the 1970's. My intern year was focused on enhancing my academic learning with the skills to be a good businessperson.

- It was a 9-5:30 job, with very little pressure. It was a job with little responsibility.

Occasionally the boss would challenge me because I was too slow, especially typing and compounding. I was very quick at packing bulk Nembutal and Nembudeine into 25s. My boss valued his reputation so much that he did not really let me develop my skills. In those days Pharmacist advice had not been thought of. What the Pharmacist said was accepted, by customers, but pharmacists did not question doctors. I had an income which meant a degree of freedom for a girl who lived in Springvale but who did not yet have a driver's license. Still there was an opportunity to party a lot. At the end of the year I sat an exam in 2 parts; a practical exam at identifying unknown liquids and/or solids and an interview with Pharmacy Board members.

- I have acted as a tutor and supervisor in recent years and have observed that the intern year is now an intense year of study, more time demanding than the previous four undergraduate years and with a lot of assignment work, time off work for Intern Training Provider (ITP) input and a much more strenuous examination at the end than I was required to sit. I have known interns to take several attempts at these exams before passing. In my time, it was almost unheard of that a person failed their board exam, except for misdemeanors.

- As a registered pharmacist in the 1970's, I worked part-time providing locum work or as an assistant pharmacist. There was not a great change to pharmacy until the advent of computers, initially in dispensing. I am not exactly sure when computers came into practice but when I was working in Bundaberg between 1981-1986 they were becoming more popular towards the end of that time. I remember working for one pharmacist in 1985- 1986 who had pirated a program, and at another pharmacy they were using Foundation (eventually became Aquarius). This enabled a historical record of a patient's medicines to be easily accessed, and I became more involved in looking at the medicine profile of a patient as significant to the medicine that I might be dispensing on each occasion. The introduction of the Schedule 3 range of products (products being taken off prescription for easier access for the patient but could only be dispensed by a pharmacist) added another layer of responsibility to pharmacists. I believe this happened in the 1990's. Doctors hated it in general.

I know I took this responsibility very seriously.

- At some time in the late 1990's, the rapidly expanding drug compendium available for prescribing, together with the increased legal obligations, high-lighted the need for continuing education, which was initially voluntary but is now compulsory, 40 hours for continued registration is now required. I do not receive any remuneration for this compulsory activity. As an Accredited Pharmacist I am required to undertake at least 60 hours of continuing education per year in order to maintain registration as an Accredited Pharmacist.

- About 20 years ago, RMMRs and HMRs were developed. I have been accredited for more than 15 years to do these medication reviews. My work time is divided about 50-50 with community pharmacy and Accredited Pharmacist work. The skills required to be an Accredited Pharmacist are those of any registered pharmacist, but the accreditation process requires the pharmacist to show good communication skills, both at the professional (doctor-pharmacist) and lay (patient-pharmacist) level, and a good clinical understanding of medicines and medical conditions, because the accredited pharmacist communicates more directly with both parties about the current medical treatment and changes that may be appropriate or even necessary. Although this happens in the community setting, medication reviews are very often requested when the doctor is seeking a second opinion from a pharmacist.

- When I undertook my accreditation as an Accredited Pharmacist I was working at Charles Sturt University as a lecturer. I saw this accreditation as a way to improve my skills as a pharmacist, and that it would assist in lecturing to pharmacy students.

- The process involved undertaking a course accredited by the Australian Pharmacy Council. It involved a communication Module, where I learned the theory of communication. I had to pass that module before attempting 10 case studies. I had to develop a medication profile for each case and was assessed on the letter that I wrote to the 'doctor' and whether I had identified the issues. It

took almost a year from start to end.

- I still have to be reaccredited every 3 years by sitting an open book exam of 40 scenarios and achieve at least an 80% pass rate.

- Now that I am accredited, I can write the report for the doctor, based on my or another registered pharmacist feedback. I do not have to interview the patient, but of my more than 800 clients (some have had 4 HMRs or RMMRs), I have only participated in one review, when I did not personally interview the client. It was unsatisfactory. The report that I provide is informed by a higher degree of expertise in medications and interactions. It is also informed by personal review of what the patients are actually taking

- Another more recent change in my pharmacy practice is in the area of professional services, apart from the provision of medicine, that are now being routinely offered; all require some specific training. The area that I am most likely to engage in, in community pharmacy, is in Clinical Interventions. Over a course of two days in pharmacy, I provided around 10 Interventions, from directing a patient who wanted an antiseptic for dog bite to go to their doctor, because an antiseptic was inadequate therapy, to checking why a patient was now taking a higher strength asthma medicine than six months ago, to denying the sale of Ventolin to an older patient who had a cough, and referring them to their doctor, because they had never been diagnosed with asthma, to recommending that a patient review the dose of his statin with his doctor (because a black box warning applies). This means that the medical profession has been alerted to a potential problem with a particular drug or dose of drug. These interventions are likely to result in a reduced burden on the health care system, and better outcomes for the patient, if they are managed in a timely fashion. An intervention may take only a minute or two, but it may take ten minutes plus phone calls to a doctor or carer.

- In my latest two days of work in Community Pharmacy, in a well-resourced and well-staffed Pharmacy, I did 304 prescriptions, between 9AM and 5:30PM. On one day I did 195 scripts and the balance on the second day; highest

workload was 71 Prescriptions (Rx) over two hours, and the lowest was 4 Rx over one hour. I had one dispensary assistant and three shop staff, all competent. The shop is cool, uncluttered and most scripts could be scanned. I recorded 10 interventions, but would have had many other discussions with patients that did not qualify as interventions. I checked 50-60 Webster packs (not all unique), made changes to two Webster packs and initiated a new pack (but not a new patient). I supervised the sale of 20 Schedule 3 medicines. I also had two discussions with General Practitioners; these were both time-consuming activities, because they, and doctors as a rule, would not speak to me until I rang back and expressed a degree of urgency about the need for a consultation. Ringing a doctor often consumes 10-15 minutes and 2-3 phone calls, usually one way. On these two days there were no errors that needed to be reported, no requests for Blood Pressure or Blood Glucose Level checks, no vaccinations (for which I always need to have a second pharmacist available), no requests from hospitals for patient profiles, and no staged supply pick-ups. Nor were there any complicated ordering issues, although some time was spent trying to source alternatives to out-of-stock.

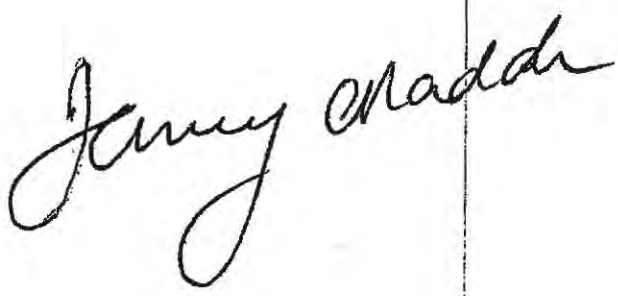
- Sometimes a small problem will escalate, for example, I go out to check that the doctor intended to reduce the dose of a medicine and the patient has no recollection of that conversation with the doctor. So, I have to ring the doctor, run the gauntlet of the staff, await a call back, ring back, only to find that Doctor has gone for the day. No solution. I then have to decide whether I dispense the prescription or not. Dispensing may cause adverse reactions for the patient. This happens often and may take 20 minutes to resolve. The only reimbursement for time spent is via interventions. So once may be enough to wreck the day. Usually 2-3 people request tests/day. S3 sales are very variable.

- In my last month of providing medication management services, I have provided 13 Medication Reviews, necessitating travel to Tumut (once x 3 reviews), Thurgoona (1 x 2), Albury (1 x 1), Humula (1 x 1) and Wagga Wagga (4 x 6). Economy of travel is not always an option, because of the need for a timely

response to the doctor, and funding for travel is often not available. So the travel must involve a round trip of 200 kilometers for a direct referral to the accredited pharmacist rather than the patient's preferred pharmacy. Provision of medication reviews is very professionally satisfying but remuneration is low, given time and travel, and usually shared between the patient's pharmacy and the accredited pharmacist. With one Pharmacy I receive the total fee of about $213, but with most, I receive $170. It takes at least 4-5 hours to produce the report to the doctor. Since pharmacists are limited to 20 HMRs / month, provision of HMRs does not provide a living wage. Provision of RMMR services is quite spasmodic, depending on the sourcing of the review from the doctor and availability of access to the aged care facility. I am contracted to two facilities with about 90 beds in total; the annual work load is usually about 60-70%. I receive $95 of the total fee which is about $110. An RMMR takes about 3 hours on average

Jennifer Madden

14/12/17



Annexure 'A4'

IN THE FAIR WORK COMMISSION

Fair Work Act 2009

s. 156 – 4 yearly review of modern awards

AM2016/28 - Pharmacy Industry Award 2010

STATEMENT OF LEON WAI HON YAP

I, Leon Wai Hon Yap, of 8 Fuji Close, Southport in the State of Queensland, say as follows:

1. I make this statement from my own knowledge, save were otherwise indicated. Where I refer to matters within this statement on the basis of information and belief, I identify the source of that information and believe those matters to be true.

2. I completed a Bachelor of Pharmacy at the University Queensland in 1998.

3. I gained Intern Registration with the Pharmacy Board of Queensland in 1998.

4. I gained full registration as a Pharmacist with the Pharmacy Board Queensland in 1999.

5. I hold current registration to practice as a pharmacist with the Pharmacy Board of AHPRA.

6. I am currently employed as a clinical hospital pharmacist by the Gold Coast Health and Hospital Service, at the Gold Coast University Hospital.

7. I held the following positions prior to commencing employment with the Gold Coast Health and Hospital Service

    7.1. Managing Pharmacist at Palm Beach Pharmacy from 2010 - 2016.

    7.2. Managing Pharmacist at Surfers Paradise Day & Night Pharmacy from 2009 – 2010.

    7.3. Pharmacist in Charge at Palm Beach Pharmacy from 2008 – 2009.

    7.4. Pharmacist in Charge at Showcase Pharmacy (Formally Border Chemmart Pharmacy) from April 2008 – December 2008.

7.5. Locum Pharmacist at Maryborough Amcal Pharmacy from Jan 2008 – April 2008.

7.6. Supervising Pharmacist at Boots Pharmacy Dundalk, Republic of Ireland from Feb 2006 – Oct 2007.

7.7. Proprietor/Managing Pharmacist at Border Chemmart Pharmacy and Kirra Beach Chemmart Pharmacy from 2001 – 2005.

7.8. Pharmacist in Charge at Tugun Chemmart Pharmacy from 1999 – 2001.

8. In my current position I am classified as a Health Professional Level 3 Paypoint 6 (0-8)

9. I am paid $45.40 per hour as per the *Health Practitioners and Dental Officers (Queensland Health) Award – State 2015*. I am paid at the rate of time and a half on Saturdays, double time on Sundays and double time and a half on Public Holidays.

10. I have not entered into an Annualised Salary Agreement/Individual Flexibility Agreement with my employer.

11. My duties in my current position are:

11.1. To provide a complete clinical pharmacy service to inpatients on my assigned ward. These duties include: the taking of medication histories from patients and reconciling with the prescriber(s) on the ward to ensure the correct medications at the correct doses are continued on admission to the hospital, providing prescribing advice and education to doctors, nurses and patients on the ward. Provide chart reviews to ensure safe and effective prescribing, and facilitating patient discharges from the ward (including advice to the doctors on the correct prescribing for discharge medications, facilitating dispensing of the discharge medications at the hospital or community pharmacy, and liaising with Nursing Homes to facilitate medication supply to residents when they enter or return to the facility.

12. During my period of employment as a pharmacist I have seen many changes in both the way I work and the type of work that I am required to do on a daily basis.

My undergraduate studies

13. During my undergraduate degree at the University of Queensland from 1996-1998, the main areas of focus in my degree was on learning the pharmacology of medicines (how medicines work), basic human anatomy, human physiology (how the body works), basic medicine compounding (creating creams, ointments and solutions), the science behind medicine design and delivery systems (tablet manufacturing and the like), prescription legalities, prescription dispensing, patient counselling, over the counter "prescribing". In our first year we covered subjects such as mathematics and statistics, physics, organic chemistry, physical chemistry, Pharmaceutics (Dosage form and design), anatomy and Pharmacy Practice.

14. In second year, we covered more organic and physical chemistry, pharmacology, human physiology, Pharmaceutics, Pharmaceutical compounding (basic ointments/creams/solutions), Pharmacognosy (plant based pharmaceuticals), computer dispensing and labelling and Pharmacy Practice.

15. In third year, we covered Pharmacology, Dispensing, Pharmacy Management, Patient counselling, and Basic diagnosis skills. All assessment was exam based except for a single group project/assignment that was required to complete in the third year of the course.

Pre-registration/Internship

16. I started my (what was then called) Pre-Registration year in December of 1998 and completed it in 1999. The requirements for the Pre-Registration year was to complete 48 weeks of supervised practice within a community or hospital pharmacy setting. There was also the requirement to be involved in the Pharmaceutical Society of Australia's (the 'PSA') Intern Program with a "Pharmacist Mentor/Preceptor" chosen by the PSA for you and a small peer group. We would meet with the Preceptor on a monthly basis where we were given instruction on the various assignments we were to undertake. In addition to this, we were required to attend a certain number of PSA education lectures. At the end of the supervised period of practice we were required to sit an open book written exam provided by the Pharmacy Board of Queensland. The exam covered topics such as pharmacy law and ethics, pharmacological questions, pharmacy practice questions etc. Once the exam was completed and if you achieved a

pass mark, you were informed by the Pharmacy Board that you were eligible for registering as a pharmacist. I can still remember driving up to the Pharmacy Board Office in Brisbane one morning, submitting my forms and paying my registration fee. I received my registration certificate and then drove back to my workplace on the Gold Coast and my boss opened a bottle of champagne and we toasted in the pharmacy. After that I went back to work as a registered pharmacist. My first hourly rate was $25 an hour and $30 on a Saturday. That was in 1999-2000.

My work as a Pharmacist

17. When I first started practicing as a registered pharmacist in a community pharmacy in 1999, my main role was one of serving customers with minor ailments, receiving prescriptions from customers, interpreting prescriptions and then dispensing them. Once prescriptions were dispensed, we would provide basic counselling to patients on how to take the medicine prescribed to them. Other duties included, collating prescriptions together for posting in to the government for reimbursement (PBS claiming), ordering stock, and putting stock away on the shelves.

18. At the time, my role as the pharmacist was one of interpreting a doctor's orders on a prescription, translating them onto a label, dispensing the medicine(s) and then explaining to the customer how to use the medication.

19. I also provided customers with over the counter medicines. The quantity and variety of over the counter medicines available was much smaller than it is today. I was also required to diagnose and treat minor ailments. Minor ailments we were permitted to diagnose and treat with over the counter medicines was limited to conditions such as colds and flu, minor aches and pain, hayfever and minor skin irritations.

20. Pharmacists are now required to be trained and competent to diagnose, treat if appropriate or refer a patient to a doctor for the above conditions as well as Bacterial conjunctivitis (Chloramphenicol), Nausea related to migraine (Metoclopramide and Prochlorperazine), medicated weight loss treatments (Orlistat), provision of Proton pump inhibitors (PPI's) for the treatment of Gastroesophageal Reflux Disease (GORD), assessing the requirement for and providing nasal decongestants facilitated with the use of Project Stop, providing Emergency Contraception (the morning after pill), oral antiviral treatments for cold sores (Famciclovir), oral treatments for vaginal thrush

(fluconazole), and the provision of Naloxone for the emergency treatment of acute opioid overdose.

21. The provision of Emergency Contraception (known as the 'morning after pill') requires pharmacists to be able to determine not only that the product will be appropriate, safe and effective for the particular patient, but also to be able to asses and assist in cases where the patient may be underage and/or there is the possibility that a sexual assault has taken place. This may require specialist knowledge of local sexual health clinics, sexual assault services, as well as the requirements for mandatory reporting of suspected cases of child sexual abuse.

22. Project Stop is a mandatory (in most states) screening and recording database set up and run by the Pharmacy Guild of Australia (PGA) to facilitate the supply of Pseudoephedrine containing nasal decongestant products. If a person requests or the pharmacist suggests a pseudoephedrine containing product to a patient, the pharmacist is required to personally request, sight and enter the details of a person's photographic identification into the Project Stop database, determine whether the person is eligible to purchase the product (has not already purchased a pseudoephredrine product very recently), and then record the sale of the particular product into the database. If a patient either declines to provide photo ID or the Project Stop database shows very recent or excessive use of pseudoephedrine products, the pharmacist is required to refuse supply of the product to the patient. This refusal of sale can often present a safety risk to the pharmacist and other staff due to the potential for causing agitation and anger from the person refused sale.

23. The requirements to record sales of Pharmacist Only Medicines have also increased with all supplies being recoded on the dispensing system under a person's medication file rather than the application of a pre-printed label on to a box/bottle prior to supply as used to be standard practice.

24. The dispensing process may have become slightly faster over the years due to improved technology and better software. However, my patients have increased requirements to assess the appropriateness of a treatment due to higher rates of type 2 diabetes, heart disease, neurological conditions, autoimmune diseases and the increasing complexity of the medicines used to treat these conditions such as many new classes of drugs,

multiple drug combination medications. With this increased complexity, the counselling of patients has also become more complex and comprehensive in order to better educate patients on the medicines they are taking.

25. I have observed that my patients are becoming more involved with their health and are increasingly looking for more information about their medicines. This has meant that I must not only have more knowledge than previous generations about the pharmacology of particular medicines but must also be better at explaining pharmacology to patients and to also be able to counter false or misleading information that a person has read on the internet and from other sources.

26. There has been the introduction of Quality Standards into the workplace with the Quality Care Pharmacy Program (QCPP) from around 2000-01 onwards. This program requires the pharmacy to meet a certain set of minimum standards of service, professionalism and quality control in order to be certified as a QCPP Accredited pharmacy. Most often, the role of the QCPP standards co-ordinator falls to the pharmacist in charge or the pharmacist manager as it does in my case. The pharmacy owner receives payment from the government to achieve and maintain these standards, however often the pharmacist responsible (in my case me) did not share in these extra payments through increased remuneration. Today, QCPP accreditation is a requirement for the pharmacy to access government funding for professional services via the Sixth Community Pharmacy Agreement (6CPA), so now there is extra pressure for the pharmacist to achieve accreditation.

27. The introduction of Dose Administration Aids (DAA's) has been another important but time consuming and mentally challenging service that has been introduced to pharmacist practice since I registered. DAA's are used by many customers to aid them to be better able to take their medicines correctly. They are a very important service offered by most community pharmacists throughout Australia. Creating a DAA involves the repacking of a person's dispensed medicines from the original containers into a single disposable 7 day blister pack that sets out a person's medicines in an easy to read and accessible way. Many pharmacies would easily have 20 or more patients receiving DAA's on a weekly basis, and often many more if that pharmacy services a Residential Care Facility or other type of service. In the past, the labour intensive nature of creating these DAA's meant that most pharmacies would charge customers a

nominal fee for providing them this service (typically between $3 - $8 per week). Recently, the federal government has realised the value of pharmacies providing this service to customers, and pharmacies are now paid $6 per week per customer to provide DAA's through the 6CPA funding. The packing of DAA's is often carried out by pharmacy assistants, however this is not always the case in smaller pharmacies where the pharmacist is expected to fill this role. The dispensing of the medicines that are packed all need to be checked for accuracy and suitability by the pharmacist (just like every other script), and then the contents of each DAA must be physically checked and certified as accurate by the pharmacist. Every tablet inside the DAA must be checked to confirm it is the right drug at the right strength at the right frequency. Again, this task is one the pharmacist has to complete, often while still fulfilling their other roles within the pharmacy.

28. Opioid replacement has occurred in community pharmacy since before I started practicing, however, at the time, it was only methadone syrup that was available and the legislative requirements for dosing were not as onerous as they are today. Methadone doses were routinely made up in advance and left on a bench within the dispensary for a client to pick up. Takeaway doses were often made up in multiple dose bottles with minimal labelling requirements. Today, the numbers of people on opioid replacement programs has greatly increased with many more clients receiving doses from within a community pharmacy setting. When I first started, having 5-10 clients was the norm, and now I have 20-40 clients using this service. Also, the legal requirements for dispensing opioid replacement has become more explicit. Doses are to be made up only when the patient presents, or if made up in advance, kept locked in an approved safe or cabinet. Takeaway doses must be in individual bottles with a child proof lid and explicit instructions written on the label. The types of opioid replacement have also increased. While there was once only Methadone syrup, there is now Methadone liquid (Biodone), Subutex sublingual tablets (Buprenorphine) in 3 strengths and Suboxone Films (Buprenorphine/Naloxone) in 2 strengths. This has made the process of supply and recording much more complicated as the ability to make errors has increased due to having seven different varieties of product being used at any one time. Upon presentation to the pharmacy (often daily), I am required to individually identify the client, assess whether they are able to be dosed (not intoxicated/affected by other drugs or alcohol), measure out the dose for them, provide the dose, watch it being

consumed and then make sure it is not diverted at any stage. Payment is then taken from the client, then the pharmacist must complete their legal requirements in terms of recording the amount given and who it was given to on their prescriptions. At the end of the month, the total amount given must be recorded in the controlled drug register and the balances of stock reconciled. Any discrepancies must then be accounted for and reported to the Pharmacy Authorities if they are not able to be reconciled. Again, this task is often completed alongside the pharmacist's other duties during each day.

29. In around the year 2000, when the state pharmacy boards were incorporated into the National Pharmacy Board and AHPRA was established, Queensland pharmacists were for the first time required to achieve a certain number of hours of compulsory professional development ('CPD') in order to be eligible for re-registration. The first year, this number was 20 hours, then second was 30 hours and the third and for each subsequent year after this it has been 40 hours per year.

30. This requirement ensures that I am otherwise more skilled and up to date with my knowledge. However, the majority of the time, the CPD learning must be done in the pharmacists' own time (not during work hours), and very rarely are pharmacists paid to undertake any CPD learning (this includes courses, workshops or conferences, as well as purchasing pharmacy journals or memberships to CPD providing organisations). Pharmacists are generally not paid their wages whilst they are attending external CPD sessions. The cost is taken on solely by the employee pharmacist.

31. Professional Services have also been quantified and incorporated into successive Community Pharmacy Agreements. The first one was Domiciliary Medication Management Reviews (DMMR's), now known Home Medicines Reviews (HMR's). This is a very valuable service, and provides an avenue for pharmacists to use their clinical knowledge by providing in depth medication histories, expert pharmacological reviews of a person's medications and providing recommendations for a patients' GP in order to best optimise a person's medications moving forward. This service is undertaken within a person's home, so the pharmacist is able to see more than just the medicines, but the conditions that the person lives in, the ability the person has to access their medicines, how they are stored, how they are consumed (and any barriers there are to this) and the overall knowledge the patient has of their medicines. In order to provide this service, the pharmacist must undertake a two stage accreditation course.

Stage 1 can be completed as either a one day face to face workshop, or as an online preparatory course, while Stage 2 requires the pharmacist to complete a Communication Module, pass a clinical multiple choice assessment and finally to complete four case studies (mock HMR's) by correspondence. The answers are graded and passed or returned to you for modification and resubmission if they do not meet the necessary requirements. This course takes about 6 months to a year (sometimes more) to complete.

32. Remuneration is available from the federal government to provide these reviews to patients upon referral by a GP. These referrals can be sent to the patients' community pharmacy and then passed on to an accredited pharmacist to complete the review, or they can be sent directly to an accredited pharmacist. If the referral is sent to the community pharmacy, once the review is completed, the owner of the community pharmacy will make a claim for payment for the service though the 6CPA funding and then pass on a portion of this money to the accredited pharmacist who completed the review. If the referral is sent directly to the accredited pharmacist, then it will be the accredited pharmacist that makes the claim for payment (and receives the full amount directly). Recently however, there have been arbitrary caps put on the number of reviews a pharmacist is able to do in any one month which has meant that it is now virtually impossible for a pharmacist to exclusively provide this service as their sole means of income. I was able to complete this course in 2013/14 to become an AACP Accredited Pharmacist. I undertook several HMR's during my time at Palm Beach Pharmacy, and found this to be a challenging but very rewarding service to provide to patients.

33. Other professional services that have been introduced (some of which are now paid to community pharmacist through the 6CPA funding) include Medschecks and Diabetes Medschecks, staged dispensing, clinical intervention recording and Provision of Absence from work certificates. These are services that I would have to prepare for and complete often while completing my other duties as a pharmacist during the day. One of the major recommendations for providing Medschecks and Diabetes Medschecks is that the pharmacist providing them not be the sole pharmacist on duty, however this is not always the case and they are often performed by one-pharmacist pharmacies. I was often the sole pharmacist on duty when I was required to provide these services during

my working day. The extra remuneration provided to pharmacies as part of the 5CPA and 6CPA funding, goes directly to the pharmacy owners and very rarely was any of this money shared with the actual pharmacist performing these services. In my own workplace, I never received any extra remuneration other than my weekly wages for providing these professional services in the pharmacy.

34. The Palm Beach Pharmacy where I was last employed as a community pharmacist also ran a Clozapine clinic from within the professional services room in the pharmacy. Clozapine is an antipsychotic drug that requires regular blood monitoring and other special monitoring in order to treat a patient safely with it. Our pharmacy would run a private clinic once a week and the local state health service would run another clinic in their building across the road on another day once a week. In essence we were servicing about 15-20 Clozapine clients per clinic (30-40 clients in total) each week. In order to dispense clozapine, the prescription must first meet specific legal requirements, then the patients' blood test results must be available for inspection on a special monitoring website. There are two websites: One is for private clients on the Clopine brand and a second for public patients on the Clozaril brand. Once reviewed, the blood results must be signed off and the details of dispensing of the clozapine entered into the relevant website. Pharmacists must be individually registered to use the websites, with the particular websites' Clozapine protocols read and understood by the pharmacist before registering to be able to dispense clozapine. This whole process is very time consuming and in my opinion, is new work, as community pharmacy dispensing of Clozapine was only made available 2-3 years ago.

35. In 2016, I was able to take up a new opportunity at the Gold Coast Health and Hospital Service as a clinical hospital pharmacist. In my last role as a community pharmacist, I was employed as the Pharmacist Manager of the Palm Beach Pharmacy. I was paid at the rate of $35 per hour Monday to Friday and $40 per hour on Saturdays. The pharmacy was closed on Sundays and Public Holidays so an hourly rate for these days was not discussed with the owner of the pharmacy. I held this role for 6 years and had not received a single pay increase over the entire 6 year period even though the pharmacy had increased its turnover by about 15-20% over this timeframe.

Leon Wai Hon Yap

18th of December 2017

PLEASE NOTE: An Application for a Confidentiality Order is being lodged for this witness

Annexure "A5"

IN THE FAIR WORK COMMISSION

Fair Work Act 2009

s. 156 – 4 yearly review of modern awards

AM2016/28 - Pharmacy Industry Award 2010

STATEMENT OF [redacted]

[redacted] in the state of New South Wales, say as follows:

1. I make this statement from my own knowledge, save where otherwise indicated. Where I refer to matters within this statement on the basis of information and belief, I identify the source of that information and believe those matters to be true.

2. I completed a Bachelor of Pharmacy at The University of Sydney in 2014. I completed a Graduate Certificate in Pharmacy Practice from the University of Queensland in 2016. I am currently studying for a Master of Clinical Pharmacy at the University of Queensland with an estimated completion date of December 2019.

3. I gained Provisional Registration with the Pharmacy Board of the Australian Health Practitioner Regulation Authority (AHPRA) in 2015.

4. I gained full registration as a Pharmacist with the Pharmacy Board of AHPRA in February 2016.

5. I hold current registration to practice as a pharmacist by the Pharmacy Board of AHPRA.

6. I am currently employed by NSW Health as [redacted] Pharmacist [redacted] and a Specialist [redacted] the [redacted] Centre [redacted].

7. Prior to commencing in my current positions I held the following positions with my current employer.

   7.1. [redacted] Pharmacist [redacted] (NSW Health) from April 2016 – April 2017.

7.2. Clinical Pharmacist at [redacted] (NSW Health) from February 2016 – April 2016.

8. I held the following positions prior to commencing employment with NSW Health:

8.1. Intern Pharmacist at [redacted] Hospital Queensland Health from January 2015 - January 2016.

8.2. Dispensary Technician at [redacted], from September 2011 – December 2014.

8.3. Pharmacy Assistant at [redacted] armacy, ACT, from March 2012 – June 2012.

8.4. Pharmacy Assistant at [redacted] Pharmacy, NSW, from January 2011 – October 2011.

8.5. Dispensary Technician at [redacted] harmacy, ACT, from December 2010 - January 2011

8.6. Pharmacy Assistant at [redacted] Pharmacy, ACT, from February 2008 - August 2008, July 2009 - February 2009

My current professional positions

9. In my current position I am classified as a Pharmacist Grade 3 at [redacted] Hospital and a Pharmacist Grade 2 at NSW [redacted]

10. I am paid:

10.1. at [redacted] $56.60/ hour, (In accordance with the NSW Health Employees' Pharmacists (State) Award 2017. Annexed to this affidavit and marked "AT-1" is a true and correct copy the NSW Health Employees' Pharmacists (State) Award 2017.)

10.1.1. with 50% loading on Saturdays and 75% loading on Sunday

10.2. at the NSW [redacted] $48/ hour, (In accordance with the NSW Health Employees' Pharmacists (State) Award 2017. Annexed to this affidavit and marked "AT-1" is a true and correct copy the NSW Health Employees' Pharmacists (State) Award 2017 and the New South Wales Hospital Scientists (State) Award for conditions of employment, including penalties. Annexed to this affidavit and marked "AT-2" is a true and correct copy of the New South Wales Hospital Scientists (State) Award.)

10.2.1. with 50% loading on Saturdays and

10.2.2. 75% loading on Sundays

10.2.3. 50% loading for the hours worked between 9pm and 8.30am

11. I have not entered into an Annualised Salary Agreement/Individual Flexibility Agreement with my employer.

12. My duties in my current positions are:

12.1. As the [redacted]

12.1.1.1. The provision and development of clinical pharmacy services to the emergency department and short stay unit.

12.1.1.2. To obtain detailed medical histories from patients and to undertake medication review where appropriate.

12.1.1.3. To work closely with other ward pharmacist with respect to all issues related to optimal pharmaceutical care.

12.1.1.4. To contribute to the discharge planning process.

12.1.1.5. To prepare pharmaceutical care plans when necessary to ensure continuity of care.

12.1.1.6. To provide information to nursing and medical staff on relevant aspects of drug usage and availability, and to assist in the training of nursing and other nonpharmacy staff in pharmacy related subjects.

12.1.1.7. Preceptor - the Pharmacy Intern. The preceptor has the responsibility to guide the pharmacist intern through the experiential education program that is essential for them to become a competent pharmacist. The preceptor assumes the role of teacher during the practical training period. The supervised practice period is intended to be one of professional and personal maturation, leading to a level of competence that will allow independent professional practice after gaining general registration. The preceptor must to assess and provide feedback on the knowledge, skills and performance of the intern throughout the training period so that experiences can be built upon and any difficulties identified and remediated in a timely manner The preceptor serves as a role model, a learning resource, an orientation to the work place, organises to expose them to the full range of professional services and provides positive and developmental feedback during the learning process.

12.1.1.8. Write and review policies, procedures and standing orders for the emergency department and the intensive care unit.

12.1.1.9. Clinical responsibility for the intensive care unit and all patients within.

12.1.1.10. Strategic planning for the pharmacy department as well as the broader hospital.

12.2. As a Specialist in Poisons Information my duties include:

12.2.1. Assessment of patients exposed to various toxins and advice on simple treatment in the home or referral to a Health Care Facility.

12.2.2. Advising medical professionals on the management and prognosis of poisonings.

12.2.3. Advising on the treatment of bites and stings.

12.2.4. Advising on the effects of drugs in pregnancy and lactation.

12.2.5. Advising on the side effects and interactions of medications.

12.2.6. Answering general queries relating to poisoning, pesticides and chemical safety.

12.2.7. Accurately recording information provided directly into the database at the time of the call.

12.2.8. Actively audit Poisons information Centre call records during each shift.

My undergraduate training

13. I started the Bachelor of Pharmacy at Sydney University in 2010. At this time, it was a 4-year undergraduate degree. Each subject had the majority of its assessments as pass compulsory with few options to 'make up' credit. The degree was accredited by the Pharmacy Council of Australia. Accreditation of the degree is required in order for graduates to become registered as pharmacists. Annexed to this affidavit and marked "AT-3" is a true and correct copy the University of Sydney 2010 Pharmacy Handbook.)

14. My first-year subjects consisted of chemistry for pharmacy, human biology, molecular biology and genetics, basic pharmaceutical sciences, foundations of pharmacy, social pharmacy and physical pharmaceutics and formulation. These subjects provided me with foundation knowledge that was built upon throughout the undergraduate program.

15. My second-year subjects consisted of drug discovery and design, microbiology and infection, therapeutic principles, physiology, pharmacology, pharmacy practice, physical pharmaceutical and formulations.

16. The third-year subjects were set out in a way that required all students to study full time. We were not allowed to take this year part-time. The subjects were divided by body systems. Each body system was taught comprehensively including a revision of the pathophysiology of the system, the pharmacology of drugs that affect the system and how the two integrate. Body systems covered included cardiovascular, renal, respiratory, endocrine, diabetes, reproduction, gastrointestinal, musculoskeletal, dermatological, senses, oncology, immunology, mental health and neurology. It was a requirement of the course to pass the exams in each system.

17. For the final-year subjects students were given the choice of applying for the industrial major, honours, or the pharmacy practice stream. Regardless of which stream was chosen each student was required to attend forensics which covered pharmacy legislation. Every student was also required to do pharmacotherapeutics, integrated dispensing and novel therapeutics. Those students not studying honours were required to complete a pharmacy management course.

18. My pharmacy degree had a focus on the quality use of medicines and how to improve patient outcomes. Students were taught how to perform professional services and how to integrate into the health care team. We are taught that why pharmacists as experts in medications are essential in the health care team. We are taught how best to communicate with patients and doctors to improve patient outcomes.

    18.1. One assessment I had was a laboratory exercise on how to determine the purity of amitriptyline using different experiments. We also learnt about the use of amitriptyline in different patient groups. This medication is prescribed for depression and to aid sleep in the elderly. We learnt about the appropriate use of this medication and when to best deprescribe it to improve mortality and morbidity in the elderly.

18.2. During my undergraduate studies we participated in role plays communicating key health messages to the general public. We learnt how to use lay man's terms to communicate these messages. For example, the pharmacokinetics and pharmacodynamics of penicillins in infections means that you want to achieve the greatest time of penicillin serum concentration above the minimum inhibitory concentration. To patients this means that you need to spread out the doses of penicillins evenly throughout the treatment period.

18.3. We also learnt how to communicate with medical prescribers. Medical prescribers have a slightly different language compared to pharmacists so we need to learn how best to communicate our issues. We learnt about structuring our interactions using the situation, background, assessment, recommendation approach. For example, "Are you looking after the 23-year-old (non-pregnant) female with mild community acquired pneumonia? She is allergic to penicillins and has been prescribed amoxycillin. Amoxycillin is a penicillin so this patient is at risk of suffering an allergic reaction. I recommend we change her to doxycycline 100mg twice a day for 5 days as she has previously tolerated this and it will treat her community acquired pneumonia just as effectively."

Internship

19. At the completion of my degree I sought and gained provisional Registration with the Pharmacy Board of AHPRA. Provisional Registrants are commonly known as Interns.

20. In 2015, my Intern year consisted of full-time work, study and exams. I was required to sit two exams; the first exam was a written exam completed after 30% of my supervised hours was achieved by the Australian Pharmacy Council and the second exam was the oral exam

21. I was required to register with an intern training provider accredited by the Australian Pharmacy Council.

22. I was required to make a training plan for their learning for the year, including obtaining 40 continuing professional development (CPD) points. Annexed to this affidavit and marked "AT-4" is a true and correct copy the Pharmacy Board of Australia Frequently Asked Questions – Continuing Professional Development for Pharmacists and Pharmacy Interns. December 2015.)

22.1. The CPD plan should include a broad range of activities relevant to the role or scope of practice undertaken. A detailed, verifiable record of activities undertaken should be kept. This should include an assessment of whether the intended outcomes of the activities have been achieved.

22.2. CPD activities may cover a range of topics that include but are not limited to: clinical education with a patient care focus, leadership or management education, quality improvement, and quality use of medicines or other topics relevant to practice as a pharmacist.

22.3. If a CPD activity is accredited by an authorised provider, the Board will accept that the activity has been reviewed for its educational quality and for its relevance to a pharmacist's practice. If a CPD activity is not accredited by an authorised provider, you will need to assess it for suitability and relevance and determine whether your individual learning needs will be addressed.

22.4. Out of the required 40 CPD credits of the Board's annual CPD requirements, at least 20 must come from Group 2 and/or Group 3 activities (that is, a maximum of 20 CPD credits can come from Group 1 activities). There is no restriction or cap on activities from Groups 1, 2 and/or Group 3 that can be undertaken by a pharmacist in a CPD period in order to meet their learning needs.

22.5. Group 1: information accessed without assessment (one Board CPD credit per hour of activity). This includes didactic presentations, and activities with little or no attendee interaction.

22.6. Group 2: knowledge or skills improved with assessment (two Board CPD credits per hour of activity). This includes activities where the participant's acquisition of knowledge or skills can be demonstrated, for example through successful completion of some form of assessment. The activities provide for the measurement of a participant's achievement of the continuing professional development objectives and individual feedback on performance in assessments.

22.7. Group 3: quality or practice-improvement facilitated (three Board CPD credits per hour of activity). This includes activities where an assessment of existing practice (as an individual or within a pharmacy practice), and the needs for, and barriers to changes in this practice, is carried out before the development of a particular activity. As a result, the activity addresses identified continuing professional development needs with a reflection post-activity to evaluate practice change or outcomes resulting from the activity. Such an activity most likely will extend over a number of weeks or months.

23. I was required to complete 1824 supervised practice hours and during this period I was required to:

23.1. Obtain a first aid certificate including basic life support,

23.2. Accurately dispense 100 items, provide proof of the dispensing audit, reflect and identify risks that can increase dispensing errors,

23.3. Make 6 different extemporaneous products (e.g. eye drops, creams)

23.4. Actively reflect on difficult situations in pharmacy practice including being asked to do something incorrectly, ethical dilemmas, breach in privacy.

23.5. Submit an adverse drug reaction report to the Therapeutic Goods Administration.

23.6. Perform a medication management review on an actual patient.

23.7. Write an evidenced-based medicine review on a medication information related enquiry.

24. In my Intern year, I completed the University of Queensland Pharmacy Intern training course. This course had four 2-day seminars that were compulsory to attend in full. It also had regular online group assignments including seven 2-week online discussion boards which covered therapeutic areas, legal requirements, ethical and pharmaceutical calculations.

24.1. As part of this course I was required to do a health promotion activity. I created a smoking cessation stall at the front of the hospital I worked in. I liaised with smoking cessation organisations and was able to get lots of educational material to distribute to visitors of the hospital and ambulant patients. I also measured the carbon dioxide concentration in participants breath (marker for blood carbon dioxide concentrations) to provide personalised smoking cessation management plans.

24.2. In order to achieve full Registration as a pharmacist I was also required to complete a 3-hour written exam, undertaken by the Pharmacy Board, consisting of 125 multiple choice questions. Annexed to this affidavit and marked "AT-5" is a true and correct copy the Australian Pharmacy Council Australian Intern Written Exam.)

25. To be eligible to sit this exam I was required by AHPRA to have completed 30% of my accredited supervised practice hours. The overall minimum pass mark is 65%. The areas covered in the exam include:

25.1. Domain 1: Professional and ethical practice, including the following standards – practise legally – practise to accepted standards. There was a required minimum pass mark of 63%

25.2. Domain 4: Review and supply prescribed medicines, including the following standards – consider the appropriateness of prescribed medicines – dispense prescribed medicines. There was a required minimum pass mark of 50%

25.3. Domain 5: Prepare pharmaceutical products, including the following standards – consider product requirements. There was a required minimum pass mark of 63%

25.4. Domain 6: Deliver primary and preventative health care, including the following standards – assess primary health care needs – deliver primary health care – contribute to public and preventative health. There was a required minimum pass mark of 50%

25.5. Domain 7: Promote and contribute to optimal use of medicines, including the following standards – contribute to therapeutic decision-making – provide ongoing medication management. There was a required minimum pass mark of 50%

26. The examinations conducted by the Pharmacy Board included a 45-minute oral examination. (Annexed to this affidavit and marked "AT-7" is a true and correct copy the Pharmacy Board of Australia Pharmacy Oral Examination (Practice) Candidate Guide 2017.)

27. I refer to Annexures AT-4, AT-5, AT-6, and AT-7 and note that there have not been any changes to the exam requirements since I sat my exam.

28. I refer to "Part 4: Problem Solving & Communication" of the exam which is conducted in role play. My exam scenario for this question was young female patient who presented a script for a poorly known smoking cessation medication. On questioning I discovered that she had a history of seizures. The smoking cessation medication prescribed increases seizure risk. The patient had not tried any other smoking cessation

therapy prior to this so I was able to contact the prescriber (with patient consent) and recommend alternate treatment.

29. Skills taught in my Intern year included detecting, diagnosing and treating minor ailments. We were also taught to detect more serious conditions, when to refer patients to another professional and to know how to treat the more serious condition. As an expert in medicines I am frequently consulted by the prescriber in order to provide the most appropriate therapy for the patient.

10 December 2017

List of Annexures

The annexures can be viewed via the following links:

1. **Attachment 'AT-1'** – Health Employees' Pharmacists (State) Award
2. **Attachment 'AT -2'** – Hospital Scientists (State) Award
3. **Attachment 'AT-3'** – Pharmacy Handbook – University of Sydney
4. **Attachment 'AT-4'** – Continuing professional development – Pharmacy Board
5. **Attachment 'AT-5'** – Australian intern written exam
6. **Attachment 'AT-6'** – Pharmacy oral examination (practice) candidate guide
7. **Attachment 'AT-7'** – Pharmacy oral examination (practice) candidate guide

Annexure 'A6'

PLEASE NOTE: An Application for a Confidentiality Order is being lodged for this witness

IN THE FAIR WORK COMMISSION

Fair Work Act 2009

s. 156 – 4 yearly review of modern awards

AM2016/28 - Pharmacy Industry Award 2010

STATEMENT OF [redacted]

I, [redacted] in the State of Victoria. say as follows:

1. I make this statement from my own knowledge, save where otherwise indicated. Where I refer to matters within this statement on the basis of information and belief, I identify the source of that information and believe those matters to be true.

2. I completed a Bachelor of Pharmacy at Charles Sturt University in 2009.

3. I gained Intern Registration with the Pharmacy Board of the Australian Health Practitioner Regulation Authority ('AHPRA') in December 2009.

4. I gained full registration as a Pharmacist with the Pharmacy Board of AHPRA in April 2011.

5. I hold current registration to practice as a pharmacist by the Pharmacy Board of AHPRA.

6. I am currently employed as a Pharmacist Manager at [redacted]

7. I held the following positions prior to commencing employment with [redacted]

   7.1.1. Pharmacist Manager at [redacted] Pharmacy from March 2016 – November 2016.

   7.1.2. Pharmacist at [redacted] Pharmacy from August 2015 – February 2016.

   7.1.3. Pharmacist at [redacted] Pharmacy from April 2011 – August 2015.

8. In my current position I am classified as a Pharmacist Manager

9. I am paid $44 per hour Monday to Friday, $55 per hour on Saturday and for Overtime, $65 per hour on Sunday.

10. I have not entered into an Annualised Salary Agreement or Individual Flexibility Agreement with my employer.

11. My duties in my current position include, providing medication in accordance with the law, current clinical evidence and in line with current pharmaceutical benefits scheme ('PBS') arrangements, performing services such as providing medical leave certificates, in-Pharmacy medication reviews, supervision of daily medication collection, screening and provision of Sleep Apnoea treatments and weight management consultations, managing all aspects of the business including staff management and ensuring the Pharmacy operates within all relevant legal framework and professional standards.

12. I am also responsible for the receipt and processing of prescriptions followed by the assembly, sale and relevant medical counselling required for that particular medicine. I must ensure that the prescription is valid according to the current National and State regulations, that the choice of medicine, the dose, the instructions to the patient and all other details are medically appropriate for the patient and the medical condition. I must also counsel the patient on the medication with an aim to ensure that the patient understands what the medication is, how to use it, that they understand any serious or common side effects that may occur and any other information that the patient may need to ensure good and safe medical treatment. I would typically dispense about 130-150 prescriptions per day.

13. I must also supervise or be involved in the supply of Schedule 2 Pharmacy Only medicines and Schedule 3 Pharmacist Only medicines where the patient does not require a prescription to access these medicines but they must be bought from a pharmacy, or directly from a Pharmacist. These regulations are for specific medications due to their side effects, the danger of inappropriate use or other safety concerns that require a Pharmacist to oversee, to be directly involved or available for consultation when they are purchased. When these medicines are supplied I am liable for the supply of these medications from both a medical and legal perspective. I must ensure that the medicines are safe for the person taking it, by considering their

medical conditions. other medication they are taking. their age and gender and any other relevant information, I must also make sure that the treatment is likely to be effective. considering the nature and severity of the condition. the treatment options and, when required. recommend an alternative treatment or make a referral to an alternative healthcare provider. I must also ensure that all medicines are supplied in accordance with their schedule. considering the quantity required, the condition being treated and any other regulations or restrictions placed on their supply.

14. There are also many unscheduled medicines or medical products (such as medical aids. wound care products or support braces etc.) that the Pharmacist must also know how to use and safely supply to a patient.

15. Increasingly. my role as a Pharmacist also involves the provision of what is normally called "Professional Services" these are services provided by a Pharmacist that don't necessarily involve the sale of a medication or product. I have worked in Pharmacies that have provided the following Professional Services: Pharmacist Vaccinations. Leave Certificates. Opioid Replacement Therapy. Dose Administration Aids. Staged Supply. Clinical Interventions. Sleep Apnoea Screening and Treatment. a Weight Loss Program "Impromy". In-Pharmacy Medication Reviews (MedsCheck) and Diabetes Specific Medication Reviews (Diabetes MedsCheck). Home Medication Reviews. Blood Pressure. Blood Glucose and Cholesterol Screening. I have supplied all of these services except Pharmacist Vaccinations and Home medication reviews due to the extra training required.

16. Many of these services require training in addition to my Pharmacy degree. some even require specific qualifications that can take months or years to acquire. I have gained training to provide Opioid Replacement Therapy in accordance with the Victorian legislation for my role at [redacted] Pharmacy. and I have gained training to provide Sleep Apnoea Screening and Treatment and the Weight Loss Program "Impromy" in my current role at [redacted] I have also attended specific training to provide good quality MedsChecks and Diabetes MedsChecks.

17. Since taking on the role of Pharmacist Manager at [redacted] Pharmacy and [redacted] Chemists [redacted] I have required a completely different set of skills and knowledge to perform my job including human resourcing. stock control and financial analysis.

My Pharmacy degree did not contain any subjects that cover these topics and I have not received any formal training from my employers. All knowledge I have on these topics have been from a personal interest, or has been learnt from observing my employers while in my previous roles. As well as performing the other tasks set out in this statement as a Pharmacist I also need to:

17.1.1. Understand and apply all relevant regulations, law and practice standards for human resource management. I have been involved in hiring, managing and terminating staff in both of these roles, this has involved disciplinary meetings, management of rosters, staff education and standards, conducting staff meetings, conducting performance reviews and many other human resourcing tasks.

17.1.2. Manage and perform necessary stock control processes such as daily ordering, which involves monitoring the level of stock on hand and ensuring sufficient stock is available for our usual sales. This process has become more difficult since my registration due to the introduction of the price disclosure process and the introduction of many high-cost PBS items (up to $22,000 for one product). Every 3-6 months I have to ensure that, for a different selection of items each time, we are at the lowest possible stock on hand to prevent unnecessary losses due to PBS price reductions. The high-cost PBS items also create a lot of risk for the business and the burden of this falls on the Pharmacist Manager to take extra measures to ensure payment will be received, that cash-flow is appropriate for the business and that the patient obtains the medication in a timely manner.

17.1.3. Track, analyse and make decisions based on financial data. Part of my role is to spend time each day looking at the gross profit, wage costs, sales traffic, prescription numbers, PBS income, product wastage, performance of promotions and professional services and analysing the data to see how it might affect the way that I am running the business.

18. I have observed that there appears to be more and more Pharmacist Manager jobs advertised, and it is increasingly common that non-owner Pharmacists are managing

Pharmacies and Pharmacy owners owning multiple pharmacies. The owner that I am employed by has a financial interest in about 50 Pharmacies. I have never met the owner of the pharmacy.

19. I have also taken on the role of Preceptor during my role as Pharmacist Manager at Elmwood Pharmacy. This involves supervising the learning and competence of an Intern Pharmacist during their registration year. This requires a lot of time, knowledge and effort. A small amount of guidance is given by the provider of the intern training program, but it mostly relies on the experience and knowledge of the Preceptor. It is increasingly falling on employee Pharmacists and Pharmacist Managers to perform this role as less owner Pharmacists are present in their Pharmacies.

20. Since I completed my Pharmacy degree the Pharmacy Board of Australia has introduced compulsory continuing professional development ('CPD') and learning plans. This has increased the burden of work for me to retain my registration by documenting the learning activities that I undergo to maintain my professional knowledge and competence. I am required to perform 40 hours of CPD activities each year and develop a learning plan to address areas of competence that require improvement. This is decided by my own self-assessment against the relevant competency standards and my current or future areas of practice, a skill that I am still learning to do. All CPD activities are done in my own time and at my own expense unless I can negotiate compensation from my employer, which I have only been successful in doing once.

[redacted]

15/12/2017

Annexure 'A7'

PLEASE NOTE: An Application for a Confidentiality Order is being lodged for this witness

IN THE FAIR WORK COMMISSION

Fair Work Act 2009

s. 156 – 4 yearly review of modern awards

AM2016/28 - Pharmacy Industry Award 2010

STATEMENT OF [redacted]

[redacted] in the state of NSW, say as follows:

1. I make this statement from my own knowledge, save were otherwise indicated. Where I refer to matters within this statement on the basis of information and belief, I identify the source of that information and believe those matters to be true.

2. I completed a Bachelor of Pharmacy at Charles Sturt University in 2009. I also have a Bachelor of Business.

3. I gained Intern Registration with the Pharmacy Board of the Australian Health Practitioner Regulation Authority ('AHPRA') in 2010.

4. I gained full registration as a Pharmacist with the Pharmacy Board of AHPRA in 2011.

5. I hold current registration to practice as a pharmacist by the Pharmacy Board of AHPRA.

6. I am currently employed as a Pharmacist in Charge at [redacted]

7. I held the following positions prior to commencing employment with [redacted]

   7.1.1. Pharmacist [redacted] Pharmacy from 2014 –2016, and Pharmacist manager 2016- 2017.

   7.1.2. Pharmacist in charge at [redacted] Chemist from 2011 – 2014.

8. In my current position I am classified as a Pharmacist-in-Charge.

9. I am paid $37 per hour ordinary, $45 per hour on Saturdays and $50 per on Sundays and Public Holidays.

10. I have entered into an Individual Flexibility Agreement with my employer.

11. My duties in my current position are rostering pharmacists, dispensary management, stock orders and control, inventory, compounding non-manufactured medicines, report to owners.

12. During my period of employment as a pharmacist I have seen a number of changes in the pharmacy sector.

13. As a pharmacy Graduate in 2010, I was working in a retail pharmacy and pharmacists were mostly performing dispensing tasks. A small amount of time was spent on administration such as stock control.

14. Since 2010, I observed the demand for services has increased. I am now providing more counseling to patients, daily stage supply of methadone and suboxone for patients getting off drugs addiction, vaccinations, medications reviews, home medications reviews and quality use of medicines. As more services are demanding of my time, I feel more pressured to do multiple things in a short period of time and do them accurately without making a mistake.

15. My normal working day involves dispensing about 250 or more scripts; checking Webster packs (dose administration aid) for those patients who can not take medication by themselves involve checking multiples tablets for the morning, lunch, dinner and bedtime doses; seeing multiple 'walk in' patients for minor health advice which average about 20 per day; seeing multiple 'walk in' patients for pharmacist only medicines request; conducting medication reviews which involves sitting down with the patient and going through their medications, inhalers, eyes drops, ointments or creams and review their use or interactions; and 'walk in' vaccinations which involves escorting the patient to the therapy room, preparing and completing all the necessary forms prior to the actual injection.

16. The nature of the demographic of the pharmacy where I work in a rural area is significantly different from many others with diverse demographics including age,

ethnic background and social economic customers. Patients with special requirements are more time consuming. For example, I spend more time with a patient who has limited English. While spending more time with this patient other tasks and 'walk in' patients starting to line up and the line gets longer and longer. This lead to a stressful work environment when I have check the scripts, supervise the staff with customers waiting. Availability of staff is also kept to a minimum so that the Pharmacy will be more profitable due to budget constraints which further adds more stress and pressure to me as the sole pharmacist on duty.

17. There is a significant amount of new work that was not previously done by pharmacists when I commenced practicing as a pharmacist. Vaccination, for instance was recently introduced. Government and regulatory changes is another. The impact of quality use of medicines, down-scheduling of medicines, ageing population/co-morbidity; increasing number of medicines and variety are putting more work and pressure on pharmacists to perform beyond what was done when I commenced practice but without additional monetary compensation. New educational/qualification requirements required to perform different aspects of your job; requirements to educate and counsel patients on the safe and proper use of medicines; more complex working environments and yet pay remains the same.

18. Since my undergraduate degree, I have had to undertake further training in order to perform the many new services provided by my pharmacy. I underwent further training for vaccinations, medication reviews, down scheduling of drugs and up scheduling of drugs. These training came at a cost to myself and I perform these services at the pharmacy and yet my pay remains the same.

[redacted]

13/12/2017

IN THE FAIR WORK COMMISSION

Fair Work Act 2009

s. 156 – 4 yearly review of modern awards

AM2016/28 - Pharmacy Industry Award 2010

STATEMENT OF KATERINA MALAKOZIS

I, Katerina Malakozis, of [redacted] Australia, say as follows:

1. I make this statement from my own knowledge, save were otherwise indicated. Where I refer to matters within this statement on the basis of information and belief, I identify the source of that information and believe those matters to be true.

2. I completed a Bachelor of Pharmacy at South Australian Institute of Technology in South Australia.

3. I gained Intern Registration with the Pharmacy Board of the Australian Health Practitioner Regulation Authority ('AHPRA') in 1989.

4. I gained full registration as a Pharmacist with the Pharmacy Board of AHPRA in 1990.

5. I hold current registration to practice as a pharmacist by the Pharmacy Board of AHPRA.

6. I am currently employed as a Pharmacist in Charge at National Pharmacies, 52 Gawler Place, Adelaide.

7. Prior to commencing in my current position/s I held the following positions with my current employer.

    7.1. 1989 – Intern pharmacist
    7.2. 1990 – Second pharmacist in permanent location
    7.3. 1991-1993 – Fulltime relief (locum) pharmacist
    7.4. 1993-1997 – Pharmacist in Charge in a small pharmacy
    7.5. 1997-2003 – Pharmacist in Charge in a medium pharmacy

7.6. 2003 –now – Pharmacist in Charge for a large pharmacy

7.7. My employment history of 28 years is with National Pharmacies, also known as Friendly Society Medical Association in South Australia.

8. In my current position I am classified as a Pharmacist in Charge

9. I am paid $48.51 per hour.

10. I have not entered into an Annualised Salary Agreement or Individual Flexibility Agreement with my employer.

11. In my current position:

11.1. I am employed as a Pharmacist in Charge at a busy pharmacy. As a Manager, I am required to manage all employees of my pharmacy, both as a team leader and as a coach as well as being the main contact point for all customers as the first port of call, for all medication or general health issues.

11.2. I dispense prescriptions and check compatibility with other medications as well as with over the counter medicine for all patients

11.3. I counsel patients on how to take their medications and how they work and what to expect from them

11.4. I perform Medschecks to assist customers in understanding how their medications work.

11.5. I supply Schedule 3 medications.

11.6. I use Medsassist . This is a real time recording system for codeine product requests from customers[So that we can monitor codeine use/abuse.

11.7. I authorise absence from Work Certificates for the community.

11.8. I record all activities for 6th Community Pharmacy Agreement (6CPA) records.

11.9. I keep adequate documentation of all significant discussions with patients.

11.10. I ensure all employees have adequate training to supply Scheduled products.

11.11. I administer influenza innoculations.

11.12. I provide health information to patients.

11.13. I supply and pack dose administration aids (DAA's) and check other non-pharmacist completed DAAs.

11.14. I ensure harm minimisation through a supply needle exchange program.

11.15. I take back unwanted medicines to remove these from circulation and eliminate environmental damage by proper disposal.

11.16. I act as a preceptor and train intern pharmacists. I have done so for approximately 18 years. Over this time period, the demands on the preceptor , as well as the intern, have increased with additional study and written workload. I am also involved in Pharmacy student training, taking on 2-3 students each year.

11.17. My pharmacy is an National Diabetes Supply Scheme (NDSS) [can you spell out what NDSS is for?] agency , which allows us to supply machines, test strips, lancets as well as insulin pump consumables to those diagnosed with Diabetes. I also assist these patients to manage their diabetes medication and health needs.

11.18. I am responsible for stock control and ordering.

11.19. I ensure safe storage and stability of medicines and advise patients on the safe storage of medicines.

12. During my period of employment as a Pharmacist I have experienced a dramatic change in procedures and processes and my work. When first trained and in my subsequent years, (1989/1990) the main tasks I performed revolved around prescriptions, including accurate dispensing, then accurate information to the customer providing a CMI (consumer medicine information) sheet as well as giving verbal advice on how to take the medication. The prescriptions also had to be collated and missing scripts identified and removed from the claim, then all were sent to Department of Health for payment. These tasks are now performed by dispensary technicians, however we still need to check the claim and personally sign it off.

13. Today, there is so much more work in our daily tasks. As accessible health care professionals, the general public will come to the pharmacist for advice rather than go to a General Practitioner (GP). There are not adequate GP numbers and waiting times can be days in some instances, so people prefer the Pharmacist. Ill individuals will come to the pharmacy for sick certificates. They will come to the pharmacy to have their flu injection, as well as other vaccinations now. They come to the pharmacy for both minor and major health concerns. We often refer customers to a GP as there are many situations that require a higher level of care. We supply Codeine products which

require close monitoring, so we use a live program to monitor use/abuse. For complete medical histories, we aim to record all interactions with patients. This process in done in computer (dispensing) programs however these dispensing systems are not designed to facilitate adequate space for these comments.

14. Customers will approach us wanting advice on weight loss. They want to improve their health by using complementary medicines. They want their blood pressure checked free of charge. They want to know what their blood sugar is doing so we check that for them . Coupled with this test we also can offer a cholesterol test. This is a guide only and referral to GP occurs if results necessitate,

15. There is a greater demand by the community to have the pharmacist deal with their health issues before they go to the doctor. All of the above mentioned occur whilst I am dispensing prescriptions and providing information on how to use these medicines.

16. Other interactions with customers are as follows: DAA's are in demand by elderly persons to manage their medications hence we have customers and/or family members requesting medication pack assistance. Customers will regularly come to the pharmacy with an expired script expecting the pharmacist to contact the prescriber to renew script, all the while you are attempting to dispense. There is also increased demand for generic prescriptions, so we are offering/explaining why these exist, why there are premiums on certain medications , and why they have to be paid. Along with this issue comes generic out of stocks which lead to snowball effect where all brands of a generic become unavailable. You are then required to find solutions for your patients. This out of stock situation was unheard of in my earlier years.

17. During my working day, I may be involved in 250-350 prescriptions per day being dispensed. During this time there would be requests for advice constantly every hour, either by customers coming into the pharmacy or on the phone. I work from 8am-5pm every day. All products dispensed are scanned via a Medicare/drug scanner to ensure minimal mistakes are made. During this time, you record customer interactions, you review customer history and offer advice and offer Medschecks. This is a sit down meeting with the customer and all their medications, both prescribed and non-prescribed to ensure they know what they are taking. There are administration tasks to be undertaken, there is stock to order, stock to put away.

18. I may need to apply first aid a customer or deal with a customer going through a crisis, (which occurred today) hence needing to calm person down take their blood pressure, and allow them to relax and counsel them. I may need to ring a GP to clarify a dosage on a prescription, or ring them to clarify their handwriting. I also will need to check the Pharmaceutical Benefit Scheme ('PBS') claim, as well as check the DAA's.

19. My management responsibilities involve ensuring that staff are performing well, making sure that all team members are compliant with the new Professional Practice Standards, as well as the new Code of Ethics for pharmacists. The professional body Pharmaceutical Association of Australia (PSA) [Kathy can you spell this out?] has a procedure on just about every supply method, so we need to be up to speed on all of these too.

20. Today Pharmacists are available in the front of shop. We have moved from behind the counter on a 'higher' floor level to 'on the front counter' interacting with the customers directly. [do you mean rather than being behind closed doors at the back? Was this how it was when you commenced?]. Customers want to see the Pharmacist for minor health issues, as well as more serious health issues. We have demands made upon us that do not have set appointment times.

21. The Pharmacist guidelines and standards have changed over the years with increasing the 'professional demands' on Pharmacists. Today we have a broad hierarchy of guidance and regulation of pharmacy practice. These begin with legislation, both Commonwealth and State. Then there are Pharmacy Board guidelines, registration standards and codes. There are codes of ethics, codes of conduct, competency standards, professional practice standards then finally professional practice guidelines. All pharmacists are expected to act in accordance with all of these, something that has evolved over the years and areas that need the pharmacist to keep up with and be up to date with. Once we understand and comply with these, we are able to dispense. There is also a requirement to do a minimum number of hours of continuous professional education, something that has been introduced in the last few years. There is a variety of options available to Pharmacists, but this is mainly completed in Pharmacist's own person time and is unpaid.

22. With the down scheduling of medication, there are more situations that require the pharmacist to be involved with. 'Pharmacy only' and 'Pharmacist Only' scheduled

medicines require the pharmacist's advice and can only be dispensed if the pharmacist believes the patient needs these medicines. More and more medications are down scheduled (no longer requiring prescriptions) so this has increased our workload. The pseudoephedrine supply requires customer identification, and we are required to use Project Stop, another live program that can monitor use/abuse.

23. As already mentioned, I am employed by National Pharmacies in Adelaide. Our Pharmacists have an Enterprise Agreement with the employer, and have successfully negotiated one every three years, for about 20 years now. Our most recent Agreement was the most challenging yet, where the employer was determined to reduce the rate of pay for the experienced pharmacists as well as create a two tier pay system for newly employed pharmacists to be on a lower rate. They were seeking to align pharmacist pay and penalties to be more closely aligned with the provisions of the Pharmacy Industry Award but were unsuccessful in achieving these. Our enterprise agreement also includes study leave, something that allows Pharmacists to attend conferences should they choose to do so. Also, the employer under this Agreement assists in contributing towards accreditation of Pharmacists to perform Home Medicines Reviews.

Katerina Malakozis

[redacted] [Date]

Annexure 'A-9'

IN THE FAIR WORK COMMISSION

Fair Work Act 2009

s. 156 – 4 yearly review of modern awards

AM2016/28 - Pharmacy Industry Award 2010

STATEMENT OF ALEX CROWTHER

I, Alex Crowther, [redacted], say as follows:

1. I completed a Bachelor of Psychology (Hons) in 2010 at Victoria University of Wellington in Wellington, New Zealand. I also have a Master of Psychology from the same Institution awarded in 2012. The bulk of my studies focussed on research methodology and statistical analysis within humanities fields including material specific to questionnaire design and analysis that is drawn upon in my statement below.

2. I am currently employed as the Surveys Manager at Professionals Australia, Association of Professional Engineers, Scientists and Managers, Australia, ('APESMA' or the 'Association').

3. My duties in my current position are the collection of data using online surveying tools for the purposes of creating market research of interest to Professionals Australia and members the association represents. This data includes regular surveys of remuneration and employment conditions in the following industries covered by the Association: engineering, science, information communication technology, local government, coal mining, and pharmacy. Results from these surveys are published in various reports and distributed to interested parties.

4. Directly relevant to the *Pharmacy Industry Award 2010* (the 'Award') is the Community Pharmacists' Remuneration Survey Report series published by the Association's Pharmacy Division since 1995. Data published in this series is collected from members of the association's Pharmacy Division, as well as non-member pharmacists that have previously interacted with the association, such as through online campaigns or social media.

5. Since 1995, the Community Pharmacists' Remuneration Survey Report series published by Professionals Australia (originally titled the Salaried Pharmacists' Association Remuneration Survey Report) has benchmarked the employment conditions and remuneration of pharmacists employed in the community pharmacy sector.

6. Reports have been published reporting data collected in the following years: 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2015, and most recently during October and November of 2016. Each survey draws from its own pool of participants, and respondents year-on-year do not consist of the same pool.

7. Annexed to this statement and marked as shown below are true and correct copies of these survey reports:

   7.1. Annexure 'AC-1' 1995 Salaried Pharmacists Association Remuneration Survey Report

   7.2. Annexure 'AC-2' 1996 Salaried Pharmacists Association Remuneration Survey Report

   7.3. Annexure 'AC-3' - 1997 Salaried Pharmacists Association Community and Hospital Pharmacists Remuneration Survey Report

   7.4. Annexure 'AC-4' – 1996 APESMA Pharmacists Branch Community and Hospital Pharmacists Remuneration Survey Report

   7.5. Annexure 'AC-5' – 1999 APESMA Pharmacists Branch Community and Hospital Pharmacists Remuneration Survey Report

   7.6. Annexure 'AC-5' – 1999 APESMA Pharmacists Branch Community and Hospital Pharmacists Remuneration Survey Report

   7.7. Annexure 'AC-6' – 2000 Annexure 'AC-5' – 1999 APESMA Pharmacists Branch Community and Hospital Pharmacists Remuneration Survey Report

   7.8. Annexure 'AC-7' – 2001 APESMA Pharmacists Branch Community and Hospital Pharmacists Remuneration Survey Report

7.9. Annexure 'AC-8' – 2002 APESMA Pharmacists Branch Community and Hospital Pharmacists Remuneration Survey Report

7.10. Annexure 'AC-9' – 2003 APESMA Pharmacists Branch Community and Hospital Pharmacists Remuneration Survey Report

7.11. Annexure 'AC-10' – 2004 APESMA Pharmacists Branch Community and Hospital Pharmacists Remuneration Survey Report

7.12. Annexure 'AC-11' – 2005 APESMA Pharmacists Branch Community and Hospital Pharmacists Remuneration Survey Report

7.13. Annexure 'AC-12' – 2006 APESMA Pharmacists Branch Community and Hospital Pharmacists Remuneration Survey Report

7.14. Annexure 'AC-13' – 2007 Annexure 'AC-7' – 2001 APESMA Pharmacists Branch Community and Hospital Pharmacists Remuneration Survey Report

7.15. Annexure 'AC-14' - 2008 APESMA Pharmacists Branch Community and Hospital Pharmacists Remuneration Survey Report

7.16. Annexure 'AC-15' - 2009 APESMA Pharmacists Branch Community and Hospital Pharmacists Remuneration Survey Report

7.17. Annexure 'AC-16' - 2010 APESMA Pharmacists Branch Community and Hospital Pharmacists Remuneration Survey Report

7.18. Annexure 'AC-17' - 2011 APESMA Pharmacists Branch Community and Hospital Pharmacists Remuneration Survey Report

7.19. Annexure 'AC-18' - 2012 Annexure 'AC-14' - 2008 APESMA Pharmacists Branch Community and Hospital Pharmacists Remuneration Survey Report

7.20. Annexure 'AC-19' - 2013/14 Professional Pharmacists Australia Community and Hospital Pharmacists Remuneration Survey Report

7.21. Annexure 'AC-20' - 2015 Professionals Australia Community Pharmacists Remuneration Survey Report

7.22. Annexure 'AC-21' – 2016/17 Professional Pharmacists Australia Community Pharmacists employment and Remuneration Report

7.23. Annexure 'AC-22' – 2016 Professional Pharmacists Australia Community & Hospital Pharmacists Remuneration Survey Report

8. Data collected and reported on in the series includes community pharmacists' hourly rates of pay including allowances, loadings, and penalty rates; additional responsibilities required of community pharmacists beyond dispensing medicine; sentiment regarding working in the community pharmacist sector; and a variety of demographics to allow for more in-depth analysis of remuneration and employment conditions, including how a survey respondent's position corresponds to the *Pharmacy Industry Award 2010* classifications.

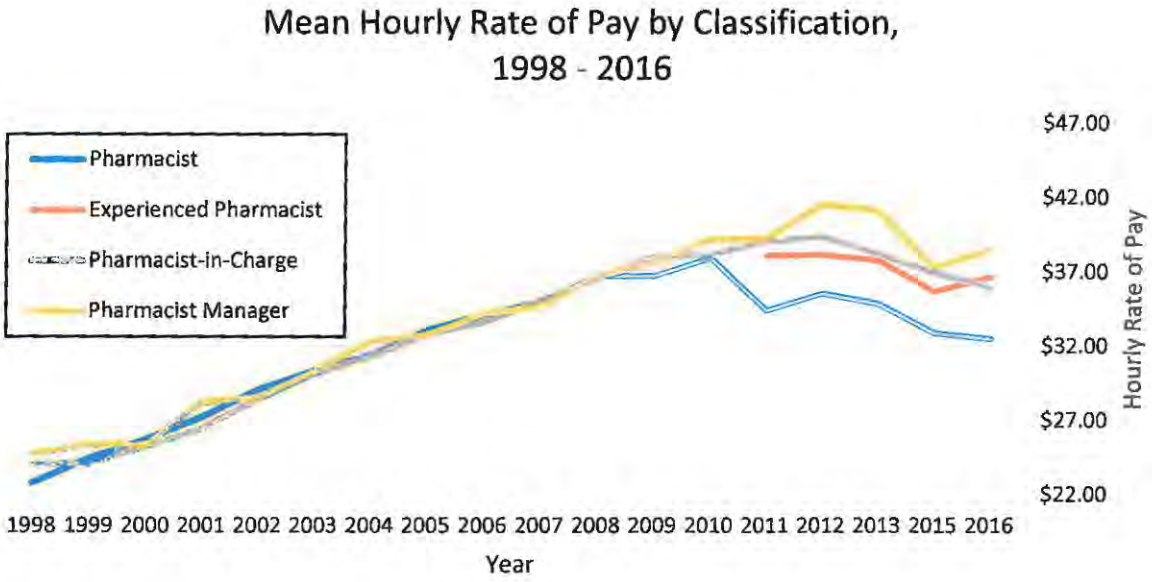
9. Respondents must self-identify as being employed as pharmacists to complete the survey. Respondents are only retained in the analyses of community pharmacist remuneration and employment conditions provided they are employed in the community pharmacy sector as a permanent employee pharmacist working either full-time or part-time. Respondents are not required to answer all questions in the survey and are only included in analysis where they have answered all relevant questions to that analyses.

10. Remuneration information is typically reported as a combination of percentiles and arithmetic means to provide an indication of the range of rates offered to community pharmacists that share certain characteristics. Figures are only reported where enough responses guarantee anonymity for respondents. Non-remuneration information is more likely to be reported as the percentage of respondents that answered a question a particular way.

2016 Community Pharmacists' Remuneration Survey

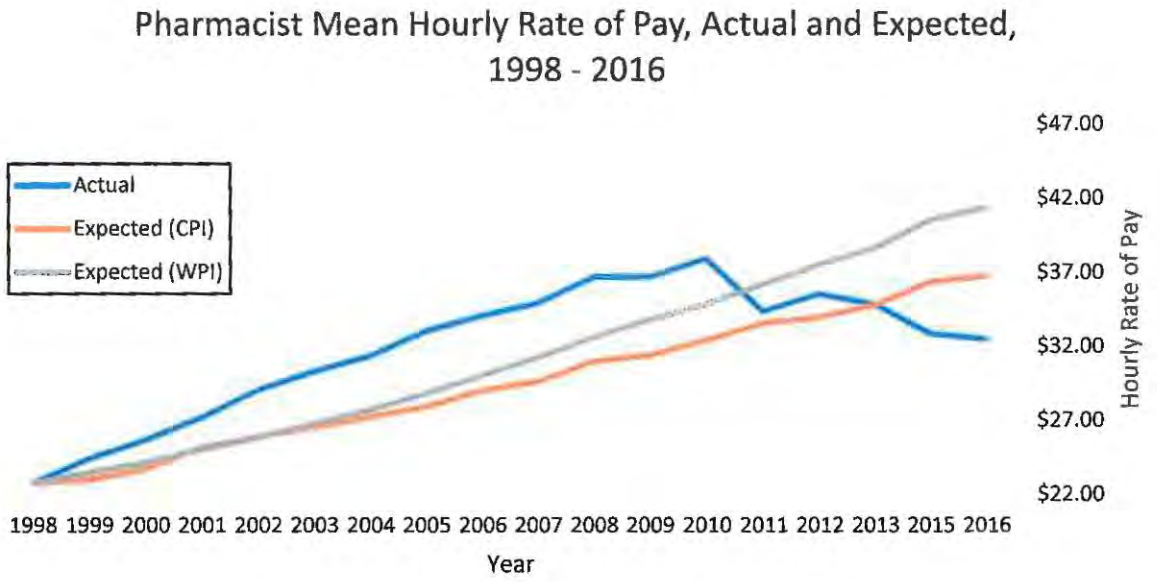
11. The 2016 Community Pharmacists' Remuneration Survey identified mean hourly rates of pay for permanent employee pharmacists at each of the classifications outlined in the Award as follows: Pharmacy Intern ($23.02), Pharmacist ($32.49), Experienced Pharmacist ($36.66), Pharmacist-in-Charge ($35.95), and Pharmacist Manager ($38.49).

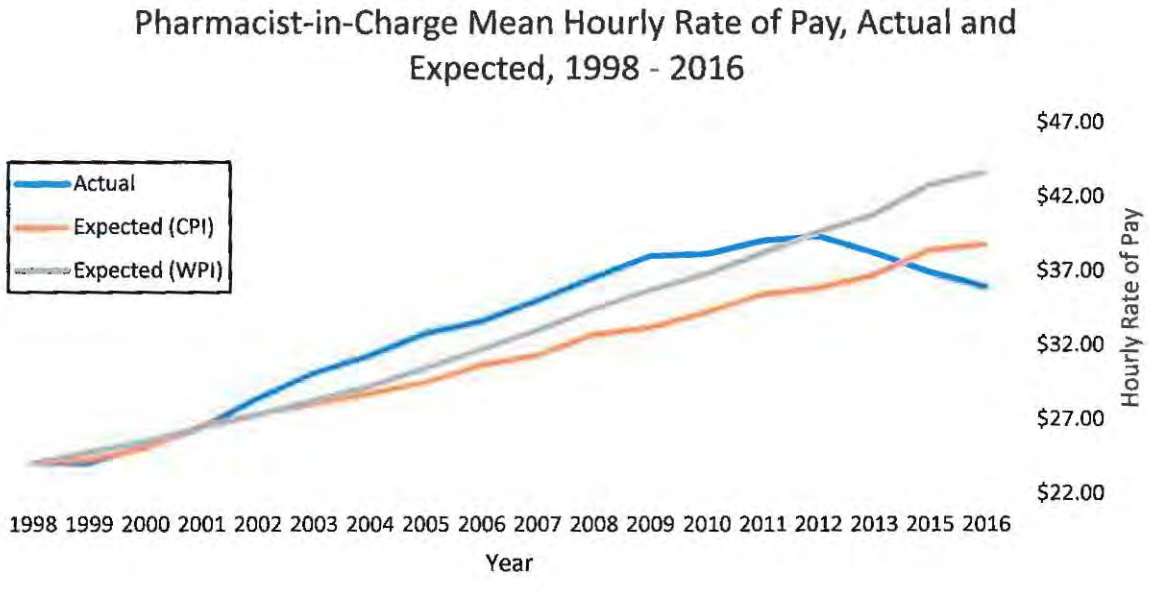
12. Mean hourly rates of pay reported by community pharmacists were lower in 2016 than they were for community pharmacists surveyed in 2011, with decreases of 5.49% for Pharmacists, 3.73% for Experienced Pharmacists, 7.94% for Pharmacists-in-Charge, and 1.86% for Pharmacist Managers. Prior to 2011 community pharmacists mean hourly rates of pay increased steadily as displayed in the accompanying graph.

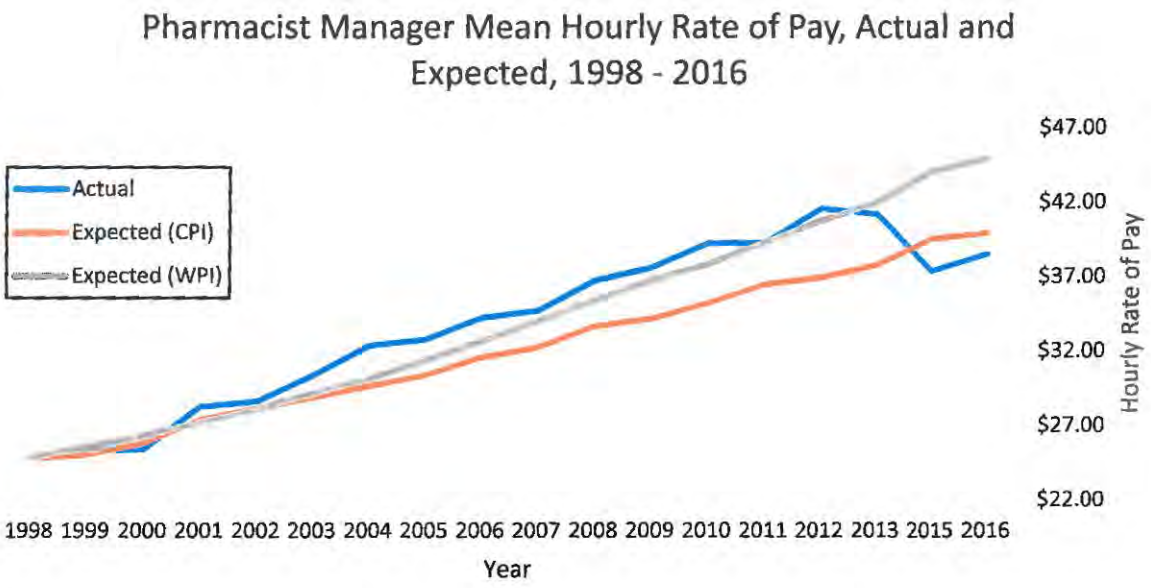


13. Growth in the hourly rates of pay for community pharmacists have also fallen behind growth in the Australian wage, as measured by the Wage Price Index (WPI), and the cost of living, as measured by the Consumer Price Index (CPI) for each of the classifications above that of Pharmacy Intern. Below are figures charting actual changes in the hourly rate of pay for pharmacists against the expected changes in the hourly rate of pay were pharmacist wages to move in line with either CPI or WPI as recorded in the June quarter of each year starting June 1998. Where the actual change in hourly rates falls below that expected based on WPI growth, pharmacists have experienced wage growth behind that of the average Australian. Where the actual change in hourly rates falls below that expected based on CPI growth, pharmacists have experienced a decrease in the real value of their wages. Since 1998, pharmacists have experienced a decline in the real value of their wages of 11.59%, Pharmacists-in-Charge of 7.35%, and Pharmacist Managers of 3.52%. Pharmacists have also experienced wage growth 21.47% below that of the average Australian, 17.69% for Pharmacists-in-Charge, and 14.29% for Pharmacist Managers. The underperformance of pharmacist wage growth relative to both CPI and WPI is largely due to stagnant and declining hourly rates of

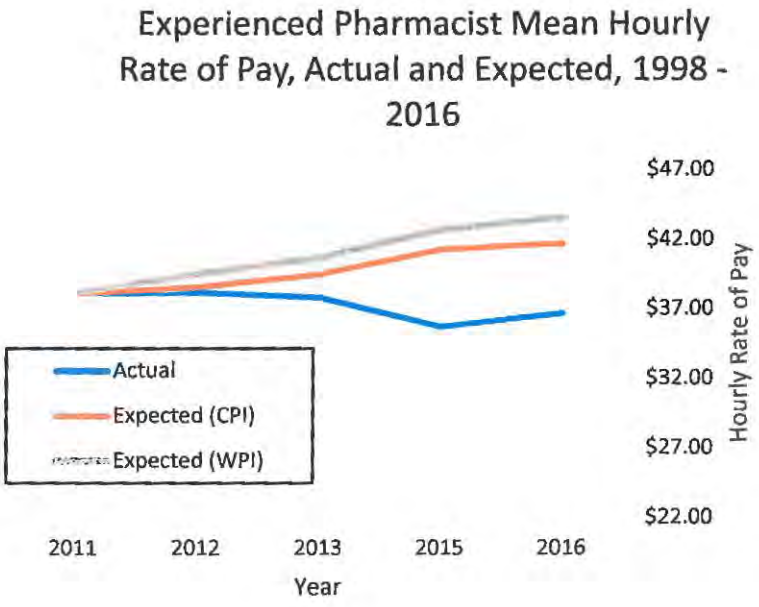
pay since 2011. Prior to 2011 pharmacists tended to outperform both CPI and WPI year on year.







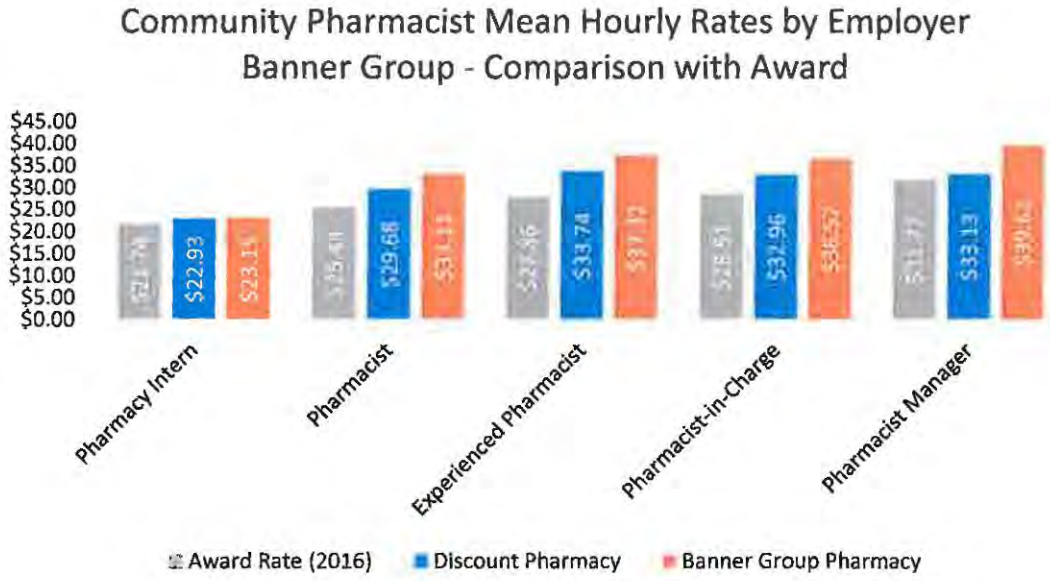
14. The Experienced Pharmacist classification was established with the *Pharmacy Industry Award 2010*. The year 2011 is the first year with any data collected for hourly rates of pay at that classification. The below figure charts changes in their hourly rate of pay against CPI and WPI starting in June 2011. As of 2016, Experienced Pharmacists have never outperformed CPI or WPI, experiencing a decline in the real value of their wage of 12.06%, and experiencing wage growth 15.79% below that of the average Australian.



15. Because the Community Pharmacists Remuneration Survey does not use the same pool of respondents year-on-year a decline in the nominal mean hourly rate of pay is likely to be reflective of a combination of both stagnant wage movement experienced by a large proportion of the workforce, as well as new entrants to the industry at each classification being offered progressively lower starting packages so as to bring down the average overall. The offering of progressively lower starting packages could be caused by either an industry wide trend towards reducing pay, or growth in the number of pharmacy chains that pay below the current market norm. In support of this, when asked during the 2016 survey in what year participants had last had a pay rise and excluding all those that had been in their current role for less than a year, 66.79% reported having not had a pay rise since at least 2015, and 53.21% reported having not had a pay rise since at least 2014. Of those that had received an increase in 2016, 47.72% reported it was only to keep their wages in line with the minimums outlined in either the *Pharmacy Industry Award 2010*, or an Enterprise Agreement they were covered by.

16. An important demographic characteristic collected in more recent Community Pharmacists' Remuneration Surveys has been which 'banner group' respondents are employed with. Analysis of hourly rates of pay was conducted by grouping these by whether they fit the description of a discount pharmacy chain. Those included as discount were Chemist Warehouse, Discount Drug Stores and My Chemist. The rest grouped together were Amcal/Amcal Max, Chemmart, Chemplus, Guardian, Priceline Pharmacy, Soul Pattinson, Terry White, National Pharmacies, any independent pharmacy, and anyone who responded Other.

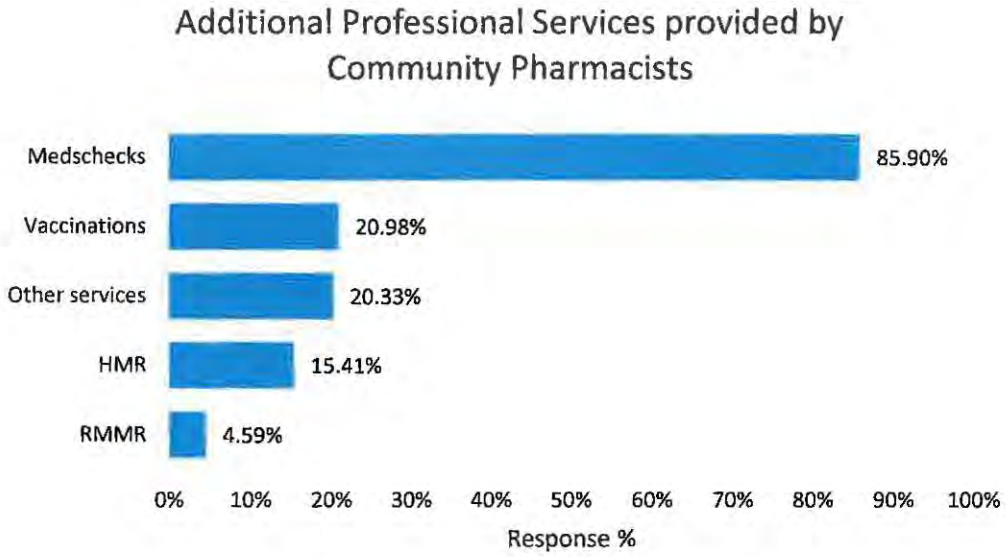
17. At the Pharmacist classification and above there was a clear difference between the mean hourly rate of pay for community pharmacists employed at discount pharmacies, as opposed to those employed at non-discount banner groups. Discount pharmacies tended to pay much closer to the minimums set out in the *Pharmacy Industry Award 2010*. Award rates presented below are from 2016, when the survey was conducted.



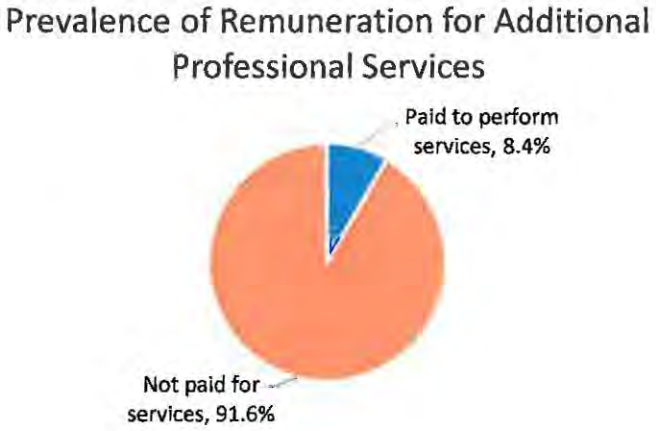
18. In the Community Pharmacists Remuneration Survey participants were asked to indicate additional services they were required to perform in their professional role beyond that of dispensing medicine.

19. The options presented in the survey included the following: HMR (Home Medicines Review), RMMR (Residential Medication Management Review), Medschecks, Vaccinations, and 'Other services'.

20. The majority of community pharmacists reported providing Medschecks services (85.9%), with Vaccinations being reasonably common as well.



21. Respondents were asked to indicate whether they received any additional compensation in relation to providing these services. Only 8.4% of respondents that performed one or more of these services reported receiving additional compensation.



Alex Crowther

13 December 2017

[redacted]

List of Annexures

The annexures can be viewed via the following links:

1. **Attachment 'AC-1'** – Salaries Pharmacists' Association Remuneration Survey Report – 1995

2. **Attachment 'AC -2'** – Community & Hospital Pharmacists' Remuneration Survey Report – 1997

3. **Attachment 'AC-3'** – Community & Hospital Pharmacists' Remuneration Survey Report – 1998

4. **Attachment 'AC-4'** – Community & Hospital Pharmacists' Remuneration Survey Report – 1998

5. **Attachment 'AC-5'** – Community & Hospital Pharmacists' Remuneration Survey Report – 1999

6. **Attachment 'AC-6'** – Community & Hospital Pharmacists' Remuneration Survey Report – 2000

7. **Attachment 'AC-7'** – Community & Hospital Pharmacists' Remuneration Survey Report – 2002

8. **Attachment 'AC-8'** – Community & Hospital Pharmacists' Remuneration Survey Report – 2002

9. **Attachment 'AC-9'** – Community & Hospital Pharmacists' Remuneration Survey Report – 2003

10. **Attachment 'AC-10'** – Community & Hospital Pharmacists' Remuneration Survey Report – 2004

11. **Attachment 'AC-11'** – Community & Hospital Pharmacists' Remuneration Survey Report – 2005

12. **Attachment 'AC-12'** – Community & Hospital Pharmacists' Remuneration Survey Report – 2006

13. **Attachment 'AC-13'** – Community & Hospital Pharmacists' Remuneration Survey Report – 2007

14. **Attachment 'AC-14'** – Community & Hospital Pharmacists' Remuneration Survey Report 2008

15. **Attachment 'AC-15'** – Community & Hospital Pharmacists' Remuneration Survey Report 2009

16. **Attachment 'AC-16'** – Community & Hospital Pharmacists' Remuneration Survey Report 2010

17. **Attachment 'AC-17'** – Community & Hospital Pharmacists' Remuneration Survey Report 2011

18. **Attachment 'AC-18'** – Community & Hospital Pharmacists' Remuneration Survey Report 2012

19. **Attachment 'AC-19'** – Community & Hospital Pharmacists' Remuneration Survey Report 2013/14

20. **Attachment 'AC-20'** – Community & Hospital Pharmacists' Remuneration Survey Report 2015

21. **Attachment 'AC-21'** – Community & Hospital Pharmacists' Remuneration Survey Report 2016/17

22. **Attachment 'AC-22'** – Professional Pharmacists Australia – 2016 Report

Annexure A.10

WORK VALUE OF A COMMUNITY PHARMACIST

Part II: Semi-structured interviews

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2017

Key abbreviations

2CPA	Second Community Pharmacy Agreement
6CPA	Sixth Community Pharmacy Agreement
BG	Blood glucose
BP	Blood pressure
CI	Clinical intervention
CPA	Community Pharmacy Agreements
CPAP	Continuous positive airway pressure
CPS	Cognitive pharmaceutical services
CVD	Cardiovascular disease
DAA	Dose administration aid
DVA	Department of Veterans' Affairs
HCP	Health care professional
HMR	Home Medicines Review
INR	International normalised ratio
MBS	Medicare Benefits Schedule
NDSS	National Diabetes Services Scheme
OST	Opioid substitution therapy
PBS	Pharmaceutical Benefits Scheme
PPA	Professional Pharmacists Australia
QCPP	Quality Care Pharmacy Program
QUM	Quality use of medicines
RMMR	Residential Medication Management Review
S2	Schedule 2
VLCD	Very low calorie diet

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Executive summary

Introduction

Pharmacists have a pivotal role to play in patient care as health care team members who are highly accessible to the general public. A significant expansion in the scope of practice of community pharmacists has become evident over the years, with increased government remuneration pledged to support cognitive pharmaceutical services (CPS) delivery in community pharmacy settings as part of the Community Pharmacy Agreements (CPA). Pressures on the sector have also led to CPS and remunerated CPS models being regarded as opportunities to drive pharmacy viability alongside improving patient health outcomes. Together with the available quantitative data on CPS currently being provided within the Australian community pharmacy context, qualitative research is important to further explore pharmacists' roles, responsibilities, experiences, and perceived impact associated with delivering CPS.

Objectives

1. To investigate and describe the cognitive pharmaceutical / health services currently provided by community pharmacists.
2. To determine the reimbursement / revenue received by community pharmacists for the delivery of cognitive pharmaceutical / health services in their practice.
3. To determine the self-reported patient health and economic outcomes of the cognitive pharmaceutical / health services delivered by the pharmacists.
4. To determine the self-reported health system economic outcomes of the cognitive pharmaceutical / health services delivered by the pharmacists.
5. To investigate the training received by the pharmacists in delivering the cognitive pharmaceutical / health services.

Methods

Qualitative semi-structured interviews were conducted between February and August 2017 with practising community pharmacists in Australia who are engaged in delivering CPS.

The initial recruitment strategy was two-pronged, and included:

- An invitation to participate in the study that was sent to a random sample of pharmacists (n=60) within the Professional Pharmacists Australia (PPA) member database (n=7500); and
- Purposive sampling of pharmacists known to the research team who, at the time of the study, were engaged in the provision of CPS. A maximum variation sampling approach was used in order to capture pharmacists from a range of ages, years of practice, practice settings, cultural backgrounds, employee/employer status, as well as to ensure gender representation.

Potential participants were provided with information about the study and those interested in participating liaised with a member of the research team to organise an interview time and location. Recruitment continued until data saturation was confirmed.

Face-to-face and phone interviews were primarily conducted by the one researcher (VT) on premises at the Faculty of Pharmacy, The University of Sydney. Prior to interview commencement, participants had the opportunity to seek clarification regarding any aspect of the study. Written informed consent was given before the interview started. All participants were requested to complete a short demographics questionnaire initially. Once completed, discussions were guided by the interviewer using a semi-structured interview protocol mapped to the study objectives.

Interviews were audio-recorded only with consent from the participant. Audio-recordings were transcribed verbatim and the transcripts verified against the audio recording and de-identified. Verified transcripts were thematically analysed via use of matrix displays. Data saturation was achieved after 22 interviews were completed and confirmed upon completion of 25 interviews.

Results

A total of 25 interviews were conducted with Australian community pharmacists, comprising 14 face-to-face and 11 phone interviews. The average interview discussion length was 51 minutes (range 33-77 minutes).

Overview of services being offered in community pharmacies

Pharmacists have seen and experienced an evident expansion of services being provided in community pharmacies. Pharmacists' roles and responsibilities have changed and also differ between the services, with increased opportunities for clinical involvement and inter-professional collaboration in the provision of patient health care. Participants perceived that a baseline level of services was being provided, applicable across the sector, with a certain level of service provision having become the status quo. However, CPS varied between pharmacies, where the business structure influenced the extent of services being provided. Smaller pharmacies were required to structure and prioritise service provision within their working capacity, available resources and expertise. Additional support via increased number of pharmacists/pharmacy staff was seen as an enabler of CPS provision.

Reforms such as accelerated price disclosure and emergence of discount pharmacy models of pharmacy have impacted the sector, and created an impetus for the industry to evolve. Sole reliance on pharmacy as a supply function was no longer seen as viable. Decreased revenue generated from dispensing prescriptions has led to increased service provision, where services were used as a point of difference between pharmacies. Furthermore, an increased scope of practice for pharmacists has led to perceived opportunities for further role expansion. However, quality of services may not be uniform across all pharmacies.

Overall, continued engagement in providing CPS by pharmacists was primarily motivated by patient satisfaction, professional satisfaction, view of the optimal direction towards which pharmacy should be heading, altruism, wanting to provide a service to the community to promote health, and duty of care. A positive outlook on pharmacy stimulated support for increased scope of practice as well as ongoing provision of CPS.

The service-oriented ethos of community pharmacy or positive professional experiences involving senior members of the profession contributed to the service-oriented practice of several participants. External factors such as decreased profit margins for dispensing medicines and that other pharmacies were also offering services were also motivators for CPS provision.

Sixth Community Pharmacy Agreement (6CPA) cognitive pharmaceutical service initiatives

Core 6CPA-funded services reportedly being delivered in community pharmacies included dose administration aids (DAAs), Home Medicines Reviews (HMRs), MedsChecks/Diabetes MedsChecks, clinical interventions (CIs), and staged supply. Pharmacists were responsible for checking DAAs, where DAAs were seen to facilitate improved patient adherence to medicines and quality use of medicines (QUM). MedsChecks allowed pharmacists to assess patients' understanding and use of their medicines, and were seen as a timely way to identify and address medication-related problems. HMRs enabled a detailed assessment and recommendations to be provided on a patient's medication regimen; positive feedback received on HMRs and the implementation of recommendations were reported. CIs encompassed a broad range of potential medication-related problems. They were primarily viewed as a change in the documentation process rather than a change in practice.

Non-6CPA cognitive pharmaceutical service initiatives

Non-6CPA CPS that were more commonly reported as being provided included point-of-care testing such as blood pressure (BP)/cardiovascular disease (CVD) checks and/or blood glucose (BG) checks, pharmacist-delivered immunisation, and opioid substitution therapy (OST). A range of other CPS were also reported, that spanned other point-of-care testing services, services provided to aged care and related facilities, chronic disease management (with and/or without diagnosis), and medication-oriented services, among others.

Notably, pharmacist-led flu vaccinations were associated with a number of perceived benefits such as improved accessibility and uptake of flu vaccinations, increased convenience and perceived cost-effectiveness, and professional satisfaction.

The most ubiquitous service that was free for patients was BP checks. Pharmacist involvement in BP checks varied between pharmacies however pharmacists were involved at some point in the process, particularly in interpreting BP readings.

Sleep apnoea diagnostic services were offered by some pharmacies, and provided convenience and comfort via the available option for patients to complete an in-home diagnostic test. Improvement in quality of life was seen in those who were diagnosed with sleep apnoea and started using a CPAP machine.

Services provided to facilities such as aged care facilities commonly centred on DAA provision for residents. Other components of the service that were offered could also comprise facility audits, supply of medication stock to the facilities, medication reconciliation-related activities, transitions of care support, and other on-site duties.

Training undertaken in order to facilitate cognitive pharmaceutical service provision

Training that had been completed by pharmacists varied significantly between undergraduate training, self-directed learning, and completion of accredited training courses. Of the service-specific training completed, accreditation courses were more likely completed for pharmacist-led immunisation, HMRs, and compounding. Non-specific training discussed for the services typically included training received from company representatives and/or self-directed learning.

Financial support received for training that was undertaken by pharmacists varied; the most common course that was financially covered by employers was pharmacist-led immunisation training. However, training opportunities received by staff potentially varied depending on their role within the pharmacy.

Financial reimbursement received for the provision of services

Reimbursements received for CPS varied between services. Services typically provided at a charge to the patient included flu vaccinations (median = $19.95 (for n=11)), OST (median = $35 per week (for n=7)), diagnostic testing of sleep apnoea (median = $100 (for n=5)), and absence from work certificates (median = $27.50 (for n=6)).

The most common CPS that was offered free of charge to patients was BP/CVD checks. Contributions for DAAs paid by users ranged from $0 to approximately $5 per pack (median = $4.25 (for n=20)). However, together with the funding received from the 6CPA, it was still regarded by pharmacists as insufficient to cover the costs involved in providing the service.

Profit margins on user-pay services were minimal. Moreover, a few participants noted that they had to decrease the fee-for-service for pharmacist-led vaccinations due to increased competition. Pharmacists were cognizant of the notion that fee-for-service, although desired, should not act as a barrier for service uptake among patients.

Alternative sources of funding other than government funding or user-pay funding models were not commonly cited; however, one source that was mentioned was the financial incentive of $5-$10 received from BG monitor manufacturers for downloading and printing reports of BG readings. This was a unique form of funding in comparison to other models as it was provided by the manufacturer themselves.

‘Free’ cognitive pharmaceutical services

User-pay funding models were not deemed appropriate for all CPS, for instance BP checks, as pharmacists perceived that patients expected the service(s) to be offered for free. Increased competition had also facilitated this expectation of services to be provided at no additional cost to the end user.

Perceived receptivity among patients for fee-for-service models were mixed. However, there was a degree of willingness to pay among patients. Encouraging customer loyalty and maintaining rapport with other service users (e.g. aged care facilities) were facilitators for providing services for ‘free’.

Other pharmacy services

Pharmacies also offered several additional services, such as a delivery service, National Diabetes Services Scheme (NDSS), Return Unwanted Medicines bins, Needle Syringe Program, SMS prescription reminders, equipment hire, among others.

In addition to CPS offered on an ongoing basis, pharmacies also engaged in services delivered offsite and/or on an intermittent basis, such as:

- Health-related presentations to members of the community; and
- Health promotion/screening events or checks, point-of-care testing offered outside the pharmacy for designated periods that tended to align with national priority area(s).

Some participants reported that other health care professionals (HCPs) offered services within the pharmacy, including a naturopath (n=2), baby nurse (n=1), and nurse (n=2). Nurse-led services included a foot care service, and wound care and ear piercing.

Broad impact of cognitive pharmaceutical services

Perceived benefits of CPS included:

- Improved patient accessibility to services and convenience;
- Cost-effective facilitation of QUM;
- Improved patient adherence, satisfaction, and loyalty; and
- Improved patient rapport, health management, patient education and empowerment.

However, it was noted that it was difficult to determine the true impact of CPS.

Broad economic impact of cognitive pharmaceutical services

Reimbursement received by pharmacists for the provision of CPS was regarded as insufficient. CPS provision contributed to the need for increased wage costs for the pharmacy e.g. to employ another pharmacist, where these costs were then offset via earnings from other aspects such as prescription dispensing and/or sale of consumables.

At a pharmacy level, services were not regarded as a primary source of stand-alone income for pharmacies but rather, had flow-on effects on other aspects of the business which contributed to profitability. At a system level, CPS were seen to have a broader cost-saving impact on the health care system e.g. via screening.

Perceptions of the work value of community pharmacists/pharmacy and the level of remuneration

Perceived core work value of community pharmacists centred on accessibility of health care and advice, and the resultant broader impact on the community. Pharmacists were perceived to be undervalued by others, which was negatively influenced by discount pharmacies. However, it was also acknowledged that pharmacists also contributed to this undervaluing of the profession. Pharmacists perceived that governments should better recognise the value of pharmacists and remunerate appropriately.

Pharmacists recognised that there was limited profit earned for many CPS, where pharmacy proprietors noted that many services were being operated at a financial 'loss' to the pharmacy. As pharmacist roles were perceived as having expanded, there was support for recognition of this expansion both professionally and financially.

> *"I feel the role has definitely expanded. I feel pharmacists today compared to five, ten years ago, are doing arguably more work and are working longer hours and spending a lot more time in private study than ever before to provide services that we may not have provided before or that are more efficient now and more comprehensive…… I have no argument for…… being recognised for that both professionally and as far as… pay as well." (P24)*

The government was seen as an important stakeholder in facilitating the increased remuneration of pharmacists.

> *"Nobody denies or doubts, from pharmacists to pharmacy owners to academics, that a pharmacist should be paid more. The question is who should wear that payment? A pharmacy owner is also a pharmacist. So they're also a business person. Should they have to… cough up more? I don't think so. I actually think the government; the only answer I can think of is either user-pay, which we know the sickest and most vulnerable in our population are not the ones that can access the user-pay [services]." (P01)*

In general, pharmacists did not receive additional reimbursements for delivering services within the community pharmacy on top of their wages. Some pharmacists felt that their wage received as an employee pharmacist was inadequate and did not reflect their knowledge, skills and contribution to health care.

> *"Look, the income is quite rubbish…… When I came out as a pharmacist, I was earning more per hour than I am now 15 years later. As a community pharmacist, I think with my experience, I'm delivering more. I'm offering more help and more experience to the patient…… I'm getting paid a good $7 - $8 less than what I was getting paid when I first came out 15 years ago as a pharmacist, where I had zero experience or one year of experience. And that is a bit disillusioning because sometimes you do start to think that 'Okay, I'm going to be working for six, seven hours. Is it worth my time?', you know, because I'm still gonna get paid that much. So do I need to go out of my way to do X, Y and Z or can I just do the bare minimum because I'm not going to get paid any more?" (P03)*

A multitude of factors were acknowledged as impacting on pharmacist wage levels. Several pharmacists reported negotiating their wage level, and believed that the onus was on the pharmacist to demonstrate their value to their employer and to negotiate their wage accordingly.

Conclusions

Pharmacists are offering a broad range of CPS within the community pharmacy setting, both via 6CPA-funded initiatives as well as non-6CPA initiatives. Almost all participants reported that their pharmacy provided 6CPA-funded initiatives such as DAAs, clinical interventions, MedsChecks/Diabetes MedsChecks, and HMRs. User-pay services being offered included pharmacist-led flu vaccinations, OST, diagnostic testing for sleep apnoea, and absence from work certificates, among other services.

CPS provision was seen to have positive impacts at both patient and health care system levels. Pharmacists felt they enabled timely and convenient access to health care for patients in the community pharmacy setting, and facilitated QUM, which then in turn had some positive impact on the community pharmacy business.

A prominent shift was evident, where professional services provision has become the status quo, indicative of a likely shift in the work value of community pharmacists. Despite the increasing provision of services and integration of CPS delivery within the community pharmacist's role, in most cases there was no additional reimbursement received by the pharmacist to deliver services specifically, other than the level of wages received. Pharmacists were aware of the complexities inherent within the impact of community pharmacy sector reforms, and CPS provision alongside the viability of the sector. However, pharmacists should be further recognised professionally and financially for their contributions as HCPs within the broader health care system.

1. Background

Pharmacists have a pivotal role as health care team members working collaboratively with other health professionals to facilitate optimal health care to meet the varying health care needs of the broader population. In particular, cognitive pharmaceutical services (CPS) provided in community pharmacy settings offer further opportunities to improve patient outcomes. Also known as professional pharmacy services, CPS can be defined as *"an action or set of actions undertaken in or organized by a pharmacy, delivered by a pharmacist or other health practitioner, who applies their specialized health knowledge personally or via an intermediary, with a patient/client, population or other health professional, to optimize the process of care, with the aim to improve health outcomes and the value of healthcare."* [1(p990)]

Community pharmacists are perceived to be "*highly accessible health professionals in terms of cost and location, particularly as there was no consultation fee involved",*[2(p867)] and well placed to offer accessible health care and health-related information.[3] Within the Australian context, there has been a significant expansion in the scope of practice of community pharmacists over the years. Notably, this change has occurred concurrently with increased government remuneration to support CPS delivery in community pharmacy settings, from up to $4 million under the Second Community Pharmacy Agreement (2CPA)[4] to up to $1.26 billion under the current Sixth Community Pharmacy Agreement (6CPA).[5]

However, to date, the investment in CPS has been modest and insufficient to sustain profitability of the community pharmacy sector, which has come under increasing pressure from the emergence and growing dominance of the discount model of pharmacy and Pharmaceutical Benefits Scheme (PBS) reforms, such as price disclosure, which have significantly reduced pharmacy income from dispensing prescriptions. As a consequence, expansion of remunerated service-oriented pharmacy models and CPS have increasingly been seen as an avenue to supporting future community pharmacy viability.[6-11] Pharmacists also view existing CPS as a means to contribute towards improved consumer medication-related understanding as well as improved quality of life and accessibility to health care.[12]

Promisingly, a *"strong belief in the value of the community pharmacy becoming a health hub; involving more than just the provision of medication advice"*[2(p868)] has also been voiced. Collectively, these findings indicate a movement away from the more "traditional" perceived role of community pharmacists as solely medication dispensers towards more service-oriented roles. Undoubtedly, this dynamic shift will see a ripple effect on the roles and responsibilities of practising community pharmacists.

Current 6CPA funding supports CPS initiatives promoting medication management (Home Medicines Reviews (HMRs), Residential Medication Management Reviews (RMMRs), MedsChecks, Diabetes MedChecks, clinical interventions (CIs)), medication adherence (Dose Administration Aids (DAAs), staged supply), rural and/or indigenous health, and other programs including the Pharmacy Trial Program.[5] In addition, community pharmacies are also diversifying with the provision of a plethora of additional CPS that are not directly linked to the 6CPA.[11] Such services will only directly generate additional revenue for the community pharmacy if the pharmacy has implemented a fee-for-service model. Notably, consumer awareness, receptivity, and uptake of CPS provision by community pharmacists in the primary care setting has been positive. Recognition of the expanding CPS offered by community pharmacists has become apparent, where the majority of respondents surveyed upon exit from a community pharmacy were aware of key services.[13] Pharmacists have been commended on the provision of CPS,[2] and consumers in general also feel that there is room for an increased scope of practice for pharmacists with respect to the delivery of CPS in primary care.[14] Accordingly, there is an evident bi-directional relationship between increasing CPS provision in community pharmacy settings and a heightened focus on patient-centred care, which is then embedded in the ethos underpinning pharmacy practice.

In conjunction with the available data that quantitatively maps the different CPS being offered in Australian community pharmacies, qualitative research exploring community pharmacists' roles and responsibilities in delivering these CPS is much needed to provide in-depth insight into current experiences in providing a range of CPS within the existing work environment.

1.1 Study objectives

1. To investigate and describe the cognitive pharmaceutical / health services currently provided by community pharmacists.
2. To determine the reimbursement / revenue received by community pharmacists for the delivery of cognitive pharmaceutical / health services in their practice.
3. To determine the self-reported patient health and economic outcomes of the cognitive pharmaceutical / health services delivered by the pharmacists.
4. To determine the self-reported health system economic outcomes of the cognitive pharmaceutical / health services delivered by the pharmacists.
5. To investigate the training received by the pharmacists in delivering the cognitive pharmaceutical / health services.

2. Methods

2.1 Ethics approval

Ethics approval to conduct this study was granted by the Human Research Ethics Committee at The University of Sydney (project number 2016/910). Participation in the study was voluntary; no financial reimbursement was given to the participants for any time and/or travel costs associated with study participation.

2.2 Method

Qualitative semi-structured interviews were conducted to address the study objectives. This method allows for insight to be gained into participants' experiences and views on the topic(s) of interest, whilst also providing the opportunity to seek further elaboration from the participant during the interview where necessary.[15] Utilisation of a semi-structured interview protocol would therefore allow for adequate exploration and follow-up of issues pertaining to the types and nature of CPS being offered in community pharmacies, along with perceptions of the impact of these services.

2.3 Recruitment

Interviews were conducted between February 2017 and August 2017. The sampling frame (and thus the inclusion criteria to be eligible to participate in the study) comprised of practising community pharmacists in Australia that were engaged in delivering CPS.

The initial recruitment strategy was two-pronged, and included:

- An invitation to participate in the study that was sent to a random sample of pharmacists within the Professional Pharmacists Australia (PPA) member database; and
- Purposive sampling among pharmacists known to the research team who, at the time of the study, were engaged in the provision of CPS.

A random sample of 60 pharmacists were selected and contacted for participation in the study via the PPA database of community pharmacist members (n=7500). This process was completed independently of the research team. The random sample was generated using a random selection program that PPA use to select participants to participate in other surveys. A total of 60 pharmacists were invited to participate in the study in order to take into account the non-response rate. Those randomly selected received a letter of invitation (Appendix 1) accompanied by the Participant Information Statement (Appendix 2) and consent form (Appendix 3) for the study. Contact details for the research team were specified in these documents; any pharmacists interested in participating then directly contacted a member of the research team and returned their completed consent form prior to the conduct of the interview.

Additionally, pharmacists known to the research team who were actively involved in the delivery of a range of health services at the time of the study were also contacted to help ensure that a spectrum of opinions had been captured in the study. A maximum variation sampling approach was applied. Pharmacists from a range of ages, years of practice, cultural/ethnic backgrounds, position held in the community pharmacy (both employee and employer/proprietor pharmacists), community pharmacy practice setting (rural/regional settings as well as major cities), socioeconomic background(s) of area of practice, as well as representation from each gender were identified by the research team members from within their networks. The identified potential participants were contacted and sent the study documents electronically (via email). Pharmacists interested in participating in the study liaised with the research team to schedule an interview time (and location, if applicable). For those opting to complete a phone interview, a completed consent form was received prior to the interview; where a face-to-face interview was preferred and scheduled, hardcopies of the study documents were also made available on the day for reading and completion.

Records were kept as the study progressed, detailing:

- the number of responses received from the PPA mail-out and the number of interviews completed as a result, as well as
- the number of pharmacists who went on to complete the interviews after receiving information about the study from the research team.

After the completion of 20 interviews, the interview data were reviewed in detail to ascertain whether data saturation[16] had been achieved. Assessment of subsequent interview data was continued through the method of constant comparison of the emergent themes/subthemes to those identified in the previous interviews. A further 3 interviews were required to confirm that data saturation had been reached.

2.4 Semi-structured interview protocol

Participants were able to complete the interview either face-to-face, or by telephone or Skype at their convenience. The face-to-face interviews and phone interviews (on the interviewer's part) were primarily conducted on premises at the Faculty of Pharmacy, The University of Sydney. All interviews were conducted by the same female researcher (VT) who is experienced in conducting qualitative research. Having a single research team member responsible for the conduct of the interviews helped to ensure that the interviews were conducted in a consistent manner.

Prior to the commencement of each interview, participants were given the opportunity to seek further clarification if needed regarding the study itself. The completed consent forms were then reviewed by the interviewer prior to proceeding with the interview session. All participants were requested to answer a short demographics questionnaire (Appendix 4) at the beginning of the interview. Face-to-face interview participants completed a hardcopy of the questionnaire; the demographic questionnaire was read out to phone interview participants and the participants' answers were recorded. Following this, the discussions were guided by the interviewer through the use of a semi-structured interview protocol (Table 1). All core interview questions were mapped to the study objectives.

Table 1. Core semi-structured interview protocol questions

Topic	Core question
Types of CPS offered – within the pharmacy	• Could you please let me know what pharmaceutical and/or health services you deliver in your pharmacy?
Type(s) of CPS offered – outside the pharmacy	• Could you please let me know what pharmaceutical and/or health services you or your pharmacists deliver outside your pharmacy?
Description of CPS	• Could you describe each of these services?
Reimbursement/revenue for CPS delivery	• What kind of reimbursement or revenue do you receive for delivering these services?
Training undertaken	• For each of the services you have mentioned, what kind of training did you receive in order to be able to deliver these services?
Impact of CPS	• What, if any, has been the impact of each of the services you described on your clients in terms of ○ Health? ○ Customer satisfaction? ○ Customer loyalty?
Economic outcomes of CPS delivery	• What, if any, have been the economic outcomes for the pharmacy?

2.5 Data analysis

Interviews were audio-recorded with written informed consent from the participants. All participants except one consented for the interview to be audio-recorded. For this interview where consent for audio-recording was not given, the field notes that were taken during the interview were consolidated immediately after the conclusion of the interview to minimise the impact of interviewer recall bias. The resultant field notes/interview summary were included in the data analysis in lieu of a verbatim transcript.

All audio-recordings obtained were transcribed verbatim. Upon completion of the transcription, all transcripts were verified against the audio recording to ensure that the verbatim transcription had been completed accurately. During this verification process, to ensure that data were appropriately de-identified, all mention of names of the participant

or other colleagues were removed from the final transcripts to be used for data analysis. In addition, suburb names mentioned during the interview discussions that could result in data identification were also removed from the finalised transcripts to ensure complete de-identification of a particular pharmacy and/or pharmacist. However, mentions of the State/major city in which the pharmacy was located have largely been retained for context where there were no foreseen risks of interview data being identifiable.

Preliminary data analysis was conducted on verified transcripts. This involved reviewing the transcription audio and multiple re-readings of the transcripts as part of the thematic analysis[17] of the transcripts. As part of the data analysis, matrix displays[18] were established at the onset of the data analysis process to support the conduct of thematic analysis and identification of themes and subthemes. Initial matrix display set-up was informed by the structure of the semi-structured interview protocol questions and refined via the inductive approach taken for data analysis. Matrix displays were also advantageous as they helped to facilitate the cross-comparison between the descriptions of the various CPS types that arose in the respective interviews as well as pharmacists' perspectives on CPS provision. Themes by CPS type could then be consolidated per interview and then compared between interviews to support comparison and contrast of emergent themes and subthemes.

Thematic analysis[17] was primarily conducted by the interviewer (VT). In order to help mitigate the influence of researcher bias on the data analysis and reporting of themes and subthemes, a proportion of transcripts were also independently analysed by a second researcher (PA) to ensure validity and reliability of data analysis. Any discrepancies that arose from the data analysis stage were discussed among the research team to ensure consistency in both the identification and reporting of themes and subthemes. Data saturation[16] was determined to be reached after 22 completed interviews.

3. Results

3.1 Participant overview and demographics

A total of 25 interviews were conducted with Australian community pharmacists, which comprised 14 face-to-face and 11 phone interviews. The average interview discussion length was 51 minutes (range 33-77 minutes). Participants were recruited from both within the research team's networks as well as via the mail-out completed by PPA (Table 2), representing a range of demographics (Table 3).

Table 2. Recruitment methods and respective response rates

Method	Respective response rate
PPA mail-out	**N = 4 interviews completed** 3 additional responses received by the research team (ineligible respondents): • 1 pharmacist was currently a hospital pharmacist • 1 pharmacist had recently stopped practising in community pharmacy • 1 pharmacist returned the consent form but was practising in a government role, therefore not eligible to participate Therefore, a response rate of 6.7% was achieved. (4 interviews completed from 60 invitation letters sent)
Recruited via research team network	**N = 21 interviews completed** 30 pharmacists (currently practising in community pharmacy) within the research team's networks were provided with information about the study. Therefore, a response rate of 70% was achieved. (proportion of those who went on to complete the interview compared to those who had received information about the study)

Table 3. Summary of participant demographics

Demographic		Total (n=25)
Gender	Male	15
	Female	10
Age	< 25 years	1
	25-44 years	19
	45-64 years	4
	> 65 years	1
Country of birth	Australia	17
	Overseas	8
Main language(s) spoken at home	English	18
	Other[a]	13
Highest level of education	Bachelor's degree	18
	Graduate Certificate	2
	Diploma	1
	Master's degree	3
	PhD	1
Primary job	Community pharmacist	19
	Consultant/locum pharmacist	2
	Academic	2
	Pharmaceutical advisor	1
	Student	1
Secondary job[b]	Community pharmacist	6
	Accredited pharmacist	2
	Academic/educator	7
	Higher degree research student	2
	Professional service position	2
	Other	2
	None	8
Number of years of practice as a pharmacist	< 5 years	6
	5-10 years	10
	> 10 years	9

[a] Four participants nominated two or more languages as the main languages spoken at home. Therefore, the total exceeds the total number of study participants.

[b] Three participants nominated two or more secondary jobs. Therefore, the total exceeds the total number of study participants. All participants worked as a pharmacist in a community pharmacy setting either in their primary or secondary job.

Participants were mostly from New South Wales (n=22), with a few pharmacists recruited from Australian Capital Territory (n=1), South Australia (n=1), and Victoria (n=1). In relation to their nominated primary job, participants worked between 15 and 50 hours a week, with the majority working within a community setting. Of the 25 participants, 17 reported that they held secondary jobs/roles/responsibilities undertaken in a range of settings (e.g. at home, university, community, hospital and/or nursing home).

Pharmacists who agreed to participate in the study represented a range of pharmacy-specific demographics (whether previously known to the research team, as they were recruited from existing networks, or ascertained during the interview).

Accordingly, overall as a group, study participants included pharmacists who:

- Held a range of positions in their respective pharmacies, from employee pharmacists/pharmacists in charge, pharmacist managers, to proprietors/employer pharmacists;
- Were working in and/or owned pharmacies located in metropolitan (n=17) or rural/regional areas (n=8);
- Self-reported working in areas ranging from areas with low patient health literacy, low socio-economic status, to more affluent area(s);
- Worked in pharmacies from a range of pharmacy banner groups;
- Worked in discount-based models of pharmacy or service-oriented pharmacies; and
- Worked in either one pharmacy or multiple pharmacies concurrently (for which information regarding service provision in each respective pharmacy was also collected, where time permitted).

3.2 Overview of key findings and structure of Results section

Collectively, the participant interviews encompassed discussions that centred on a broad range of themes and subthemes related to the research objectives.

Participants delivered a range of ongoing services within their work setting(s). These could be broadly classified as either 6CPA-funded CPS initiatives or non-6CPA funded initiatives. An overview of these services forms the initial section of the Results in this report. This is followed by descriptions of each of the individual services, the roles/responsibilities inherent in delivering the service, and their perceived impact.

Training completed by participants to support their capacity to deliver these CPS, where applicable, ranged from broad training/professional development activities to specific accredited and/or non-accredited training undertaken in relation to specific service(s).

With respect to financial reimbursements received, aside from 6CPA funding that was eligible to be claimed for the delivery of certain CPS, service delivery varied from no financial reimbursements received to services that were operated via a user-paid model that supported the viability of delivering these CPS in the community pharmacy setting.

In addition to ongoing CPS, there were a number of other services reportedly offered within the pharmacy, delivered offsite and/or on an intermittent basis for which the degree of pharmacist involvement varied.

Participants detailed broad impacts of services, which centred on facilitating patient access to services and enabling quality use of medicines (QUM). Furthermore, perceived economic impacts of CPS were also discussed, with the complex and multifactorial nature of their impact on community pharmacy earnings highlighted.

A number of changes to pharmacy practice were also detailed by participants, namely an expanded scope of practice as well as service provision, observed shifts in the roles and responsibilities of pharmacists, the impact of industry reforms that have acted as an impetus for changes within the profession, as well as other positive and negative changes to practice. Related to this was then participants' perceptions of the work value of community pharmacists, primary motivators for providing CPS, as well as perceptions of the wages/degree of remuneration at both the pharmacy and pharmacist levels, which are then presented in the later subsections of the Results section.

3.3 Overview of services being offered in community pharmacies

Key findings – overview of services

- Participants perceived a core set of services applicable across the sector, being provided by pharmacies.
- Services varied between pharmacies, where the business structure was a factor influencing the extent of services being provided.
- Smaller pharmacies were required to structure and prioritise service provision within their working capacity and available resources and expertise.
- Additional support via increased number of pharmacists/pharmacy staff was seen as an enabler of CPS provision.
- Roles and responsibilities of pharmacists differed between the services.

When discussing CPS that were being offered within community pharmacy settings, participants alluded to a baseline or standard/normal practice and repertoire of services, applicable to community pharmacy practice across the sector.

> *"Our approach in the model that we kind of use is very much service-based and service-driven. So some of the services that we provide include your basics and your regulars- or at least we consider them so." (P08)*

> *"We do the standard ah pharmacy service as well, like HMRs, MedsChecks." (P22)*

Additional services on offer varied between pharmacies and depended on the business model/structure in operation in a particular pharmacy. For example, pharmacists who worked in smaller pharmacies and/or where there was generally only one pharmacist on duty at a given time noted that the size of the pharmacy and thus consequent lower numbers of staff was a factor which influenced the feasibility of the provision of some services. For a smaller pharmacy, service provision had to be structured within the existing working capacity of the pharmacist(s), expertise of the individual pharmacist(s) working in the pharmacy, and also taking into account the baseline tasks that required completion. This led to the pharmacy becoming just *"your bare-bones pharmacy" (P17)*, implied as either during certain times or for most of the time.

> *"We do all the services although I must say like, being the sole pharmacist, I sometimes don't have time to do those services. So it's basically dispensing, front of shop OTC requests, checking [DAAs] on Sundays." (P18)*

Adopting a model of practice that had a larger team of pharmacists and/or availability of support via additional pharmacy staff appeared to enable the provision of CPS in the pharmacies. Promotion of the services being offered by the pharmacy to other health care professionals (HCPs) to further promote inter-professional collaboration and/or time to focus on business development/service implementation was also described as being part of the role of a few employee pharmacists working in service-oriented pharmacies.

Collectively, a range of services were reportedly provided in the pharmacies where participants worked at the time of the interviews. On occasion, participants appeared to have some difficulty identifying and/or recalling all distinct activities and services undertaken. This necessitated prompting by the interviewer on some occasions to confirm whether the service was provided (e.g. regarding more 'standard' services or services that were not provided on a daily basis).

> *"There are so many that we do. And we do them kind of [on a] day-to-day basis. Yeah, you lose track of what you actually do, kind of, in the whole scheme." (P08)*

Pharmacist roles and responsibilities also varied between the different services. One participant commented that they perceived a distinct difference between what they regarded as a 'true service' as opposed to other services such as blood pressure (BP) or blood glucose (BG) checks. Rather, these were perceived to act as pivot services that helped to facilitate patients to engage with other services.

> *"True service: something that involves follow-up that you're trained to do. And that I guess can make a difference to their life somehow. So I guess with those ones there…… most of the time, they're promotional…… It's to get someone to understand that, you know, that they have something else going on…… So most of the time, we use that as like a…… pivot service or a promotional thing. That's probably why I see that more as that, I'd say." (P16)*

Interestingly, a participant who was a consultant/locum pharmacist had noticed that there was a degree of difference in service provision and uptake of certain services between pharmacies based in metropolitan and non-metropolitan areas.

> *"So things like sleep apnoea machines tend to be more prevalent in country areas where there isn't hospitals. So you wouldn't do it in the city. It is not worthwhile because you've got lots of big teaching hospitals that would offer that service and people go there rather than come to a pharmacy for it. You do tend to get a lot more people wanting compounding and expensive things in the city. The country…… we would maybe get one compounding script a week here, whereas when I work in the city, there would be, you know 10, 20 a week at a place that doesn't compound, that you would outsource." (P19)*

Table 4 provides an overview of services provided in the pharmacy that would typically have some pharmacist involvement in their delivery, and were not explicitly restricted to certain times/occasions in the year. In addition, a number of other services were also being offered. For the purposes of this report, these have not been presented as part of Table 4 specifically as:

- They primarily involved other HCPs working within the community pharmacy setting (please refer to Section 3.9);
- May have involved the pharmacist at some point in their delivery but for instance, were more dispensing/supply-related and/or did not specifically utilise pharmacists' expertise in health and medicines (please refer to Section 3.5, xii; Section 3.10); or
- Were offered on an intermittent basis (please refer to Section 3.11).

Table 4. Overview of the range of cognitive pharmaceutical services offered in/by each respective community pharmacy (as reported by study participants) on an ongoing basis which would have some pharmacist involvement

	6CPA-funded CPS					Non-6CPA funded CPS																
						Point-of-care testing / screening / monitoring							Chronic disease management (and/or diagnosis)				Medication-oriented		Acute care	Hospital-related		Other
Parti-cipant	Staged supply	CIs	Meds-Checks/ Diabetes Meds-Checks	HMRs and/or RMMRs	DAAs	Nursing home/ Aged care/ disability facilities	Flu vaccin-ations	BP/ CVD	BG	INR	Choles-terol	Gluten/ Coeliac-related	Diabetes educator/d iabetes services	Weight manag-ement	Sleep apnoea/ CPAP	Smok-ing cess-ation	Comp-ounding	OST	Wound care and/or other first-aid	Hospital discharge-related services	Hospital pharmacy service	Absence from work certifi-cates
P01	x	✓	✓	✓	✓	✓	✓	✓	✓	x	x	x	x	x	x	x	x	✓	✓	x	x	x
P02	x	✓	✓	✓	✓	✓	x	✓	✓	x	x	x	x	x	x	x	x	✓	✓	x	x	x
P03	x	✓	✓	✓	✓	x	x	✓	x	x	x	x	x	x	x	x	x	x	x	x	x	x
P04	x	✓	✓	✓	✓	x	✓	✓	✓	x	✓	x	x	✓	x	x	x	x	x	✓	x	x
P05	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	x	x	*	✓	x	x	x	x	x	✓	x
P06	x	✓	✓	✓	✓	✓	x	✓	x	x	x	x	x	x	x	x	x	x	x	x	x	x
P07	✓	✓	✓	✓	✓	x	x	✓	x	x	x	x	x	x	x	x	x	✓	x	x	x	✓
P08	✓	✓	✓	✓	✓	✓	x	✓	✓	x	✓	x	✓	✓	✓	x	✓	✓	x	✓	x	x
P09	x	✓	✓	**	✓	x	✓	✓	✓	x	✓	x	x	x	x	x	x	✓	x	x	x	x
P10	x	✓	x	✓	✓	x	✓	✓	✓	x	x	x	x	x	x	x	x	x	x	x	x	x
P11	x	✓	***	x	✓	x	x	x	✓	x	x	x	x	x	x	✓	x	✓	x	x	x	x
P12	x	✓	✓	✓	✓	✓	✓	x	x	x	x	x	x	x	✓	x	x	x	****	x	x	✓
P13	✓	✓	✓	x	✓	x	x	✓	x	✓	✓	x	✓	x	x	x	x	✓	x	x	x	x
P14a	x	✓	✓	✓	✓	x	x	x	x	x	x	x	✓	x	x	x	x	✓	x	x	x	x
P14b#	x	x	✓	✓	x	x	✓	✓	x	x	x	x	✓	x	✓	x	✓	x	x	x	x	x
P15	✓	✓	✓	✓	✓	x	x	✓	✓	x	x	x	x	x	x	x	x	x	x	x	x	x
P16	✓	✓	✓	✓	✓	x	✓	✓	✓	x	✓	x	x	✓	✓	x	✓	✓	x	x	x	✓
P17[c]	x	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	x	x	x	x	x	x	x	x	x	x	x
P18a~	x	X	x	x	x	x	x	✓	✓	x	x	x	x	x	✓	x	x	x	x	x	x	✓
P18b#	x	✓	✓	✓	✓	x	x	✓	✓	x	x	x	x	x	x	x	x	x	x	x	x	✓
P19	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	x	x	x	x	✓	x	x	x	x	x	x	✓
P20	✓	✓	✓	x	✓	x	✓	✓	x	x	x	x	x	x	x	x	x	x	x	x	x	✓
P21a	✓	✓	✓	✓	✓	x	✓	✓	x	x	x	x	x	x	x	x	x	x	x	x	x	x
P21b#	✓	✓	✓	✓	✓	x	X	✓	x	x	x	x	x	x	x	x	✓	x	x	x	x	x
P22	✓	✓	✓	✓	✓	✓	X	✓	✓	x	x	x	x	x	✓	x	x	✓	x	x	x	x
P23	✓	✓	✓	✓	✓	x	✓	✓	x	x	x	✓	x	✓	x	x	x	x	x	x	x	x
P24a	✓	✓	x	✓	✓	x	x	✓	x	x	x	x	x	x	x	x	x	x	x	x	x	x
P24b#	✓	✓	✓	x	✓	x	x	✓	x	x	x	x	x	x	x	x	x	x	x	x	x	x
P25	✓	✓	✓	✓	✓	x	x	✓	✓	x	x	x	x	x	x	x	x	✓	x	x	x	x

Key

✓ = Explicitly reported as being offered in the respective pharmacy (but not necessarily solely by the study (interviewed) pharmacist themselves).

x = Not explicitly reported as being offered in the respective pharmacy (N.B. this is self-reported data from the participant).

* = Offered in the pharmacy but is offered by trained pharmacy assistants who act as weight loss consultants.

** = HMR requests outsourced to another pharmacist, with no financial incentive received by the pharmacy.

*** = Offers MedsChecks "unofficially" – patients are unwilling to sign the paperwork so they cannot be claimed as MedsChecks to obtain 6CPA funding.

**** = When asked about future services that the participant would like to start offering, fee-for-service wound care was mentioned. However, the participant then went on to state "we do, do wound care but we don't charge for it".

= This data pertains to the second community pharmacy in which the participant was also working in.

N.B. Cholesterol checks as detailed by P08 and P16 are integrated into their weight management program.

[c] P17 is primarily a consultant pharmacist working in various settings, offering HMRs and RMMRs, and regularly locums for a particular pharmacy 2 days a month. Hence, the data provided for this participant incorporates services offered as a consultant and/or offered in this pharmacy.

~ = Non-PBS pharmacy.

Range of CPS offered in community pharmacies

Many pharmacists reported that the pharmacy that they worked in offered services that fell under the 6CPA (and therefore reimbursed via 6CPA funding). However, pharmacists also described many services that fell outside the 6CPA funding model which were then either user-paid services or offered for free, depending on the respective service and/or pharmacy.

6CPA services typically mentioned by participants included DAAs, CIs, and MedsChecks. Pharmacists perceived these to be embedded within 'normal practice', rather than necessarily regarded as novel services that are distinct from routine practice within a community pharmacy setting.

> *"My expectation of what you should be doing as a pharmacist. That's really what I see is your role- is to try and improve the patient outcome. So clinical interventions should be what you're doing anyway, regardless of if you are getting paid for it. And same with MedsChecks, to a degree, is really what you should be doing. So that's why I've considered them…… part of every day." (P23)*

From Table 4, the pharmacies that offered a smaller profile of services tended to self-nominate as a small community pharmacy (mostly only 1 pharmacist on duty at a given time). As mentioned previously, this was likely linked to the capacity of the pharmacist(s))/size of team to offer a larger suite of services.

3.4 6CPA cognitive pharmaceutical service initiatives

Key findings – 6CPA CPS

- Core 6CPA-funded services reportedly being delivered in community pharmacies included dose administration aids (DAAs), Home Medicines Reviews (HMRs), MedsChecks/Diabetes MedsChecks, clinical interventions (CIs), and staged supply.
- Pharmacists were responsible for checking DAAs, where DAAs were seen to facilitate improved patient adherence to medicines and QUM.
- MedsChecks allowed pharmacists to assess patients' understanding and use of their medicines, and were seen as a timely way to identify and address medication-related problems.
- HMRs enabled a detailed assessment and recommendations to be provided on a patient's medication regimen; positive feedback received on HMRs and the implementation of recommendations were reported.
- CIs encompassed a broad range of potential medication-related problems, and were primarily viewed as a change in the documentation process rather than a change in practice.

i) Dose administration aids

The provision of dose administration aids (DAAs) was one of the most common services provided by pharmacies in which the participants worked. They were provided to both community-based patients (supported by 6CPA funding) and residents of aged care facilities (not supported by 6CPA funding).

Other pharmacy staff were involved with packing DAAs in many instances; however, a pharmacist was responsible for checking DAAs.

> *"Luckily, we've got a technician who is very experienced with that. Ah she basically dispense[s] the drugs, pack[s] it and all we need to do is check it. So yeah, so it doesn't really affect the pharmacist much." (P09)*

In a few settings, pharmacists were involved in the packing process as well as checking.

> *"We have a couple of [staff] who…… do it. But we also have some of the pharmacists who do it as well. So times when the pharmacist isn't busy, they're also expected to pack. And a pharmacist always checks so that the packs are done but not sealed. Ah and then, they're checked and then the pharmacist seals it and then signs it." (P23)*

Pharmacists also liaised with doctors where necessary regarding any issues, changes and/or prescriptions required.

DAAs were often delivered to the patients, with no additional fees charged for delivery. One participant in particular stated that the pharmacist themselves did the delivery to ensure the safe use of medicines.

> *"Delivery home visits which often the pharmacist does themselves, not a delivery driver….. and the reason for that is you can get mistakes in tiny blisters and [if] you [have] got an untrained person visiting someone in their house and the question that you've asked is 'What day is your alternating warfarin? Starting one tonight?' and you don't know what answer is going to come back to you." (P01)*

DAAs afforded the pharmacist an opportunity to *"informally check compliance" (P06)*. With respect to the impact of providing the DAA service, it was seen to have led to:

- Enabling QUM through improved adherence;
  "So with DAAs, the benefit is that we are making sure there is quality use of medicines because of better compliance and adherence, and we're able to monitor that and help the patient with solutions if they're not coping." (P01)
- Increased willingness to utilise DAAs, not only among the older population but within the younger population as well;
- Increased patient satisfaction and loyalty;
- Increased opportunities for monitoring (directly and indirectly);
  "In terms of their health, if they take their medication properly then it has impact on them positively in their lives. And also because we deliver every single week, there has been many occasions when we've knocked on the door, no one is there; they have actually collapsed. So, we have detected on that point…… There's frequent monitoring. And because of the frequent monitoring….. we are able to assess people's health a lot better." (P05)
- Reduced medication errors;
- Increased convenience for the patient;
- Enabling more effective medication management among the patient population; and/or

- Guaranteeing that the prescriptions for the medicines being packed in the DAA would be dispensed by that particular pharmacy.

"So the whole DAA service I think is probably the one that's got the most opportunity in terms of growth for pharmacy because…… we've got an elderly population. It's getting….. more complicated in terms of medications and medical conditions and it's a good way of being able to assist patients. So I guess it's a win-win for pharmacy and patients because as a pharmacy offering that service, it allows you to retain that customer, provides better loyalty while at the same time, there is some form of funding there available." (P21)

However, the impact of DAAs was not always perceived as positive. One participant in particular had observed a *"decline in people after they've been put on [DAA] packs. They lose interest in what their medicines are." (P17)*

"Well, that's basically the one that I've noticed most… you'll go into a person's home and you'll talk to them about their medicines, and you do, you fit into two categories of people. Let's not talk about the [DAA] packs, let's just talk about the people.

You got the people who know everything about their medicine, well they think they do, but they know what they're for…… and they notice when they change.

Then you've got the people who also kind of fit into that category that know what they are, but can't remember, but…… they know they've got that medical condition and they're kind of actively trying to be a bit proactive about that medical condition.

And then you've got 'Oh, wouldn't have clue. Wouldn't have a clue.'…… 'Well, I just do what the doctor tells me.'……

Now, I see people move from the first category towards the second category if they get a [DAA] pack." (P17)

ii) MedsChecks/Diabetes MedsChecks

MedsChecks involved a consultation between the pharmacist and the respective patient (expected to benefit from/eligible for a MedsCheck), and required pharmacists to use their expertise in health and medicines. Discussions centred on the patient's medicines, how they were being used, answering any queries the patient may have had, and relevant patient education/reinforcement. An assessment of the patient's current medications for any potential interactions and/or the need for referral (e.g. for an HMR) was also conducted. A report was also then written on the findings and recommendations from the MedsCheck.

> *"We'll go through all their meds with them, find out what they know about all the new stuff. Most of the people who've come out of the hospital, obviously the general recommendation would then be that perhaps they would get a [DAA] pack." (P19)*
>
> *"We go through all the new tablets, definitely, that they've been given. We also go through their old tablets just to make sure that they were in fact taking them correctly because the number of times people go to hospital, get added new tablets and they haven't been taking the old ones is quite amazing really……*
>
> *The other thing we would go through is what the doctor's told them…… 'cause often with a hospital discharge, it would tell you what was wrong with them and we'll get them to see if they understand what's going on and explain why these tablets are so important…… a very simplistic version of how they work and how they'll make them feel better even if they won't notice anything. So I find that's quite helpful for getting people to actually take their tablet." (P19)*

Logistical considerations linked to conducting MedsChecks were raised. MedsChecks would generally be booked in with the patient in advance to ensure that a pharmacist would be available and that there would be sufficient time to complete the MedsCheck. In general, the time taken to conduct a MedsCheck was reported to be approximately 20-30 minutes at least, and possibly up to an hour depending on the individual. More than one pharmacist was generally required to be working in the pharmacy at the same time in order for other pharmacy tasks to be completed.

> *"They're a bit more structured so we have to do those on days where we've got more than one pharmacist because the person doing it can't be the pharmacist in charge of dispensing…… They're normally done on appointment basis because they are a bit more formal and we need to make sure we allocate enough time and that the patients allocate enough time and understand that they're going to be with the pharmacist for a good half an hour, minimum." (P21)*

One participant also raised that *"part of the difficulty is that…… if they're unable to come to the pharmacy and they are at home, then we technically can't go to their home to do the MedsCheck. That would involve an HMR in which case, the doctor would liaise with our HMR pharmacist." (P06)*

MedsChecks were reportedly linked to other services provided by the pharmacy and/or tended to be delivered in relation to certain circumstances, for instance:

- Clinical interventions leading to MedsChecks,
- DAA initiation prompting a MedsCheck,
- Diabetes MedsChecks *"intertwined primarily with… diabetes services" (P08)*,
- Patient(s) recently discharged from hospital, or
- Broad needs of the local demographic e.g. *"especially [in] the area where I work, there [are] a lot of elderly people…… and they may have been on certain medications for a very long time, and they've never been reviewed on how they are going." (P03)*

One pharmacist also discussed the impact of the formal remuneration pathway available for MedsChecks on service quality between pharmacists/pharmacies and the overall remuneration claimed/received.

> *"What happens is we are given paperwork to say 'This is how a MedsCheck should happen.' and we're only going to be remunerated if someone signs the consent form and someone does this and someone does that. So you've got your good pharmacist [who] is like 'Look, I've just got too many patients to see', who never claims.*
> *And then you've got those…… when I say those, I mean some certain franchises that have been the reason why we got caps on MedsChecks in the first place… Where they…… [have] done the paperwork for people that haven't received the MedsCheck…… a true MedsCheck." (P01)*

With regards to the impact of MedsChecks, some of the impacts noted by the participants included:

- That *"it gets the conversation going about something" (P16)*, an opportunity to bring up any concerns;
- Timely intervention that does not depend on a formal request from a doctor;
- Improved patient education and identification of medication-related problems; *"Things like MedsChecks offer you the chance to have a remunerated service, to actually sit down with a customer, understand them…… help them to understand their medicines and really, you know, build that rapport…… They feel comfortable with you understanding their health concern." (P04)*
- May lead to a reduction in the number of medicines the patient has been taking (which may lead to potential economic and/or health benefits for the patient);
- Improved patient adherence due to increased understanding about their medicines and the rationale for their use;
- Positive health outcomes due to flow-on effects from a MedsCheck; *"There's always more positive health outcomes because anyone who's agreed to come and spend time with the pharmacist, you're usually getting people who generally are concerned with their health. You're not getting people who are a bit blasé about things or don't have an interest…… If you've got someone for half an hour of their time, you generally know that they're going to take things seriously…... So there's definitely been outcomes, obviously because you're more thoroughly going through things with that patient more so than what you would just at the point of dispensing. There are interventions that you might find in terms of, you know, interactions that you never really got a chance to figure out, notice other things inadvertently through communication with the patient that's, you know, triggered the ability to get their GP to follow up on things. So health outcome-wise, there's definitely a strong improvement in health outcomes as a result of MedsChecks, for example." (P21)*; and/or
- Improved perception that the pharmacy is service-driven.

Despite the positive impacts associated with MedsChecks, one pharmacist noted limited interest for participating in MedsChecks within their patient demographic. Another participant also cited unwillingness of patients to sign the required MedsCheck paperwork which meant an inability to claim reimbursement. However, despite this, the participant continued to offer 'unofficial' MedsChecks due to perceived duty of care of a pharmacist. As there was a limit to the number of MedsChecks that can be remunerated on a monthly basis, it was queried whether or not this was a rate limiting factor that could inhibit the conduct of MedsChecks for patients.

iii) Home Medicines Reviews (HMRs)

For most pharmacies where HMRs were offered, participants stated that they themselves were not accredited to conduct HMRs. Either a pharmacist on staff was accredited to conduct HMRs, or another pharmacist was subcontracted to conduct them, and/or HMRs were referred to accredited pharmacists who were external to the pharmacy itself. An agreement existed between the HMR pharmacist and the pharmacy regarding reimbursement/claiming. Several pharmacists stated that they were currently accredited themselves (n=6).

An HMR involved an initial interview with the patient in the patient's home in order to obtain relevant information about the patient and their medicines. Following on from this (and after sourcing relevant information e.g. recent blood test results), the pharmacist would undertake an assessment of the medication regimen, identify any medication-related problems, and formulate recommendations which are summarised in a written report sent to the patient's pharmacy and their doctor. As summarised by one participant, the report would include a tabulation of prescribed medicines and dosages for the specific patient, how the patient was actually using the medicine, and any relevant issues e.g. any medication storage issues, incorrect technique (e.g. device-related).

With regards to the impact of HMRs, a number of complex economic factors in relation to HMR remuneration, the caps in place on the number of HMRs that can be conducted in a calendar month, and their impact were raised. The caps were perceived to negatively impact patients and were seen to potentially increase health care costs for the health care

system indirectly. In addition, a participant who was an accredited pharmacist also observed that the current level of remuneration was insufficient to ensure patient access to HMR(s) and high quality HMR report(s).

> *"I think the cap makes it worse because the cap makes it worse for the patient. Because sometimes you identify a patient that needs it, but you don't want to do it pro bono because what's the point in that? It devalues your work if you start doing things for free. So you just don't see that patient. So what does that mean? That patient ends up with a hospitalisation potentially because of medication misadventure and that probably costs the tax payer $5000 for that presentation." (P01)*

One pharmacist also said that in their pharmacy, both the employed pharmacist who is HMR-accredited and the subcontracted pharmacist had *"waiting lists longer than what they can get to 'cause it's not enough." (P23)*

Examples of positive impacts of HMR were positive feedback from doctors on the HMRs and frequent implementation of the pharmacist's recommendations. A participant stated that patients also provided positive feedback on the HMR process; it had also been a positive driver for pharmacy loyalty. Despite tangible impacts such as reviewed dosages and decreased pill burden, regarding health outcomes, one participant noted that the impact of HMRs on health outcomes was *"a hard one to…… see in a short time." (P12)*

iv) Clinical interventions (CIs)

Pharmacists perceived clinical interventions (CIs) as a service ingrained in the practice of pharmacy, however *"not really something… that the customers really know about; it is just something that we… record… for ourselves." (P07).* Formal service-specific training was not often mentioned in relation to CIs.

CIs encompassed:

- Interventions related to over-the-counter (OTC) medicines;
- Problems/issues detected and resolved by the pharmacist, for instance *"an overdose or under treatment or compliance, all kind of issues that you need to talk to the customer or talk to the doctor" (P10)*; *"a new medication and particularly if there was an interaction" (P17)*; this may have then led to *"some areas that we can educate them a bit better or help them or assist them. And we try to sort of just show them how they can manage a situation before it gets any worse." (P03)*
- Potential interactions between medicines; and/or
- Prevention of inappropriate medication use.
  "It's usually deflecting people when they want something because their uncle, brother, mother, cousin, [or] neighbour told them that they should have it and really, it's not appropriate." (P19)

Interestingly however, 6CPA-funded CIs were mainly viewed as a change in documentation procedures rather than a change in practice, whereby assistance from pharmacy staff to support the documentation process was described on occasion.

> *"I think the clinical interventions is something that pharmacists already do on a daily basis but we just don't record it so now we just have to work the recording and documenting into our workflow." (P20)*

CIs themselves were seen to have positive benefits for patients due to the utilisation of pharmacists' health and medicines expertise e.g. prevention of side effects. However, the impact could vary according to the nature of the CI itself. One pharmacist also commented that undertaking CIs was an effective auto-feedback loop that helped to encourage a more proactive approach on the pharmacist's part.

"I think it's more the way that you document things. But at the same time, especially when we're reminded about clinical interventions, you probe for things more and you become a better history taker, you know, a better questioner and things like that. So it kind of… It's a reminder of how you should be practising." (P16)

v) Staged supply

Staged supply was a service offered by pharmacies depending on the needs of the patient.

"That's basically something that is needed to be done, especially for certain S8 or opioid medication that the doctor doesn't want the patient to have on them all the time or benzodiazepines that need to be more strictly regulated in dosing." (P07)

Inter-professional collaboration between the prescriber and pharmacist was noted. Staged supply was intended to help reduce the likelihood of overdosing, potential misuse or abuse, and to help promote their safer use with associated monitoring. It may have been initiated by either the pharmacist or the prescriber, where no fee-for-service was paid by the patient.

"Staged supply just provides a good way for us to keep a record…… by keeping it at the pharmacy for them. So it's more safe for them and easier for us to monitor and easier for the prescriber to prescribe as well." (P20)

"Sometimes…… at our end, we've rung the doctor and said we think this is a good idea. Other times, the doctor's requested it. It's probably a mix, an equal mix of the two. And sometimes that comes out of a sit down chat with someone and saying 'I really… you are taking way too much of this.'" (P23)

A positive impact was seen by participants for those patients receiving staged supply.

"When they do come back to us, they feel like there is a point of care and that's increasing health outcomes. But also like, we are able to monitor how they are going and then we can communicate with their doctor. So it builds a rapport for all of these…… So I guess it impacts on their health." (P05)

"I think it is a good system and the majority of them, who are genuinely wanting to do something about their health, appreciate it and appreciate that what we've put in place is for their own, it's for their benefit. And then they can see a benefit and that's been really good." (P23)

3.5 Non-6CPA cognitive pharmaceutical service initiatives

Key findings – CPS initiatives that were non-6CPA

- Non-6CPA CPS that were more commonly reported as being provided included point-of-care testing such as blood pressure (BP)/cardiovascular disease (CVD) checks and/or blood glucose (BG) checks, pharmacist-delivered immunisation, and opioid substitution therapy (OST).
- A range of other CPS were also reported, that spanned other point-of-care testing services, services provided to aged care and related facilities, chronic disease management (with and/or without diagnosis), medication-oriented services, among others.
- Notably, pharmacist-led flu vaccinations were associated with a number of perceived benefits such as improved accessibility and uptake of flu vaccinations, increased convenience and perceived cost-effectiveness, and professional satisfaction.
- The most ubiquitous, free service for patients was BP checks. Pharmacist involvement in BP checks varied between pharmacies. However, pharmacists were involved at some point in the process, particularly in interpreting BP readings.
- Sleep apnoea diagnostic services were offered by some pharmacies, and provided convenience and comfort via the available option for patients to complete in-home diagnostic testing.
- Services provided to facilities such as aged care facilities commonly centred on DAA provision for residents.

i) Opioid substitution therapy (OST)

Opioid substitution therapy (OST) was reported to generally involve an agreement/ understanding between both parties (the pharmacy and the patient) of the rights and responsibilities associated with OST and its provision. Pharmacists' roles included interviewing patients potentially eligible to commence OST, measuring out doses for patients (inclusive of takeaway doses and relevant labelling/dispensing of the OST, where applicable), and supervision of dosing at the pharmacy. Patients paid a nominal fee for OST, expressed by participants as either a weekly or per dose fee.

OST was seen to have an impact in a number of ways. Patients were deemed to be satisfied with the service. Economically and health wise, *"it is definitely a beneficial service that we are providing like monetary wise, financially, and also I guess service wise, because it's much better for them to be on this program than doing what they were previously" (P07).* A pharmacist proprietor based in regional New South Wales noted:

> *"We've had a few people ah finish the program. I think we're on our 4th in a year…… A lot of these people you know, comparing to other places I've worked, are really committed to stopping heroin altogether…… which is beautiful. You know…… it's being able to aid in that that makes it worthwhile…… Helps them integrate back into society…… a lot of them have picked up new jobs." (P22)*

ii) Pharmacist-delivered immunisation (flu vaccinations)

Pharmacist-delivered flu vaccinations were offered by the pharmacies of a number of study participants. Several also mentioned that either they or other pharmacist colleagues had recently completed their training and/or ensured that their pharmacy met the pharmacy layout requirements to provide vaccinations and would be offering the service in the near future. For those who were keen to offer immunisation, but had not done so at the time of the interview, availability of space (especially where patients can lie down for injections) was cited as the primary barrier.

The service was user-pay and involved answering any initial patient queries regarding the vaccination, patient completion of a consent form which included questions such as *"Have you ever had Guillain-Barré syndrome? Are you allergic to eggs, feathers? Have you fainted after a flu vaccination? Are you on oral corticosteroids? And things like that just to make that clinical assessment. Are you feverish at the moment?" (P16)*. This form was then appraised by the pharmacist and if appropriate to proceed, the patient was then taken into the consultation room and the flu vaccination was administered. Patients were also requested to wait in the pharmacy for 15 minutes post vaccination for monitoring. A few participants also mentioned that the patient or GP were provided with a record/letter that detailed the flu vaccination received by the patient.

Participants had noticed an increase in patient uptake of flu vaccinations over time. In addition to patient walk-ins, there were also agreements in place with local employers who organised for their staff to receive the flu vaccination. Although some patients were eligible to receive government-funded flu vaccinations (via the National Immunisation Program Schedule), the increased convenience likely contributed to patient's willingness to pay for and receive the service at the pharmacy rather than visiting the GP. Perceived positive impacts noted by participants, specific to flu vaccinations, included:

- Improved accessibility to, and uptake of, vaccinations of people who would not have otherwise been vaccinated;
- Increased convenience to patients in receiving flu vaccinations;
- Improved cost-effectiveness for the patient i.e. reduced time for patients to be vaccinated in comparison to wait times that would be associated with GP visits;
- Positive feedback on the service from patients;
- Improved professional satisfaction for pharmacists in being able to offer the service; and/or

  "The vaccination service has been so rewarding and so that's where the money part of it, really… I know that we're probably out of pocket but we all feel really good being able to do the service. And I think job satisfaction has to come into play a little bit as well with our interns now being able to vaccinate when we're there." (P12)
- Opportunity for delivery of other services like MedsChecks.

  "I particularly like it 'cause you have the patient in the pharmacy for a full 15 minutes 'cause they need to wait around for 15 minutes after. So for ones that I've done…… some of them it's actually rolled into a MedsCheck or you know, a quick chat about their medication…… because they are there and they are present and they are in the pharmacy." (P04)

iii) Point-of-care testing

a. Blood pressure (BP) checks/monitoring/cardiovascular disease (CVD) risk screening

BP checks/monitoring was the most common health screening check/monitoring service offered, where the vast majority of pharmacies offered it for free.

The nature of the BP checks/monitoring service described by participants varied; for instance, some stated that a pharmacist was always involved whereas others had it as a self-service option (e.g. BP monitor was accessible to patients or; as mentioned by one participant, a more complete health station that measured BP, Body Mass Index, body fat percentage, with an option to complete an AUSDRISK assessment, where results could then be emailed to the patient themselves and an option that allowed the patient to request a consultation with a pharmacist if desired) or a trained staff member would complete the BP reading. However, although pharmacist-trained staff members may have taken the BP measurement, in general, the pharmacist or intern pharmacist was involved at some point in the provision of the service as a whole, in particular when interpreting the BP reading(s).

Participants found that there were certain types of patients who would get their BP checked. BP checks and/or monitoring could be pharmacist-led (e.g. a new prescription had been presented for a BP medicine, the patient was on BP medicine(s), there was a perceived need for regular monitoring between GP visits, or the patient was not feeling well), doctor-led (e.g. the doctor had requested the patient to get their BP monitored) or as a result of a direct consumer request (e.g. if they were feeling unwell and requested their BP to be taken, they were taking BP medicine(s), were concerned, or just wanted to know their BP).

Initially, patients were requested to sit down for a short period of time prior to multiple BP readings being taken. BP readings were then often recorded. This varied from a card or booklet given to the patient with the reading(s) jotted down to recordings made in the Guildcare software which then also led to the capability of printing out a record of all previous readings. A triage system was implemented in some pharmacies where if the BP reading was recognised as high or low, or if the patient had further queries, the pharmacist would then be involved by way of further counselling and/or recommendations for follow-up readings to be taken. Referral to the doctor on occasion also occurred where necessary.

Counselling on cardiovascular risk, diet and/or lifestyle that could improve their BP, where relevant, was also provided by the pharmacist or intern pharmacist. Adaptation of the Know Your Numbers campaign was mentioned by a few participants.

> *"It's a simple questionnaire. As far as the physical measurements, there is a weight measurement, ah BMI and ah blood pressure, that's it. Using a lot of those, they are just looking at simple risk factors." (P24)*

One participant also mentioned that *"sometimes we even then do a blood glucose check as well… and determine their risk of getting diabetes at the same time." (P22)*

Where there was an anomaly in their BP reading or if a need was identified for repeat measurement(s), patients were counselled and advised to return to the pharmacy to enable further monitoring of their BP. Patients were then referred to their doctor if needed, for instance if their BP was consistently high or low.

In terms of its impact, there was a level of perceived convenience and/or cost effectiveness for the patient associated with doing BP checks at the pharmacy, and improved accessibility and/or motivation for members of the community to monitor their health. This was perceived to translate into patient satisfaction and/or loyalty to the pharmacy.

> *"It gives them a picture. It gives them something that they can gauge, measure, and it makes them more compliant, I feel. They're more interested in their progress…… It's just a simple measurement, like [a] blood test. And I think anything that we can measure makes them more interested. So, blood pressure, blood sugar, cholesterol– it gives them figures that they can aim for." (P24)*

In addition, *"by offering that ongoing free service of blood pressure monitoring, we can recognise when, you know, maybe their regimen could be improved, whether their dose is appropriate. So that in itself is directly help[ing] their health. At least we hope." (P06)*

Interestingly, a participant who was working in a pharmacy based in rural/regional New South Wales commented that it provided reassurance to patients particularly due to difficulty accessing GPs in the area.

"The blood pressure I think provides a bit of comfort because it's hard to get into the doctor's here. It is not like you can just go down the road and wait. They say 'Oh no, come back in four days.'

Now, if they are worried about their blood pressure, or they are feeling funny, you know they think 'Oh my, my husband had a stroke and I feel funny. Oh.' And they stress. But if you can tell them 'Well look, your blood pressure is not high. It's not bad. It's okay', and kind of reassure them, they go 'Oh ok. You know, I can wait 'til I see the doctor.' That kind of thing." (P19)

b. Blood glucose (BG) testing

Some participants reported that they offered BG testing, whether it was stand-alone testing or in conjunction with other checks and/or counselling e.g. BP and/or CVD check(s), or linked to demonstration of the use of a BG meter. These could be either walk-in patients requesting a BG check or regular patients, for instance those who came in for regular BG checks, who were concerned that their BG meter was not working properly, who may have diabetes/gestational diabetes, or patients identified by pharmacy staff who may be at high risk. One participant mentioned that they provided BG checks as part of their participation in the diabetes screening 6CPA-funded Pharmacy Trial at the time of the present study (a second participant also mentioned that they were participating in this trial also).

BG readings were generally recorded, with patient referrals to their GP made where appropriate. As an extension to BG checks, a few participants also mentioned that they also had the ability to provide free BG meters to patients. Where a new meter was provided, the patient would be counselled on how to use it.

c. Cholesterol testing

Cholesterol testing was offered by some pharmacies, either embedded as part of their weight management programs or via point-of-care testing using a specific monitor (capable of measuring more than 1 parameter).

"Well the device that we actually use takes quite a bit of time to work so they're –it's a 180 second countdown so you are actually sitting down with the patient. By the time you've got ready, and you prick the finger, you get the blood sample, and then you start the clock. So you know, probably close to 10 minutes there by the time you've spoken through the result so it is probably – the $10 is probably undervalued for the pharmacist's time. Umm, but again it's a starting point to changing the mindset around payment for services." (P04)

Interestingly, one participant commented that the uptake for this service was low in their pharmacy which could be attributable to the cost ($30 for the test) and that the pharmacist would initially recommend for a complete blood test to be ordered by the doctor.

"Knowing that you had to pay about $30 for a finger prick test- like, people didn't really want to do it, yeah. And…… while it's like a more convenient way of doing it, rather than wait[ing] for the doctors, I still think a full blood count might benefit them because it's not just cholesterol. So I do encourage that first because they should get their body checks every like year anyway. But I mean if [they] are willing to pay, I am more than happy to do it for them." (P05)

d. International normalised ratio (INR) testing

International normalised ratio (INR) testing was not a common service offered by pharmacies. Upon request for a check from the patient, an INR test was completed; one pharmacist stated that they generally did not charge for it whilst the other pharmacist believed that there was some sort of charge but was unsure of the exact amount (however, not many INR tests were conducted). One pharmacist cited increased professional satisfaction from inter-professional collaboration, whereby the local GP referred their patients to the pharmacy to get their INR checked and the participant was subsequently involved in the decision-making about warfarin dosage adjustments. Another pharmacist noted that there were limitations to the degree of interpretation and recommendation that could be given in relation to a single INR test.

"We can't really judge someone's… level based off one little finger prick test. That would be dangerous and that's not really within our scope of practice, so we don't do that. But if someone wants to check, because they haven't been for a while and they feel like they are bleeding more, yes we can do that and we can tell them if it's high or lower than what they are supposed to be on. But we cannot do anything else apart from that. So we could probably say 'Well, you probably should go and see the doctor 'cause your INR is very low. It's probably not therapeutic.' or we can say 'Oh, it was quite high. You're probably going to be at risk of bleeding. You probably need to talk to your doctor about your dose.'" (P19)

"Obviously if it was super-duper high, we would, you know, ring the doctor and send them down there quick smart– or even to [the] hospital. Hasn't happened so far." (P19)

iv) Diabetes education services

Of those who offered diabetes education services, a few participants mentioned that there were pharmacists who were accredited diabetes educators in the pharmacy that they worked in; one participant also mentioned that they themselves were in the process of completing the relevant training to become an educator. Diabetes education services were on occasion linked to the completion of MedsChecks with patients. Where provided, diabetes education services involved the downloading of BG meter readings, interpretation of these readings by the pharmacist, and subsequent counselling/patient education to assist with the patients' management of their diabetes.

"With the downloads that we do, we're able to, you know, get the money out of there and then the patients have a graphical representation of how their sugar's been. And that gives not only them but their endocrinologist or their GP a better idea because often…… what they usually use is trends rather than individual numbers…… If I can ah visually see that the trends….. tend to spike in certain areas or are low in certain areas and if I can pinpoint that through like maybe a dietary intervention…… it's something that you can show the patient then and there and they quite like that." (P14)

One participant noted that the diabetes service helped with promoting customer loyalty *"because…… they felt that they're getting something special". (P13)*

v) Sleep apnoea

Sleep apnoea services provided in pharmacies included both the facilitation of at-home diagnostic testing for sleep apnoea and/or treatment of sleep apnoea i.e. continuous positive airway pressure (CPAP) machine provision and support for patients with sleep apnoea.

The diagnostic testing was a user-pay service; however, a few participants mentioned that there was also some financial subsidy of the service itself via Medicare payments for the relevant medical practitioners involved in the process e.g. provided there was an appropriate referral from a GP in place. Instructions for the use of the take-home diagnostic testing machine were given to the patient at the pharmacy; the patient then took home the device for the overnight in-home sleep study. Two participants also mentioned that as part of the sleep apnoea diagnostic testing service, rhinomanometry was also conducted (in the pharmacy; one participant also mentioned that spirometry was conducted in addition to this). Proceeding the completion of the home test, the machine was then returned to the pharmacy, where the relevant data was downloaded from the machine and sent to a specialist for interpretation. A report was then provided to the pharmacy and/or GP. Where sleep apnoea was diagnosed, patients had the option of trialling a CPAP machine (in the case of moderate or severe sleep apnoea for instance, as per the appropriate recommendation for the individual patient) for a period of time and purchasing one for use at home in order to help manage their sleep apnoea.

Support of patients using the CPAP machines as part of the treatment/management of sleep apnoea involved regular review of their results to check for adherence and ensure appropriate maintenance and use.

> *"The specialist actually tells us whether, from the results of the machine, they've got sleep apnoea or not. Ah from there, if the patient chooses to treat, we do hire sleep apnoea machines and also sell them. So we fit them with the right mask, make sure everything's, you know, fitting well, not leaking…… They go home with it. They come back every two weeks. And we download data from the machine. Make sure that everything is running smoothly. Look at their peak pressures…… average pressures…… lead times and things like that as well." (P22)*

A benefit of the service noted by several participants related to the comfort and convenience of the option for in-home sleep apnoea diagnostic testing. One participant working in a rural/regional pharmacy also noted that it improved access to the testing as it meant that patients did not have to travel all the way to the city in order to do the test.

> *"The sleep apnoea is– when people pay for it, it's quite popular. Not everyone wants to pay for it because it is a little bit expensive, but the ones who do see a huge benefit from it. Plus, they don't have to go all the way to Sydney for it. There isn't another service closer. So they really like that." (P19)*

Participants had observed positive benefits for those who were diagnosed with sleep apnoea and who were started on the use of a CPAP machine.

> *"It changes someone's life. If they actually get diagnosed with sleep apnoea and they go on to a machine, you always will hear about it. People come and say 'I used to be sleepy throughout the whole day. Like this has actually changed my life.' And you especially see that when something goes wrong. If they had stopped using the machine for a night or two or if their mask wasn't fitting well, they'll come and be like 'I can't sleep. Like, I didn't know how I functioned before.' So…… there is the most noticeable impact with someone's life." (P16)*

vi) Compounding

Several participants described the compounding services offered in their pharmacy. A variety of medicines were able to be compounded.

> *"We do all other non-sterile compounding, from veterinary compounding to women's health in terms of hormone replacement therapy, to men's health. Paediatric things…… commercial products from capsules to suspensions, you know, omeprazole suspensions that aren't available commercially." (P21)*

Participants reported patient satisfaction with compounded products, for instance where the ability to tailor a medicine to the individual resulted in a better product for them. One pharmacist proprietor also noted a higher level of financial reward and professional satisfaction associated with compounding due to the increased skills acquired and applied in order to provide the service.

vii) Aged care/nursing home/disability facilities services

Services provided to aged care/nursing home/disability facilities by pharmacies were typically performed in accordance with a contract between a pharmacy and the specific facility. Rather than the completion of formal training courses, pharmacists generally learnt how to provide the service(s) via experiential learning. It predominantly comprised the provision of DAAs. In addition to DAAs, a few participants mentioned that there were other services also provided, such as:

- Supply of medication stock to facilities;
- Destruction of dangerous drugs;
- Participation in Medication Advisory Committee meetings;
- On-site troubleshooting when required;
- QUM audits at the facilities every 3 months;
- Other audits *("We inadvertently check compliance when we go there and do audits. So these aren't official audits that an accredited pharmacist would do. These are audits that we do as a supply pharmacy: checking the stock that we have sent them and just checking that, you know, they're using it, they're disposing of old stock appropriately." (P06)*);
- Medication reconciliation efforts; and/or
- Facilitation of transitions of care.

A participant who was an accredited pharmacist also detailed that they conducted RMMRs for facilities.

viii) Wound care and/or other first-aid

Wound care services were not commonly reported to be offered in most of the pharmacies where participants were working. One participant mentioned that all pharmacists were able to offer wound care within the scope of *"bare minimum registration requirements" (P01)*; another participant detailed that either the nurse or pharmacist who worked at the pharmacy would offer the wound care service. This would include dressing skin tears, first-aid wound care scenarios, or situations where patients were not able to access a doctor straight away. Assistance was also provided for follow-up wound care to support self-management post consultation with the doctor.

> *"They are not able to redress the wound themselves at home because it's…… hard to get to or they can't rip the [branded wound care product] off or the [branded wound care product] or whatever it is. Or if they're unsure about how to…… what to put on first, if it's a gel or the [branded wound care product] or etc. So they would just come in and we offer for them to come in whenever they need to get anything done, provided it's not you know fully infected. If it's within reason, then we do provide that." (P02)*

ix) Weight management

Weight management services varied between pharmacies, from less structured to more structured programs, and were generally linked to the sale of weight management products such as meal replacements/very low calorie diet (VLCD) products. One participant mentioned that their weight management service was offered by trained pharmacy assistants who were weight loss consultants. Similarly, another participant stated that pharmacy staff were trained by the banner group to be weight loss consultants, whereby the pharmacist would be involved in *"the initial discussion with the patient about what they want out of the program…… We look at their cardiovascular risk factors or their blood glucose things, or discuss their arthritis knee pain and what they want to get out of it. And then if there's any issues that need to be clarified with the doctor, we send a referral to the doctor and then the patient can then start on the weight loss program…… The [staff] do most of the testing. So if it is blood pressure things, they would take it and we would then look at it." (P23)*

Another participant detailed that their weight management service was not an actively promoted service but rather *"tailored to the particular patient who's using it. It's not sort of one that's branded or marketed. It is…… offered as a support tool and patients know it's there if they want it. I think it's one that's associated with an in-pharmacy service now given that we've stocked a range of weight reduction formulas over the years…… It's just one that's there and it's not one that I'd necessarily actively seek out but it's there if a particular patient wanted it." (P04)*

Two participants reported that their pharmacy implemented a specific evidence-based weight management program. This program was detailed to be tailored to the individual and integrated VLCD in conjunction with consultations involving tailored patient education and counselling on diet and lifestyle factors, as well as checks of weight, BG, BP and cholesterol screening as part of the monitoring process. After the initial consultation, patients would generally come in to the pharmacy on a weekly basis, where follow-up tailored consultations would take place (at no extra charge to the patient on top of the initial fee).

> *"Usually, they come in on a weekly basis…… restock their products, speak about all the things that they've been having trouble with, going through and just making sure that the meals are there… we focus a lot on the meal that they're making themselves because the program kind of gradually tapers them off the meal replacements…… The big focus is on…… what to make yourself…… The session will be a lot of counselling. They're generally about half an hour. The initial one is about an hour and then the other ones are about half an hour depending on how long they need just about…… nutrition, education around that…… every month, every couple of months, we'll do the bloods again." (P16)*

Within the pharmacies offering this evidence-based weight management program, *"for those who implement it really well, they love it and they see the results and it's life changing" (P08)*; for instance, the program has played a role in helping patients better manage sleep apnoea or reduce their insulin dose.

x) Hospital-related services

Hospital-related services varied. One participant stated that they assisted with hospital discharge to help "*make it easier for the hospital discharge pharmacist" (P04)*. This primarily involved "*ensuring continuity of care and making sure that when a patient's discharged, they have everything that they need" (P04)* e.g. a DAA or counselling on a new medicine.

Another participant reported that the community pharmacy in which they worked acted as the pharmacy that serviced a particular hospital. Services provided included the dispensing/supply of medicines prescribed by the hospital doctors (inclusive of clozapine), ward stock audits, and destruction of dangerous drugs/other ward stock where necessary.

A third participant also detailed a unique hospital discharge-related service that was conducted in collaboration with the local hospital, which was in its early trial phase at the time. The pharmacy was operating extended hours in close proximity to a hospital whereby the aim of this service was to reduce hospital readmissions. Patients who had been recently discharged from a specific ward were able to go to the community pharmacy where medication reconciliation and relevant discharge counselling was then conducted. If appropriate, a DAA was also able to be organised for the patient. Patients were also required to follow-up with their GP within a week. The impact of this service noted to date was patient satisfaction associated with reduced wait times within the hospital setting.

xi) Absence from work certificates

Absence from work certificates were reported to be offered by some pharmacies. This service was generally not promoted to patients, and thus delivered upon request from the patient as a user-pay service. This was seen as preferable to help avoid misuse of the service. In order to provide the certificate, a consultation with the patient was conducted (which a few participants mentioned was aided by a template/checklist) to ascertain whether the provision of an absence from work certificate was appropriate and within the scope of practice of the pharmacist. A certificate was issued to the patient where appropriate. Participants did not detail extensive impacts of this service, which may have been associated with the level of awareness among patients that pharmacists offered this service, and as it was an ad hoc service.

"I don't think very many people around us know about this service that we're providing. And also because we are just next door to the medical centre. I think more people think to go to a GP than come to a pharmacist for this." (P07)

xii) Other CPS or tasks performed as part of the role of a community pharmacist (with minimal emphasis on routine dispensing and counselling)

Certain participants also mentioned that that there were other services also being offered in their pharmacy (Table 5).

Table 5. Other CPS offered in community pharmacies

Participant	Description of service
P01	**Schedule 2 (S2) medicines area** *"As far as professional services, I would say that your S2 area in itself is a professional service area. And we try and put a white coat, be the pharmacist or an intern, into that area to make sure that patients aren't just self-selecting inappropriate schedules/medicines and that there is a pharmacist in that area as well as around the vitamins area to make sure that some evidence-based recommendations are being made."*
P05	**Contraception-related services** • MS-2 Step provision (for termination of pregnancy) *"The pharmacist needs to be registered, the doctor needs to be registered."* *"In terms of training, 'cause there is a lot to read for it, you need to know what you are doing. You need to make sure because it's a life we are talking about. You need to make sure that the patient knows what they are doing as well. You need to make sure that there is right documentation, that the doctor is actually registered to write for them…… and then you have to be emotionally prepared to speak to these people, who are probably a little bit like anxious or what not as well."*

Participant	Description of service
P11	**Smoking cessation service** • Patients who smoke were identified and their smoking habits, smoking cessation and its benefits were discussed. *"For the beginning, we recommend [the] patch and the gum or lozenges together or spray. And after a few weeks, if they come back, then we check for whether they still smoke or not…… but sometimes they don't come back so it's hard to… to follow-up."* *"If they do come back, then we check whether they are still smoking. If they use the patch correctly and regularly and if they still have any cravings for nicotine."*
P23	**Coeliac disease-related testing** • Finger-prick blood test conducted by pharmacist, with interpretation of results • Online training, offered by banner group, completed by the pharmacist in order to provide this service *"It's put into a little device and then it is just a time thing…… then…… there is an interpretation and whether or not…… warranting further investigation by the doctor. It can rule out gluten intolerance. It looks for immunoglobulin sort of markers…… so it doesn't say you have coeliac but it does rule out some gluten issues. And you then refer them on to their GP."*
P23	**Asthma service/counselling** *"It's more about making sure correct technique, demonstrating devices…… and then just patients self-assessing how they think their control is."*

Participants also mentioned other tasks that they completed as part of their role as a community pharmacist, such as:

- Dispensing/supply-related accountabilities: S100 supply e.g. clozapine, HIV medicines;
- Utilisation of the MedsASSIST real time monitoring system for medicines containing codeine; and/or
- Quality Care Pharmacy Program (QCPP) accreditation.

3.6 Training undertaken in order to facilitate cognitive pharmaceutical service provision

Key findings – Training completed by pharmacists to enable CPS provision

- Training varied significantly between undergraduate training, self-directed learning and completion of accredited training courses.
- Of the service-specific training completed, accreditation courses were more likely completed for pharmacist-led immunisation, HMRs, and compounding.
- Non-specific training discussed for the services typically included training received from company representatives and/or self-directed learning.
- Financial support received for training undertaken by pharmacists varied; the most common course that was financially covered by employers was pharmacist-led immunisation training. However, training opportunities received by staff potentially varied depending on their role within the pharmacy.

i) Broad training and professional development

A broad range of training and professional development pathways to enable the provision of CPS were described. Pathways ranged from studies completed as part of the pharmacist's undergraduate degree and/or registration/intern training, self-directed learning (e.g. learning completed to meet continuing professional development requirements), to formal training courses and/or accredited training (e.g. HMR accreditation, immunisation training, attendance at conferences/therapeutic updates, training specific to the service(s) for which the pharmacist was primarily responsible for). Increased services had resulted in increased training being sought out and/or completed by pharmacists.

> *"Personally, we've had to adapt with the changes to the pharmacy. And so previously, I believe there was less of a[n] important focus on these services being provided…… now they're definitely a lot more prevalent, I think, in community pharmacy. How have I changed? …… I think with the added… prevalence of these services being made available, a lot of chemists like myself are trying to improve our knowledge in other areas, so that we can adequately and confidently perform services…… that are useful…… We're able to learn a lot from our colleagues…… naturopaths and nutritionists….. So, I think training is a big thing. And so, I've put a lot of focus into that later in…… [my] career." (P24)*

Intern training provided by the respective pharmacies in which they had worked in was mentioned by a few pharmacists who had less than 10 years' experience as very important in helping to enable them to provide services in their current role.

Non-specific training was undertaken over the course of participants' practice via experiential learning i.e. *"learn as you go" (P02)*. Training was also provided by company representatives and/or via training offered by the respective banner group.

ii) Specific training completed to deliver certain cognitive pharmaceutical services

Training reportedly completed specifically to enable the participant to provide a service varied between the different CPS, ranging from no specific training to accredited courses.

a) DAAs

No formal training to help pharmacists provide the DAA service was reported. It was seen as an accountability that was covered by a pharmacist's general registration; mentorship received from more senior pharmacists passed on to others within the work setting also enabled pharmacists to provide this service as part of their role. One participant cited gaining assistance from the DAA provider over the phone.

b) MedsChecks

In the main, no formal MedsCheck-specific training was undertaken by pharmacists. One participant mentioned that they had completed a short Guild training course specifically for MedsChecks/Diabetes MedsChecks. Other pharmacists mentioned reading relevant documents. Upon reflection, accredited pharmacists noted that their HMR training and/or experience had an impact on their provision of MedsChecks.

> *"I find that HMRs, we do go into probably a little bit more detail, but I do find that my HMR experience allows me to probably offer a little bit more in the MedsChecks. And that's why sometimes I can't just finish them there and then in half an hour. I might have to go away and think about it…… it normally does need a referral back to the doctor." (P12)*

c) Home Medicines Reviews (HMRs)

The participants who were currently accredited themselves had completed the relevant HMR accreditation training and were up-to-date with subsequent re-accreditation requirements.

d) Opioid substitution therapy (OST)

Regarding training, no formal training for OST services was cited. One pharmacist mentioned reading some materials about how the service should be provided when preparing for QCPP accreditation, however *"you just kind of learn as you go really. That I learnt through like the pharmacist at our other store who had been doing it." (P16)*

e) Pharmacist-delivered immunisation (flu vaccinations)

To be able to provide vaccinations, pharmacists had completed an appropriate immunisation training course as well as CPR and first-aid training to ensure their certificates were current.

f) Blood pressure (BP) checks

In order to offer BP checks/monitoring, previous undergraduate training and/or self-directed learning were mentioned by a few participants.

> *"For blood pressure, it's purely from readings. So from the Heart Foundation, there [are] a few articles on how to measure blood pressure and also from like previous pharmacist experience and from talking to other pharmacists, 'this is how you do it'….. And also from the actual manual of the machine." (P05)*

g) Blood glucose (BG) checks

Of those that mentioned training regarding BG checks, experiential learning on the job, any training received as part of the intern training program and/or information/training provided by company representatives were raised. Although participants implied that pharmacists generally conducted BG checks, one participant mentioned that other trained pharmacy staff members may also be involved.

"All the [staff] at work have been trained to do blood glucose. Again, if they are not a pharmacist, then they haven't been trained to advise in any way or counsel them on it. But if they see ranges that are outside of the norm, which is outside of the norm of the table we have given them, then they will refer." (P05)

h) Cholesterol testing

One participant mentioned that they received training on the use of the testing device from the pharmacy's banner group as well as the company representative.

i) Sleep apnoea

Pharmacists were trained by the CPAP machine manufacturer representatives and also completed informal training through experiential learning via other pharmacist colleagues who had previous experience with providing the service. Rhinomanometry and spirometry training, provided by the machine manufacturers, was also completed by the pharmacist where the sleep apnoea diagnostic testing service also included this testing as part of the overall service.

j) Compounding

Pharmacists were trained in compounding; courses were completed via the compounding supplier, or they had been trained by fellow pharmacist colleagues. One participant also detailed the experiential learning that occurred from case to case.

"A lot of the rest of it is learnt on the job and you're constantly having to learn new skills. And a lot of it involves just really sound knowledge of…… formulating…… a preparation from start to finish. From considering stability to considering…… the best way to ensure that, you know, it's administered correctly to a patient. And a lot of that has to do with tailoring it to that individual so it is definitely something where you sort of do it case by case." (P21)

iii) Financial support of pharmacist training

Financial support received from employers for training varied. One participant commented that the anticipated remuneration benefits compared to the costs of training were potentially seen as insufficient incentive to undertake further training.

> *"It's also very expensive sometimes. If you wanted to do a course, then it is quite a few hundred dollars and you do not…… get it back……Sometimes, you do think 'Frankly, is it worth my time? I'm still going to be paid what I get paid…… by the owner.' And now if I go and do [an] immunisation workshop, which I will be out [of pocket], you know, $800 – $900." (P03)*

Although there were occasions where the costs of training was borne by the pharmacist themselves, some employers did support pharmacist training for professional development, whether it be through provision of leave or through financing relevant training completed by pharmacists. A common course that was covered by employers for pharmacists was immunisation training. However, not all staff may have received the same opportunities regarding training from employers; for instance, precedence may have been given to pharmacist managers to complete further training or the nature of support given was dependent on the individual's negotiating power/initiative as to what they would like to get trained in.

> *"As a manager in the pharmacy, I was often taken on training weekends and courses. And I also try and attend conferences where possible, because you then stay abreast of what's happening in the industry and you can take ideas back." (P04)*

> *"They [the employer] cover all my training… Anything in terms of training to do with pharmacy. They cover my cost…… So anything that's free, I will go to." (P05)*

> *"Well I usually negotiate with the employer, saying that 'Ah well, I am going to be here. I am going to provide that service for your business.' So they usually pay for them. The conference CPD for pharmacists…… sometimes they pay for it, sometimes I pay for it." (P09)*

Interestingly, in addition to pharmacy-related training, one participant also mentioned that they had sought out and completed training in business management in order to further their own value as a pharmacist in providing CPS within a business context.

> *"I've also sought out not necessarily professional services but other courses that can help me understand business and help me to run businesses. So I'm trying to offer a different level of value, I guess. So not just in being able to deliver a service but to be able to manage a business that can deliver professional services." (P04)*

Importantly, it was noted that *"it's up to the pharmacist then to train other pharmacists or the intern or shop assistants on how to provide the services as well" (P07)*. For instance, seasonal training/refreshers for minor ailments that were more prevalent during particular seasons of the year were conducted for pharmacy staff by the pharmacist.

3.7 Financial reimbursement received for the provision of services

Key findings – Reimbursement received for CPS provision

- Reimbursements received for CPS varied between services.
- Services typically provided at a charge to the patient included flu vaccinations, OST, diagnostic testing of sleep apnoea, and absence from work certificates.
- The most common CPS offered free of charge to patients was BP/CVD checks.
- Contributions for DAAs paid by users ranged from $0 to approximately $5 per pack. However, together with the funding received from the 6CPA, it was still regarded as insufficient to cover the costs involved in providing the service.
- Alternative sources of funding other than government funding or user-pay funding models were not commonly cited; however, one source that was mentioned was the financial incentive received from BG monitor manufacturers for downloading and printing reports of BG readings.
- Profit margins on user-pay services were minimal. Moreover, a few participants noted that they had to decrease the fee-for-service for pharmacist-led vaccinations due to increased competition.
- Pharmacists were cognizant of the notion that fee-for-service, although desired, should not act as a barrier for service uptake among patients.

Overall, as pharmacies provided a range of CPS, the financial reimbursement received for each of the services also varied, and encompassed both funding received from the government or a user-pay fee-for-service model.

6CPA-funded services

Clinical interventions (CIs)

The funding model for clinical interventions (CIs) (at the time of the interviews) via the 6CPA was regarded as non-transparent funding. It was not clear in advance how much would be reimbursed for each CI. This was particularly noted by pharmacist proprietors.

Aside from the 6CPA incentives received for CIs by pharmacies, one pharmacist reported previously receiving a team financial incentive (now ceased) as a motivator that was appreciated and helped to increase the number of CIs collectively documented. The incentive was a bonus received if the target number of CIs for the defined period was achieved.

User-pay services

There were a number of user-pay services that were offered by pharmacies to patients (Table 6). There was a degree of variation between pharmacies and the fees paid to receive the service. Overall, flu vaccinations, OST, diagnostic testing of sleep apnoea, and absence from work certificates were provided at a charge. The most common CPS that was offered free of charge to patients was BP/CVD checks.

Table 6. Summary of user-pay services

CPS	N, total number of participants reported the service being offered	N, no fee-for-service paid by patients	N, user-pay fee-for-service	Minimum amount charged	Maximum amount charged	Median charge (based on user-pay fee-for-service)
DAAs	25[a,b]	4	20	$0	$5.20 or $5.30	$4.25 (for n=20)
Flu vaccinations	13[c]	0	11	$14.95	$30	$19.95 (for n=11)
BG checks	14[c,d]	8	4	$0	$10	$6.50 (for n=4)
Cholesterol checks[a,e]	7	1	4*	$0	$30	$10 (for n=3)*
BP/CVD checks	24[c]	21**	1	$0	$2 (non-concession) $1 (concession)	$2 (non-concession) $1 (concession) (for n=1)
Sleep apnoea (diagnostic testing)	8[a]	0***	6***	$99	$150 (non-concession)	$100 (for n=5)***
Opioid substitution therapy (OST)	11[f]	0	7	$30	$42	$35 per week (for n=7)
Weight management	5[a]	2	2	$0	$50 (initial consult fee)	$50 (for n=2)
Absence from work certificates	6	0	6	$20	$30	$27.50 (for n=6)

[a] Missing fee-for-service data for 1 participant.

[b] Two pharmacists reported that DAAs were offered in one of two pharmacies that they worked in.

[c] Missing fee-for-service data for 2 participants.

[d] One participant mentioned that they provided BG checks as part of their participation in the diabetes screening 6CPA-funded Pharmacy Trial, therefore not a user-paid service.

[e] N.B. As mentioned previously, two participants stated that the cholesterol testing was primarily integrated in the weight management programs that were offered in the pharmacy (one participant also mentioned that testing was available independently of the weight management program, despite no direct requests for the service from patients); therefore, calculation of the median did not include these.

[f] Missing fee-for-service data for 4 participants.

* Stand-alone cholesterol checks (i.e. excluding checks integrated into weight management programs); one participant stated that they were unsure of the specific amount but that there was a charge to cover the cost of the test strip if a cholesterol check was requested on its own (however testing was primarily integrated in the weight management program).

** One participant stated regarding BP measurements: “We encourage a donation…… but that doesn't go to remunerating the staff members for taking the blood pressure.” Therefore, this was considered as not fee-for-service.

*** One participant was unsure of the exact costs to the patient involved in providing the service; one participant was not completely sure however was of the mind that there was no charge for obtaining readings off the CPAP machine (however, this does not appear to relate to diagnostic testing).

Remuneration received for provision of DAAs

Although the provision of DAAs to community patients received some 6CPA funding (via the Pharmacy Practice Incentives) to a certain extent, it was also common to have a nominal payment made by the consumer as well. Reimbursement received directly from patients for DAAs varied, ranging from no additional charge to the patient to a per-pack charge of no more than approximately $5 per pack. However, even with the fee charged per pack, this was regarded by participants as insufficient to cover the time and costs associated with providing DAAs which included pharmacists' time as well as consumables.

Aside from mentions of some funding received as part of the 6CPA for DAA provision, a few participants reported that they had patients who were repatriation patients and thus eligible to receive DAAs funded by the Department of Veterans' Affairs (DVA). To ensure that their DAAs were continually funded, a review was conducted by the pharmacist every 6 months to *"assess the need for that continual packing. And you kind of have to sit and chat to them and speak with the doctor, see what's changed, if anything, and then you send that report back to the DVA and then they continue on with the process." (P03)*

Financial reimbursement for aged care/nursing home/disability facilities services

Where some facilities would charge for DAA provision to nursing homes, others would provide additional services such as delivery for free. Therefore, the revenue earned was highly linked to the dispensing/supply of medicines.

> *"For example, to people in aged care facilities, we don't have an ongoing charge for the actual service itself because I guess from a business perspective, it's to remain competitive compared to other pharmacies who may be interested in servicing nursing homes. But also, we probably gain like enough from just the actual cost of medications as well and the amount we get remunerated for that." (P06)*

However, one participant commented on a shift in recent years regarding the level of reimbursement for the service itself, impacting the overall financial viability of ongoing service provision.

"About five years ago, it was given that there would be some sort of a patient charge. In recent times, the new nursing homes that we have taken on board have really struggled with this concept…… We have had to renegotiate the terms with some of them. And some of them involved actually having to move on to no charge at all for any of the packing which is really a shame because it does cost all of our labour costs. And we have a lot of team members who are involved in processing the changes, packing the changes, and we've got pharmacists to check every day. We've got a delivery guy that's on the roads and these costs are really… need to be funded for but we can't really do anything about it. It just kind of comes off the bottom line." (P02)

"You still have to weigh up 'Okay, well, there is this many beds- do we take it or do we leave it?' And I think at the end of the day, if the volume is going to help us keep up with the cost because we're doing more scripts then yeah?..... Probably still makes it feasible. But definitely not by much." (P02)

Alternative sources of funding supporting BG testing and/or diabetes education services

A few participants reported that they were able to provide free BG monitors and/or received some financial reimbursement/incentive of $5–$10 from the manufacturer to download and print reports of BG readings from the patient's machine. This reimbursement was received as part of a deal/arrangement with the manufacturer. In comparison to other sources of funding, this was unique in that it was provided by the manufacturer themselves and consequently, may have been a key facilitator in maintaining the viability of services involving diabetes education and BG monitoring.

One participant reported that the accredited diabetes educator(s) providing the service in the pharmacy received funding via Medicare Benefits Schedule (MBS) payments.

Perceived profitability of user-pay services

User-pay services typically did not attract 6CPA funding. For some services such as flu vaccinations and DAAs that were user-pay or had a user-pay component, the profit margins on some services were quite minimal. When commenting on the level of reimbursement received via fee-for-service from vaccinations, it was deemed to only allow the pharmacy to break even.

> *"Even though there's a payment…… it's a way for us to give back to [the] community because let's face it, that fee that they're paying doesn't… it probably just breaks even at the end of the day." (P20)*

Regarding the fee for flu vaccinations, a few participants noted that they had to decrease the charge for the service in order to remain competitive due to increased competition. For a pharmacist proprietor who funded pharmacists to become accredited, there was a greater burden involved in recovering these costs. Regarding the fees associated with OST, one participant commented that the fee-for-service (about $5/day) was appropriate, reflecting a balance between ensuring appropriate access to the service by patients who needed it, affordability for these patients to help ensure therapeutic needs are met, in addition to factoring in what was involved in delivering the service. There were financial benefits for the pharmacy as *"we get the methadone for free and then we are charging." (P07)*

In the case of wound care services, patients were not charged for the wound care service itself but only the product(s) that were used. One pharmacy in particular would like to charge patients for their wound care services in the future.

> *"If I have to bandage up someone's hand, what do I get to do? I get to sell them the bandage. I didn't get to sell them my time for appropriately bandaging it or, you know, anything like that." (P01)*

Importantly, although there was a desire to see pharmacists reimbursed for services via a user-pay model, it was seen as important to be cognizant that any fees did not act as a barrier to service uptake, for instance for weight management services where patients were also required to purchase meal replacements/VLCD products as part of the program.

3.8 'Free' cognitive pharmaceutical services

Key findings – 'Free' CPS

- User-pay funding models were not deemed appropriate for all CPS, for instance BP checks, as pharmacists perceived there to be a patient expectation for the service(s) to be offered for free.
- Increased competition had also facilitated this expectation of services to be provided at no additional cost to the end user.
- Perceived receptivity among patients for fee-for-service models were mixed. However, there was a degree of willingness to pay among patients.
- Encouraging customer loyalty and maintaining rapport with other service users (e.g. aged care facilities) were motives for providing services for 'free'.

Perceived patient receptivity to fee-for-service

Among participants, there were mixed opinions regarding the perceived receptivity of patients towards fee-for-service models. There was a perceived unwillingness, in some cases, among patients to pay for a service that could be obtained for free from another pharmacy unless there was adequate understanding on the patient's part regarding how the service was implemented.

> *"Thinking about all these services that some pharmacies can do, but probably not to the level that we do it at, and yet you know, they always mention the word 'free'. So the problem is like, if they don't- unless they actually realise how we do it, they [the patients] won't really want to do it if they hear that there's some sort of a cost involved." (P02)*

User-pay funding models were not perceived as appropriate for certain services such as BP checks, where there was a perceived expectation (from consumers) for it to be free.

> *"If people had to pay to do their blood pressure, no one would do it because there's other pharmacies that do it for free. So that's the expectation. That's the consumers' expectation. And now if we were to change that, then that would cause…… quite a bit of backlash." (P20)*

Starting to charge a nominal fee for some services was done on occasion as a stepwise approach in working towards helping to change patients' perceptions regarding free advice/service that has traditionally been made available through pharmacies, which could then in turn help patients place value on these services. Changing the mindset of patients regarding the introduction of a fee-for-service model was perceived to be harder for established services in comparison to new services such as pharmacist-led vaccinations.

> *"We've always charged for [DAAs]. That's something that's been there since I started…… I think we are trying to change the mindset around blood pressure so that it's not just something free. So that's harder because consumers have been getting those for free for a long time. For immunisation, that was really easy because there was a brand new service…… so that was certainly an easier one because you are applying a value to a pharmacist service that people have never had before." (P04)*

However, several pharmacists acknowledged that there was a degree of willingness to pay among patients (which may be more so than in the past) if considering:

- They recognised the value in the service;
- The benefits outweighed the cost, for instance the reduced wait time to receive their vaccination from the pharmacy in comparison to the GP surgery and the associated cost of the pharmacist-administered vaccination;
- The pharmacist's time dedicated to providing the service to them; and/or
- The limited level of reimbursement currently received for pharmacists' time specifically.

One participant also commented that it varied between the services and how they had been implemented. In addition, another participant commented that as patients were aware that pharmacies received some financial incentive for providing DAAs, there was an expectation that they should be free to the patient.

Rationale for providing CPS at no extra/limited cost to the patient/user of the service

Services were provided for 'free' to patients to encourage customer loyalty.

> *"I guess the principle behind providing like free services is that, I guess in a nutshell, you provide these free services and in return, you hope that patients will come back to your pharmacy because of the services – because of the 'great service that you provide'. And that results in more traffic and you know, building a stronger customer base around that." (P06)*

> *"We're unable to sell medications or products at like a discount chemist because we don't have that buying power but…… in order to compensate for that, we provide all these free services." (P06)*

Increased competition has also fuelled a degree of expectation for service(s) to be provided at no additional cost, which has resulted in a shift in who bears the costs associated with providing the service.

> *"We have had to really evolve with the times because of the competition that's around. Just like patients shopping for pharmacies, there are pharmacies shopping or the nursing homes shop for pharmacies as well. There's a lot of 'Oh they don't charge- will you charge?' It's again expected that you do everything for nothing- packing, delivering, all the [DAA] packing material. They all cost a lot of money." (P02)*

A particular example was provided by a participant regarding DAAs, where a fee-for-service was not charged as part of a business decision driven by the status quo despite the costs and time associated with providing the service.

> *"That's a commercial decision based on the state of the industry. Most pharmacies don't charge for it. In a competitive industry, it's sort of dictated by what the industry is doing. As much as we'd love to charge for it, 'cause like I said there is definitely a discrepancy in the income that it generates compared to the cost, I think most pharmacies highly underestimate the amount of cost involved in providing that. I don't think anyone's sat down and actually done the income versus cost of it. You know, people just see…… there's money coming in from it, but they don't realise how much…… staffing, resources, consumables and everything is in the mix." (P21)*

Regarding BP checks, a participant highlighted that they chose not to charge for it as it was an endeavour that warranted fee-free provision to patients, with the desire for recognition of the role of the pharmacist taking precedence. This participant also focused on long-term rather than short-term generation of income.

> *"A lot of people do charge or are trying to charge. I just feel this, you know, trying to…… better in the community … It's something that I'd rather, you know, donate my time to…… I understand why people charge for those services. A lot of times they do need to but just in the circumstances where I'm at, I think it's more important just to get recognition." (P22)*

The appropriateness of charging a patient for a service that the pharmacist deemed was necessary for them was raised, for instance with BP and BG checks which were regarded more so as a gesture of goodwill.

> *"I agree that we should be remunerated for our services, but at the same time if someone comes in and you feel that they really need…… a blood sugar measure or a blood pressure measurement, well one, I would feel awkward saying 'I think you need this' and then charging them…… I don't really see that as a true service…… that's more of a goodwill thing that pharmacies should provide as ongoing monitoring." (P16)*

Services were on occasion provided for free in order to maintain rapport with those receiving the service e.g. aged care facilities.

3.9 Services offered by other health care professionals within the pharmacy setting

Some participants mentioned that there were services which were being provided by other health care professionals (HCPs) working within the community pharmacy itself (Table 7).

Table 7. Summary of services offered by other HCPs within the community pharmacy

HCP (reported by n participants)	Service(s) offered
Naturopath (n=2)	• Naturopath was present in the pharmacy some days of the week to provide related services.
Baby nurse (n=1)	*"She is in our pharmacy on Thursdays for about four hours at a time…… no appointment necessary. It's a free service that we provide. Mums just basically line up and wait for their turn to get their babies weighed, to get their head circumference and their length measured." (P07)*
Nurse (n=2)	**1. Nurse-led foot care service (rural/regional setting) (n=1)** • No podiatrist in the town • The nurse provided some podiatry-related services in the pharmacy (not to the same extent as a podiatrist) • Referral pathway to the pharmacist if the patient was diabetic; the pharmacist would then refer the patient if foot care was poor **2. Wound care and ear piercing provided by nurses (n=1)** • Nurses worked as pharmacy assistants on staff

3.10 Other pharmacy services

Pharmacies also reportedly offered a number of other services, which included:

- Delivery: most had a delivery driver (N.B. one participant (based in a rural/regional setting) stated that the pharmacist did the deliveries themselves);
- Ear piercing;
- National Diabetes Services Scheme (NDSS): provision of BG test strips and needles;
- myDNA testing/screening (mentioned by one participant);
  "That's more…… not a service per se, but it's there for the patient to use. And it tests for basic CYP enzyme deviations to see if medicines are kind of affected." (P08)
- Needle Syringe Program;
- Return Unwanted Medicines bins;
- SMS prescription reminders;
- Equipment hire e.g. crutches, wheelchairs;
- Health books borrowing/library service (uniquely mentioned by one participant);
- Hearing clinic (provided by another party in the pharmacy);
- Beauty-related services; and/or
- Other non-pharmacy services e.g. post office, parcel collection point, money transfer service, signing of statutory declarations.

3.11 Other services delivered offsite and/or on an intermittent basis

In addition to the CPS offered by pharmacies on an ongoing basis, pharmacists also engaged in community outreach initiatives, for instance:

- Presentations to members of the community on a designated health topic i.e. patient education within the community setting (n=3); and/or
  "For example, we go and present at the community centre off the road – like once a year. It's actually been [another pharmacist's name] doing it the last few times. So they often invite us to go and talk to the elderly community for a session – like an hour or two-hour session about a topic of their choice." (P02)
- Health promotion/screening events, checks or periods which involved point-of-care testing/screening outside the pharmacy (e.g. stalls outside the pharmacy, at a local gym, community event, or in the shopping centre) or within the pharmacy, with a specific focus that tended to align with the national health priority area(s) such as cardiovascular health and diabetes.

3.12 Broad impact of cognitive pharmaceutical services

Key findings – Broad impact of CPS

- Perceived benefits of CPS included improved patient accessibility to services and convenience; cost-effective facilitation of QUM; improved patient adherence, satisfaction, and loyalty; and improved patient rapport, health management, patient education and empowerment.
- However, it was noted that it was difficult to determine the true impact of CPS.

On a broader level, participants' perceived that services offered in community pharmacies had the following benefits:

- Improved accessibility to services and convenience for patients;

  (also emphasised by pharmacists working in rural/regional settings)
- Community pharmacy as a triage system;

  "The major difference on health is timely access to it. We can't always help someone, but we can triage them and that is the main difference. It's why effort should be put into community pharmacy because not everyone that has a cut or a sore or some head lice or a headache needs to end up in ED…… We are at least a triage system. So the difference that our pharmacy makes is we can make some judgment calls on how unwell someone is and whether they want to spend their time waiting six hours to see a doctor or whether they should drive to another town." (P01)
- Cost-effective facilitation of QUM for patients;

  "We 100%, through the quality use of medicines, like minor ailments, triage and all the rest of it, are improving the health of the people in our community because they can't access it in a timely fashion anywhere else and for it cheaply, really." (P01)
- Improved patient adherence to medicines;

- Improved patient loyalty and satisfaction;

  "Once they recognise that you're a pharmacy that provides these services and…… they find [these services] useful, then they will keep coming back…… In their mind, it establishes the point that our pharmacy is a place where they can come to get advice and to access these services rather than a standard retail shop…… Ultimately at every pharmacy, you can buy medications from. That's the common factor. But the variable is…… some pharmacies may provide a lot of services whereas other pharmacies may not provide any service. For many patients, that's the distinguishing factor for where they choose to go." (P06)

  "In terms of their satisfaction, like I found out there's two types of satisfaction. There's the first type of satisfaction where patients are directly appreciative of the fact that you've spent time with them to chat with them…… offer these services for free…… That strengthens their loyalty to the pharmacy.
  And then the second type of satisfaction is when they come back to you and say 'Hey, look this really helped. I want to do it more.' or ……'Thank you for the advice you gave me the other day.'" (P06)
- Improved rapport with patients and patient health management through counselling and intervention(s); and/or
- Improved patient education and empowerment.

However, several pharmacists noted that the impact of services *"on health is hard to measure" (P05)*, or that it was difficult to ascertain the true impact of CPS that were being offered in the pharmacy.

> *"I don't know. I think it's hard to really say, given the services that we provide. I think if we provided more disease state management services then I could probably answer the question a bit more easily because then you would see a progression, I guess, in someone's weight management or cholesterol management or blood pressure management. But because we just sort of do blood pressure monitoring and it's just like a snapshot of what their health is like at that time, I don't know. I don't feel like I can answer that question very well." (P07)*

> *"Whether they will be loyal or not, it's hard to say. Because nowadays, if we sell [products that are] too expensive, then they go somewhere else unless they appreciate our counselling." (P11)*

> *"It'd be very nice to measure that. I wouldn't know, I guess. I don't know how…… like, I've got a lot of individual success stories. I have a lot of shared stories that I can tell about patients who [have] kind of been helped…… mostly sort of anecdotal evidence, nothing that can be…… if there's a nice study that showed the impact of patient outcomes on these things, that would be fantastic." (P13)*

One participant mentioned that the transactional nature of some interactions with patients, i.e. a lack of receptivity on the patients' part for discussions with the pharmacist, contributed to missed opportunities to help patients. Although the long term impact of services was seen as difficult to accurately ascertain, a participant elaborated and stated that there may be cumulative benefits accrued from smaller interventions conducted with the same patient over time.

> *"What impact does that have long term? I mean, I can't. I don't know. It's, you know, it's too big a question for me to answer, I guess. But you make…… small interventions here and there that kind of build up with time. So if you've seen a patient for a long time, then you might have done [a] HMR on them and then you've [done] a few clinical intervention[s], you've offered them [the] DAA service. Sometime down the line, you've also had a MedsCheck done on them. I guess that all helps in terms of keeping that patient well but how do you materialise that benefit? I'm not sure." (P13)*

3.13 Broad economic impact of cognitive pharmaceutical services

Key findings – Broad economic impact of CPS

- Reimbursement received by pharmacists for the provision of CPS was regarded as insufficient.
- CPS provision contributed to the need for increased wage costs for the pharmacy e.g. to employ another pharmacist, which were then offset via earnings from other aspects of the pharmacy such as the dispensing of prescriptions and/or sale of consumables.
- Perceived viability of community pharmacy has been impacted by PBS reforms.
- Services were not regarded as a primary source of stand-alone income for pharmacies but rather, had flow-on effects for other aspects of the business which contributed to profitability.
- CPS were seen to have a broader cost-saving impact on the health care system e.g. via screening.

The economic impact of CPS was multifactorial. Participants stated that the reimbursement for pharmacists' time associated with CPS provision at present was insufficient, where increased time was required to provide CPS.

> *"You lose money on the things that take time – so in your wages…… We are not paid for complexity. We are paid for the same amount of money for that statin script that was just – you know, your 50 year old person with no other problem and the same amount of money for that person who got a high creatine kinase." (P01)*

> *"You spend more time with them compared to maybe some other pharmacies but you're not actually being rewarded for that time in any way." (P02)*

Furthermore, the additional wage costs, for instance to have another pharmacist working in order to enable certain CPS to be provided, was a further consideration. There was a necessity for the revenue earned from the dispensing of prescription medicines and sale of other consumables within the pharmacy to subsidise the provision of CPS and offset any additional costs/losses, for instance wage costs, which would be associated with providing CPS.

> *"Even with PBS price reductions, it's the only guaranteed income we have." (P01)*

> *"We can't subsidise doing something for free if we don't churn [out] script[s]…… If we don't have, you know, vitamins. If I can't make gross profit dollars on some of the other things, I cannot provide my proper pharmacist services." (P01)*
>
> *"If we make a loss… on the [DAA] pack, then we get profits back from somewhere else, something else like over-the-counter [products] or a gift, because we sell gifts as well." (P11)*

Decreased funding available to pharmacies through initiatives like PBS price reforms have had an impact on the perceived viability of the community pharmacy sector, with complexities inherent in ensuring community pharmacies remain profitable enough to continue to provide services.

> *"If you're going to eat up that space….. Those funds, then there's no point in paying them because not many people are going to uptake those professional services if they cannot afford to maintain them or can't afford the cost involved…… They involve time, they involve people, they involve employing, you know, assistants and other pharmacists…… If that pharmacy is not profitable enough, then it's not going to be able to carry on that responsibility. So, that's my big picture…… It's an exciting time to be in pharmacy as well but…… the picture is getting darker…… I'm not sure what the solution is." (P13)*

Due to the limited available funding for CPS, individual services were not seen as a primary means to generate profit for the pharmacy in silo to other aspects of the business. Rather, increased uptake of CPS was seen as potentially having positive flow-on effects for the business profitability as a whole. Pharmacists and/or pharmacist proprietors perceived CPS as a means to increase foot traffic, encourage customer loyalty, and/or provide added value for existing regular customers, which could then lead to economic returns for the pharmacy.

> *"Well usually, the people who are coming in to get their blood pressure checked and all those sort of thing[s] are already on loads of medications and they're regular customers. So they come in and they buy stuff and they have their loyalty card…… they're a loyal customer so it's a kind of a bonus for them. You wouldn't have that many drop-ins who would be looking for that…… So it's not like you're not getting money out of them. You are making enough profit from them anyway." (P19)*

> *"You know the reason why doctors…… do services and make money out of services is because they're funded by the MBS. And you know, that's just not there for pharmacists. So once again, it becomes a thing to get people in the door to improve the core business, or what's seen to be core business, because that's what's generating the bulk of the income for pharmacists. So they'll do everything to get people in the door to keep growing that side of things. But until the funding model changes, pharmacy services will not change the uptake of them, the perception of the public of them- a number of things, I guess." (P21)*

From a health system perspective, the provision of CPS that involved screening for instance was seen to have a positive economic impact on the health care system overall.

> *"Screening is one of the ways. Let's say, talk about health systems. It's one of the ways that saves the government money…… It's better to prevent than treat. So in terms of…… trying to prolong the PBS, trying to prolong the Medicare system, I think it's very undervalued and…… it's underutilised." (P22)*

It was perceived that the savings attributable to pharmacists, for instance via PBS price reforms, should be given back in some way to pharmacists themselves.

3.14 Perceptions of changes in the practice of the profession

Key findings – Perceived changes in the practice of the profession

- Pharmacists have seen and experienced an evident expansion of services being provided in community pharmacies. A certain level of service provision has become the status quo across the sector.
- An increased scope of practice for pharmacists has led to perceived opportunities for further role expansion in future. However, quality of services may not be uniform across all community pharmacies.
- Pharmacists' roles and responsibilities have changed, where there were now increased opportunities for clinical involvement and inter-professional collaboration in the provision of patient health care.
- Reforms such as accelerated price disclosure and emergence of discount pharmacy models of pharmacy have impacted the sector, and created an impetus for the industry to evolve.
- Sole reliance on pharmacy as a supply function was no longer viable. Decreased revenue generated from dispensing prescriptions had led to increased service provision, used as a point of difference.
- Perceived positive changes to the profession included the impact of increased competition leading to innovation and increased CPS remuneration via the 6CPA.
- Perceived negative changes to the profession included the price-focused paradigm shift impacting the fee-for-service sought, decreased viability of community pharmacy, and the devaluing of pharmacy due to discount pharmacies and price reductions.

Expanded scope of practice and service provision

Participants perceived there to have been a number of changes in the practice of the profession in the course of their own careers. Participants acknowledged the clear move towards service provision, where expansion of services had become prominent among their individual practices. This expansion of services contributed to the status quo, as mentioned previously, where certain services that a few years ago would have been regarded as novel were now part of normal practice. The increasing scope of practice for pharmacists has increased pharmacists' perceived potential capabilities and also signalled that the future of the profession held potential for further expansion and change.

> *"I haven't done it myself yet but I'm now capable of delivering immunisation which 8 years ago, I couldn't. I should be capable of delivering some mental health first aid which I couldn't do eight years ago. I'm excited about the fact that maybe I could be a pharmacist in a GP surgery one day." (P01)*

> *"Definitely more services. All these services are new. Like in the last 5 years, they've all crept up, probably earlier than that but that's sort of what I've noticed…… It's become very important…… to both be knowledgeable about or at least aware of that in our training as well. Because it's a point of difference. It's here to stay…… there seems to be a push to add more value to what a pharmacist's role is." (P24)*

It was remarked that *"the ethos behind what we do is the same but it has evolved in that time. So we've got better at what we do. We've got better at service delivery and we've got better at identifying and meeting the needs of the consumers" (P04).* In addition, although there were changes in the documentation processes to enable appropriate claiming for available remuneration from the government, pharmacy practice was still patient-centred.

> *"It's become a lot more important in the last few years where we really have to strive to get the payments from the government for the service that I think we would otherwise have provided anyway. But now it's a matter of making sure it's documented so that we can get paid for it. But I think in terms of doing the proper counselling, it's never changed. We do the same. We have given the patient the same amount of our time and the service, the level of service and quality of service hasn't changed. But we try and keep that, the pocket of the community who are able to identify and appreciate that we are a service-oriented pharmacy, not a discount pharmacy." (P02)*

In contrast, due to the perceived short length of time in practice (7 years), one pharmacist in particular noted that they had not observed many changes in the practice of the profession, which was likely due to a lack of staff which meant that emergent services could not be implemented in their particular pharmacy setting.

It was also acknowledged that there may be differences in the quality and types of services offered between pharmacies.

> *"I think a lot more people now are preaching services. They're talking about it [more] than they used to be. I think a lot of pharmacies still might not have the same general concept of what's a service, [and] what isn't, type of thing. So I think you know a lot of pharmacies might just be focusing on things like blood pressure and blood sugar where I think there's so much more that a pharmacy can be involved in." (P16)*

Shift in pharmacists' roles and/or responsibilities

One participant who had 47 years of practice as a pharmacist noted a significant change in available technologies, medicines, as well as medical conditions affecting the population, which had an impact on pharmacists' practice and the health care of patients.

> *"We didn't take people's blood pressure…… Well you didn't have diabetes machines as far as I remember…… You didn't have Type 2 diabetes back then as much [as] you have it now. Yeah we were a healthier lot, I think, after the war. So there was none of those extra services. There was no medication reviews." (P17)*

In recent years, there was seen to be an *"increased acknowledgement of the role of pharmacists as part of the health care team in this time" (P04).* There were increased opportunities for the clinical involvement of pharmacists and inter-professional collaboration in patient care.

> *"Being able to do HMRs and MedsChecks…… being able to write down and write… to a doctor and say 'Oh you know, have you checked on their serum chemistry for something?'…… Being involved in their patient care is the biggest change, I think." (P12)*

> *"The rolling out of HMRs and MedsChecks in the last five years have been huge. Like I think it just kind of cements…… our strengths and our skills as pharmacists that we can provide these services." (P18)*

Moreover, a shift of certain responsibilities and tasks previously performed by pharmacists as part of their role had been passed on to trained technicians and other pharmacy staff if possible, which has helped enable pharmacists to focus on service provision. Consequently, in the process, this then resulted in the up-skilling of other pharmacy staff members.

Industry reforms as a stimulus for changes within the profession

Reforms impacting the community pharmacy sector, such as accelerated price disclosure as part of Pharmaceutical Benefits Scheme (PBS) reforms, and the clear emergence of a spectrum of pharmacy models that ranged from discount pharmacies to service-oriented pharmacies had become more prominent.

> *"One thing that comes to mind straight away is this very prominent emergence of different models of pharmacy. I mean there was always different models of pharmacy. But now I think it's quite clear…… I see it as a spectrum…… during my time as a pharmacy student and as a pharmacist, I've seen that distinction become more clear-cut." (P06)*

> *"The big elephant in the room is, you know, the rise of warehouse-style pharmacies which has changed the perception of pharmacy for consumers. They think it's now very retail-focused. And so as a clinical pharmacist then, it's up to us to differentiate ourselves. So that's been a big change as well." (P18)*

These changes have acted as an impetus for the industry to evolve, where the viability of pharmacy cannot continue to be solely reliant on the supply/dispensing of medicines.

> *"You just can't rely on it being a supply function anymore, I think is the biggest thing. To me, pharmacy has always been about the patient but it was very easy to make money just by doing scripts. And you have to think outside of that now to make it a viable thing…… You have to do a lot of prescriptions to make up for what you've lost…… if you are just doing prescriptions like that just to make ends meet, you don't have time to focus on the patients. So I don't think it is good." (P23)*

Decreased remuneration from the dispensing of prescription medicines has prompted an increase in service provision, where more services were being provided and services were utilised as a means to achieve a point of difference.

> *"Back in those days, look I don't think we did, besides like ear piercing or blood pressure checks, blood glucose checks and stuff like, sleep apnoea and the immunisation programs. [DAAs] really picked up as well and MedsChecks, Diabetes MedsChecks. We weren't able to do that before." (P05)*

Pharmacists and patients have become more price-conscious and from a practice perspective, this was perceived to contribute to *"a paradigm shift towards, at times, more of…… a price war sort of thing with medications and that hampered our ability to concentrate on services as much" (P14)*. The response to the changing climate of pharmacy stimulated both proactive and less proactive responses. However, there were mixed perceptions of the nature of the effect of increasing pressures as a result of these changes.

Positive changes to the practice of the profession

On the other hand, several pharmacists felt that these economic pressures have acted as a stimulus for positive evolution within the industry. Increased competition was viewed as a means to breed excellence and resulted in the need for the active creation of opportunities.

> *"A lot of people are seeing that change occur and might see it as a negative. But for those who are passionate about the industry and about the field, we see it as positive. Or at least I do. And it's a positive because it brings the best out of an industry. It's the hard times and the difficulties that actually bring the best out of a particular profession and I think that's what this kind of particular climate of price disclosures and all that has actually brought to pharmacy. It's brought a better pharmacy industry. One that is more patient-focused and one that supports collaboration and I think that's an awesome industry to be a part of……. It's very difficult for a lot of pharmacists to see that, particularly those who have been in the profession for longer than a few years." (P08)*

Formalisation of services through 6CPA initiatives requiring formal documentation of what a pharmacist would do as part of the scope of their practice has now allowed for further reimbursements for certain CPS. However, despite this, the documentation required was also seen to act as a barrier to service provision and/or quality service provision, for instance misuse of the system which may have contributed to the introduction of a cap on MedsChecks.

Negative changes to the practice of the profession

The increased competition was seen to have a negative impact on the practice of the profession, for instance due to price-focused measures, the inability to charge higher amounts on services due to potential resistance from patients/consumers and/or status quo, and the viability of the pharmacy itself. Where some pharmacies have focused on expanding their services, smaller pharmacies where there may be fewer resources and staff to facilitate implementation of new services may have felt that their viability has been compromised. Participants mentioned that certain pharmacies were struggling to remain viable.

> *"At the moment, with the price reduction of the government, yeah that affects us a lot. And if this continue to be like that, then we don't have much profit and with the competition…… I don't think that we will……. be viable. I don't know. I just go with the flow and hope that we get more support from the government." (P11)*

The emergence of discount pharmacies and price reductions was also viewed as a contributor towards the devaluing of pharmacy.

3.15 Perception of the work value of community pharmacists/pharmacy

Key findings – Perception of the work value of community pharmacists/pharmacy

- Core work value of community pharmacists centred on accessibility of health care and advice, and the resultant broader impact on the community.
- Pharmacists were perceived to be undervalued by others, influenced by discount pharmacies.
- It was perceived that governments should better recognise the value of, and appropriately remunerate, pharmacists.

Accessibility of advice and health care provision by pharmacists was seen as a core asset embedded in the work value of community pharmacists.

> *"Perhaps we are the only profession where you can go in and just get advice for free, and by so many people, offering blood pressure monitoring or even blood glucose." (P02)*

> *"You're still standing there as an open professional provider. So open to the community, open to people to come and ask you for advice." (P02)*

Work value lay not only in the context of economic outcomes of CPS but the broader impact on the community as a result of the provision of health care.

> *"It's hard to put a dollar value on the hours you spend. But I think, at the end, it's worth it. Just to make sure the community is healthy and getting the best care." (P22)*

> *"If you're looking at the short term, you're probably making a loss; a lot of effort on your behalf. But I think long-term gain is worth it. Also, knowing that, you know, you're changing someone's…… health outcomes. Changing… or preventing them from, you know, chronic diseases. I think that's where…… the real worth is." (P22)*

Work 'undervalue' of a community pharmacist was also alluded to. The perceived value of community pharmacy from the perspectives of others outside of pharmacy was also reported to be negatively impacted by the discount model of pharmacy where the focus was on reduced prices.

> *"I still think a lot of people just don't know what we provide, as customers. They just don't know what's a HMR, what's a MedsCheck. They have no idea. But I think…… it's got its role to play– as in the impact on the patient is there." (P18)*

> *"The way that they [discount pharmacy] keep slashing the prices down together with the government…… it makes pharmacy look like they're worth nothing. And it really doesn't account for the amount of time and the cost that's involved in us looking after the patient all the time and giving them service." (P02)*

Another participant felt that efforts of community pharmacists were not as valued by patients, and similarly, there was disconnect between the perceived work value of a pharmacist that was conceptualised during the undergraduate degree in comparison to actual accountabilities and experience.

> *"Just not worth it…… what you imagine during your uni time, your dream is quite different to your actual daily work. It's just never-ending dispensing and never-ending abuse from the customer, yeah. Occasionally, you have the satisfaction from work…… honestly, not everyone appreciate[s] the help from the pharmacist. And yeah, you lose your patience, ah passion after a long time." (P10)*

However, a participant also acknowledged that pharmacists were also responsible for this undervaluing of the profession. Pharmacies potentially overworking their staff due to a supply-oriented workflow, which in turn leads to reduced time spent with the patient, was an example of issues related to the work environment where *"as a result, patients no longer see the pharmacist as someone that they can go to for advice. They just see the pharmacist as someone who hangs back in the dispensary and gets their medication out. So definitely part of it – it's to blame on us." (P06)*

The need for the government to recognise the value of pharmacists and to remunerate accordingly was also noted.

> *"You [pharmacists] are really well trained, you are experts in medicines, you know stuff about minor ailments, [and] you're good at triaging people. You're great communicators. You come from different background[s], you can speak different languages to the citizens of Australia and you have the biggest access, or the most number of hours open. People will walk in– they don't need an appointment. We [the government] should be chucking all money possible to keep people in their homes for longer and the pharmacist is the answer." (P01)*

Of particular interest was one participant's description of an initial 'undervaluing' of their own work value as a pharmacist, which was then highlighted by their employer during wage negotiations.

> *"I went in there with a figure that was above award and they came back to me and said 'You're undervaluing yourself.' So that was my 101 in negotiation. I learnt on the job because I was told by my employer that I undervalued the rate that I proposed I would work for. And that's where I really value my employers…… they were quite open with me and they said 'We think you're worth more than that. This is what we'd like to pay you.'…… That was quite a big learning experience there in terms of placing value on yourself." (P04)*

It was noted that CPS provision had to be valued by proprietors in order to facilitate adequate support for their provision; unwillingness of employers to provide support via additional staff posed difficulties for a pharmacist expected to perform the same duties with less support.

> *"You can try to do it on your own in a clinical setting but I've only ever seen it work for ones where I have the support of another pharmacist doing all the other day-to-day things…… to enable us to have the chance to speak to people in a reasonable setting. So I think it's always a good thing. It comes down to time, money and unfortunately, that…… falls on the owners to see the value in it." (P24)*

Upon reflection, a participant who was a proprietor noted that involvement in the *"business side of pharmacy" (P21)* had resulted in a difference between the perceived contribution of their practice as a HCP compared with what their current role entailed to ensure business viability in a competitive industry.

"It can be quite difficult to ensure that a pharmacy is viable just by operating. In a manner, you start getting thrown and side-tracked on focusing on things that you probably didn't see yourself doing when you started off in pharmacy. It…… is a very difficult industry. It's an industry where unfortunately, it's been impacted by numerous government saving measures…… It's really made a lot of pharmacists work really hard for not a great deal of remuneration. And you know, pharmacists are desperate to make a profit in their business.

A lot of them have invested a lot financially, you know mentally, socially in their business and they need to ensure that there is some sort of return on that so they are, you know, steering into more non-evidence-based… means. You know, focusing on selling vitamins and anything that seems to be the popular thing at the time just to ensure that their business viability is maintained.

So I guess it is a lot different from what I thought I'd be doing. I guess to become a pharmacist, you feel like you're gonna…… really be…… doing professional services and you know, having a great impact on their medications. And you do get that opportunity sometimes; definitely not as much as what we'd like to or what we should be doing." (P21)

3.16 Motivation for providing cognitive pharmaceutical services

Key findings – motivation for CPS provision

- Continued engagement in providing CPS by pharmacists was primarily motivated by patient satisfaction, professional satisfaction, view of the optimal direction towards which pharmacy should be heading, altruism, wanting to provide a service to the community to promote health, and duty of care.
- A positive outlook on pharmacy stimulated support for increased scope of practice as well as ongoing provision of CPS.
- Service-oriented ethos of the community pharmacy or positive professional experiences involving senior members of the profession contributed to the service-oriented practice of several participants.
- External factors such as decreased profit margins for dispensing medicines and that other pharmacies were also offering services were also motivators for CPS provision.

Key motivators for continued engagement in providing CPS were patient satisfaction, professional satisfaction, view of the optimal direction in which pharmacy should be heading, altruism, wanting to provide a service to the community to promote health, and duty of care.

> *"So there is no incentive. So when we look back at the lack of consistency across the pharmacy network, where you've got, you know, your discounters doing one thing, you've got people trying to do services, there is no incentive other than pure altruism and maybe our practice standards and our ethics that makes them want to do anything better when we are purely talking about remuneration… as a link to job satisfaction." (P01)*

> *"We didn't go to uni for four years and then [do] the intern year so that we could stand behind a counter and not interact with the patient. So we are up-skilled in how to communicate, you would hope. We are up-skilled in problem solving, in triaging. So we should be using those skills to make a difference in our patients' or clients' lives…… It's just a different time." (P01)*

Several pharmacists did have a positive outlook on the profession, which stimulated the ongoing provision of services and support for the expanded scope of practice.

> *"I think because there is a consumer demand and a consumer need for the service. We know that there is a need to free up GPs, certainly, so that they can deliver health care above the scope of a blood pressure check. But it's something that can certainly be delivered in community pharmacy and is well within the scope of pharmacists' practice. So currently, I don't think we are operating to our maximum scope of practice. I think we're operating on the peripheries of, but we have a whole lot more that we can do. And I think immunisation is a really great starting point from telling the government that we can deliver preventative health care and public health initiatives on behalf of the government where…… we are not charging them a Medicare provider's fee or an MBS item. This is a consumer-paid initiative.*
> *So I think you can sell your value in savings back to the government as long as pharmacists are appropriately remunerated in the process…… I think people are slowly starting to realise that they can access that– through pharmacy." (P04)*

The influence of the service-oriented ethos of the pharmacy where participants had previously worked, or positive professional experiences with more senior pharmacists, inspired several participants who have since remained service-oriented. Increasing service provision was a means to engage with patients but also a means to retain their customer base as other pharmacies were also offering services. External factors have also resulted in a drive to provide CPS, with one prominent factor being the reduced profit margins from the dispensing of medicines.

3.17 Perceptions of level of wage/remuneration in pharmacy for cognitive pharmaceutical service provision

Key findings – Perceptions of level of wage/remuneration for CPS provision

- Pharmacists recognised that there was limited profit earned for many CPS, where pharmacy proprietors noted that many services were being operated at a 'loss' to the pharmacy, financially.
- As pharmacist roles were perceived as having expanded, there was support for recognition of this expansion both professionally and financially.
- The government was seen as an important stakeholder in facilitating the increased remuneration of pharmacists.
- In general, employee pharmacists did not receive additional reimbursements for delivering services within the community pharmacy on top of their wages.
- Some pharmacists felt that their wage received as an employee pharmacist was inadequate and did not reflect their knowledge, skills and contribution to health care.
- A multitude of factors were acknowledged as impacting on pharmacist wage levels. Several pharmacists reported negotiating their wage level, and believed that the onus was on the pharmacist to demonstrate their value to their employer and to negotiate their wage accordingly.

Remuneration at a pharmacy level

Both employee pharmacists and pharmacist proprietors recognised that there was limited profit earned on the many services being offered by pharmacists. Pharmacist proprietors mentioned that many services were operated at a 'loss' to the pharmacy from a financial perspective. The following participant comprehensively encapsulated the concept of services as a 'loss leader'.

> *"I think the remuneration definitely needs to change. Because everyone's using services; those that are even remotely interested to go down that pathway are still using it as a 'loss leader' so to speak to bring in customers so that they will bring in their prescriptions and buy front-of-shop items. It's still the same concept; you aren't actually doing the service because that's, you know, doing anything for the business itself. Yes, it definitely does make your day-to-day enjoyment out of, you know, the profession a lot higher…… I know for myself that when I spend most of the day doing*

things like that, there's a bit more….. satisfaction in the profession. You feel like you're being a bit more useful in what you're doing. You're using your knowledge a bit better and having an impact on the patient.

However though, the problem that we have and, that I can say as a pharmacy owner, is that at the end of the day and at the end of the month, you need to make sure that you've got enough to be paying your staff…… keeping everything, you know, running financially sound. And if your model is just purely on service, unfortunately, the way we are remunerated does not allow for you to run a very highly service-driven model unless it's a bit of an extra component to your business and you've already got a very strong prescription base and front-of-shop. So I think that's the biggest problem– those pharmacies that are already very busy say that they don't have the time for services. And those pharmacies that are trying to grow need the dollars and cents to be happening and it's not coming from services." (P21)

A pharmacist proprietor noted that there were increased wage costs associated with servicing aged care/nursing home facilities; however, this was offset by security in having contracts with nursing homes in addition to the script volumes. Therefore, a trade-off existed between security and increased wage costs and thus, had an impact on the remuneration received by the pharmacy as a whole.

Remuneration at a pharmacist level

Mixed perceptions existed on the level of remuneration received for pharmacist roles in community pharmacy. As pharmacist roles were seen to have expanded, there was support for recognition of this expansion to be given both professionally and financially.

"I feel the role has definitely expanded. I feel pharmacists today compared to five, ten years ago are doing arguably more work and are working longer hours and spending a lot more time in private study than ever before to provide services that we may not have provided before or that are more efficient now and more comprehensive…… I have no argument for…… being recognised for that both professionally and as far as… pay as well." (P24)

Who should be responsible for facilitating the increased remuneration to pharmacists was questioned by participants, where the government was seen as a key stakeholder in supporting this process.

> *"Nobody denies or doubts, from pharmacists to pharmacy owners to academics, that a pharmacist should be paid more. The question is who should wear that payment? A pharmacy owner is also a pharmacist. So they're also a business person. Should they have to… cough up more? I don't think so. I actually think the government; the only answer I can think of is either user-pay, which we know the sickest and most vulnerable in our population are not the ones that can access the user-pay [services]." (P01)*

In general, participants mentioned that they did not receive any reimbursement additional to their wage for the delivery of services (or there was no explicit mention of personal financial incentives received) within the community pharmacy setting.

> *"We know that the government will reimburse or it will bring more profit to the company, or it will bring more customer[s] in or it will keep your customer[s] loyal, regular, but we just do it. We don't get anything from it. Yeah. So if you ask for a pay raise: 'I'm sorry, the PBS reform is really hard.' If you ask for more [staff]: 'Sorry, I don't have the budget.'" (P10)*

Some participants stated that what they have been paid as an employee pharmacist was inadequate and did not recognise their knowledge, skills and contribution to health care. This dissatisfaction with the present wage level could serve as a disincentive (from a wage perspective) to be a better pharmacist.

> *"Look, the income is quite rubbish…… When I came out as a pharmacist, I was earning more per hour than I am now 15 years later. As a community pharmacist, I think with my experience, I'm delivering more. I'm offering more help and more experience to the patient…… I'm getting paid a good $7 - $8 less than what I was getting paid when I first came out 15 years ago as a pharmacist, where I had zero experience or one year of experience. And that is a bit disillusioning because sometimes you do start to think that 'Okay, I'm going to be working for six, seven hours. Is it worth my time?', you*

know, because I'm still gonna get paid that much. So do I need to go out of my way to do X, Y and Z or can I just do the bare minimum because I'm not going to get paid any more?" (P03)

Conversely, another participant raised the notion that the incentive for undertaking additional training should be to add value to one's own skills set which would then in turn increase bargaining power when it came to wage levels.

"No one likes talking about money. It's something that people don't enjoy, particularly when, you know, you don't have a lot to bargain with. But if you're prepared to up-skill, you commit to additional training, you add value to what you can offer a business… So if we're talking about a community pharmacy setting, then I think there is a lot of opportunity for early career pharmacists, any pharmacist really, to invest in themselves or seek investments of others to then grow their skillset to have a higher negotiating power." (P04)

There was acknowledgement of the multitude of factors that impacted on pharmacist reimbursement via wages in pharmacy, where *"it's just controlled by so many different factors and the person who is in the least control of it is the pharmacist who is working for someone" (P03).* However, in contrast, others negotiated their hourly rates with their employer to tailor for their circumstances or perceived expertise and value that they could offer to the business.

"The business have invested in my training. And they have provided me with the skills to deliver in their business. But there is a big 'but' there: that also adds to my value to their business. So even though they have invested in me, I think that's reasonable for an employer to invest in their staff. So I have in turn negotiated a high, in comparison to award, hourly rate and also a different rate for weekends when I'll be working with less staff but expected to deliver the same high professional service level." (P04)

"Yeah financially speaking, because of my negotiation skills, financially I'm happy. I'm not getting minimum award wages like other pharmacists that I know of…… But I do feel for the pharmacists who are on the minimum award wages to do all these extra services and plus dispensing as well. So they [are] basically required to dispense and do the extra services for minimum wages." (P09)

A few participants reflected that the onus lay with the pharmacists themselves to demonstrate their value and subsequently negotiate their wage with their employer.

> *"Do I expect to get paid more as an employee pharmacist? Not really… because the entire profession is struggling…… I probably was making more money as a proprietor…… But I also worked a hell of a lot more as a proprietor compared to an employee pharmacist. So, back to your question, do I believe now that I should get paid more? No. Do I believe that over the next 6 to 12 months that after I've proven that my MedsChecks are doing what they are supposed to do, do I expect my proprietor to look into it? Then, yes. But you gotta provide value. You gotta add value first before you ask for remuneration." (P25)*

When participants reflected on wages versus job accountabilities and stress, the level of remuneration was perceived by pharmacists from both a pharmacy perspective and on occasion, from an individual perspective, as a factor for consideration. One participant in particular utilised an analogy to emphasise the self-perpetuating cycle regarding workload, lack of reimbursement, and the impact on service provision to patients.

> *"It sort of like a self-perpetuating cycle. So for example, we can look at Pharmacist A who is overworked – who is trying to give, you know, the best care to their patients…… Say for example, as a result of, you know, external factors such as price disclosure…… I guess the amount of remuneration that the pharmacy business gets is lower now. Therefore, the pharmacy can't hire as many pharmacists or the pharmacists get paid less and then that adds to the stress as the pharmacist, you know. Because there is less staff, the pharmacist is given more work to do, has less time to say, for example, provide these free services and that in itself affects I guess the investment into providing services. And then as a result of that, it comes back around. And, for example for a service-based model, customers will flock to discount models and that again decreases the profits and the remuneration of that pharmacy where Pharmacist A is practising and then it just sort of continues on." (P06)*

A participant proposed financial incentivisation for pharmacists to provide services as a means to encourage CPS delivery, for instance via a bonus to be given to the pharmacist delivering the service. At present, in general, pharmacists received the same wages despite increased work expectations.

4. Discussion

Participating pharmacists reported that their pharmacies were currently offering a wide range of CPS, consisting of both 6CPA and non-6CPA funded services. Broadly, the key CPS offered on an ongoing basis can be categorised as those aimed at medication management and review, point-of-care testing/screening/monitoring, chronic disease management and/or diagnosis, and vaccinations. Training completed by pharmacists to support CPS provision ranged from self-directed learning to completion of formal accreditation. Key perceived impacts of community pharmacy and the CPS being provided included facilitating access to primary health care, monitoring due to regular point of contact, and the potential to contribute towards coordinated care. Economic outcomes of CPS at a system level were seen as positive by pharmacists, due to the savings for the overall health care system. However, at a pharmacy level, remuneration received for CPS ranged from no revenue, to 6CPA funding, to user-paid services, where pharmacists typically did not receive supplementary financial remuneration in addition to their wages in order to provide services as part of their role. At an individual pharmacist level, mixed opinions were raised with regards to wages and the level of remuneration seen as appropriate.

Profile of CPS being provided within community pharmacy settings

CPS reported to be offered by the participating pharmacists or in their pharmacies included 6CPA CPS and other non-6CPA CPS, which comprised user-pay services such as flu vaccinations or services provided for free (e.g. BP/CVD checks). The broad profile of CPS identified in the present study overlaps with the CPS identified as part of the UTS Barometer in recent years[7, 11] the Pharmacy Services Expectations Report,[19] and previous research.[12] It comes as no surprise that 6CPA-funded services formed the crux of the CPS profile offered by pharmacies, which is likely attributed to the available government funding that supports the ongoing provision of these services. When examining the literature, the reported provision of DAAs by 94% of pharmacies[19] was comparable to the rate of DAA provision by pharmacies in the present study. Similarly, BP/CVD risk checks and home delivery were among the more prevalent non-6CPA funded services being offered in the present study, comparable to previous research.[19] McNamara et al.[20] detailed similar ubiquitous provision

of BP checks with or without comprehensive utilisation of CV screening tools. This is likely due to the broader appeal of implementing such services, as they may be seen as easier to implement, more appropriate for the primary care role of the pharmacist, and supportive of the role of general practitioners. Collectively, the identified range of CPS is a positive indicator that the data from this qualitative study has captured the diversity of CPS being offered in Australian community pharmacies and demonstrates the validity of the sample and participants recruited into the study. Moreover, when examining the services provided within community pharmacies from an international perspective, a recently published report by the International Pharmaceutical Federation, entitled "Pharmacy: a global overview – workforce, medicines distribution, practice, regulation and remuneration 2015-2017",[21] found that medication reviews, chronic disease management CPS, as well as point-of-care testing were available in at least 47% of countries that responded to the survey. This indicates that the profile of CPS offered by pharmacists in Australian community pharmacy settings also share some similarities with CPS offered in other countries.

There was increased diversity seen in the non-6CPA funded services offered by pharmacies in comparison to the core 6CPA-funded services. Interestingly, non-6CPA funded services such as weight management and smoking cessation services were only reported by a small proportion of participants. Considering that most pharmacies commonly stock products such as nicotine replacement therapy options and VLCD products/meal replacements, this was lower than the expected rate of CPS provision for these types of services. One explanation may be that some CPS may be regarded by some pharmacists as 'routine practice' or an extension of dispensing-related activities rather than formalised CPS and thus not flagged for discussion. In particular, this may be more applicable among service-oriented pharmacists working in pharmacies that provide advanced CPS. For instance, with regards to 6CPA-funded services, this may also explain why there was a lower proportion of participants in the present study who reported that their pharmacy offered staged supply in comparison to the findings from a previous survey.[19] This again emphasises that services may have become normalised in the provision of health care within the community pharmacy setting and have altered baseline pharmacy practice. Pharmaceutical care in this regard is well within the scope of what pharmacists can offer, whether as a defined service or as part of 'routine practice'.

From the findings of this study, it is evident that there has been a shift in the CPS delivered by community pharmacists in addition to regular dispensing-related duties and counselling practices that are also undertaken concurrently. As the focus of this study was to explore CPS provided by pharmacists, it is likely that the present study has not captured all tasks completed as part of community pharmacy practice that utilise the pharmacists' expertise due to the subsequent shift in community pharmacists' perspectives on their role. Considering the plethora of activities undertaken by pharmacists within the community pharmacy setting, there may also be recall bias together with differences in what pharmacists would define as a professional service versus routine practice. An operational definition was not provided to participants as we wanted pharmacists to volunteer their own experiences within their pharmacy context. This was evident with some pharmacists querying whether some services offered would be considered as actual professional services. This reinforces once again that the baseline level of pharmacists' roles and responsibilities and the status quo has shifted, where the current 'standard' elements of practice may have been regarded by the profession as CPS or advanced practice 10 years ago, for example. Consequently, when examining community pharmacy as a whole, the repertoire of formalised services should be evaluated together with standard activities, such as routine practice and counselling, which have notably increased over time. Community pharmacy is a unique sector of the health care system that provides primary care services to many within the population through balancing provision of quality CPS, profitability and viability of the business aspects of pharmacy, in addition to its supply function. The continued expansion of CPS alongside baseline practice then in turn reinforces the concept and desired shift for community pharmacy towards becoming a health destination for patients.[2]

Perceived impact of CPS

Key broad impacts of CPS identified in the present study, as perceived by participants, included their convenience and accessibility, improved patient education and QUM, which is in agreement with previous research.[12] Participants in the present study also noted a number of positive impacts specifically regarding the CPS that they offered in their pharmacy. The CPS-specific positive impacts noted by participants for services such as DAAs (improved customer loyalty, improved adherence, improved patient convenience, reduced medication-related errors, opportunity for ongoing monitoring, effective medicines management, script retention at the particular pharmacy), CIs (prevention of medication-related problems, improved overall patient health), BP/CVD checks (cost-effective, easily accessible service for patients), and MedsChecks (improved patient knowledge) were comparable to pharmacists' perceived reasons that underpinned the success of these implemented services previously outlined in a UTS Barometer report.[7]

Difficulty in appraising the actual impact of CPS was discussed by participants despite the mention of broader perceived impacts on health and/or economic outcomes. Although the accessibility of community pharmacists as HCPs is well recognised,[2, 3, 12] how this accessibility translates to improved outcomes may be more difficult to ascertain. Compulsory cost-effectiveness appraisal for CPA-funded services, for instance, has only been formally introduced as part of the 6CPA.[5] Therefore, this may explain the subsequent difficulty that participants had in ascertaining the actual impact of CPS implemented in their practice. Furthermore, services that do not attract funding from government may not have the financial means to conduct cost-effectiveness analysis studies. Thus, as seen from participants' comments, there is a need for further longitudinal studies and improved CPS impact indicators. In order to more comprehensively determine the quality and impact of CPS within the Australian context, future research should endeavour to capture comprehensive economic, clinical, and humanistic outcomes data on services that are currently implemented in practice in order to help determine where the work value of community pharmacists is most substantial, in the short, medium, or long term, to help better inform evidence-based standards and guidelines relevant to practice.

Perceptions of the value of CPS as a surrogate measure of the work value of community pharmacists

The value of CPS is intrinsically linked to, and representative of, both the perceived and actual positive impacts of these CPS from the perspectives of CPS end users, CPS providers, and other key stakeholders. From the semi-structured interview findings, pharmacists perceived the CPS they offered as having both professional value for themselves (thus yielding professional satisfaction in their delivery), value with respect to the positive impacts for patients (predominantly centred on timely, convenient access to services in the primary care setting, potentially contributing to improved health), value for the pharmacy (via indirect and direct remuneration received for CPS), and value for the health care system (translated as perceived net savings with respect to overall government health care expenditure). The value of CPS being offered by pharmacists has been recognised,[2] not only by others but by the pharmacists who are actively delivering these CPS, as also evidenced by the findings of this study. However, the concept of perceived value of CPS is complex and is likely to vary in accordance with different CPS and viewpoints.

Participants mentioned a perceived unwillingness of patients to pay for a service that is offered for free at another pharmacy. Quantitative research conducted in relation to the Review of Pharmacy Remuneration and Regulation via online surveys indicated that *"for those interested in accessing particular services, there was a willingness to pay for some of these services [for the majority of interested consumers: vaccinations, absence from work certificates, compounding/medication packing, wound care, screening/diagnostic services, health promotion, and/or medication review services]. This however is not the case for pharmacist advice about treatment or medicines – the vast majority of these consumers (at least 90%) claimed to want to access this advice but few (just 10%) indicated a willingness to pay for it."*[22(p5)] Therefore, user-pay funding models may not be feasible for certain services which can then impact consumers' perceived financial value of the specific service. For example, where previous research has reported that the vast majority of pharmacies do not charge for BP checks,[20] as was seen in the present study, this can have flow-on effects for the perceived value and subsequent remuneration of pharmacies and pharmacists from a government and employers' perspective. Many services are not adequately remunerated

for the pharmacists' time and expertise in delivering the service but rather, remunerated via indirect earnings from the sale of product(s) used in delivering the service; for instance, this could include flu vaccinations where the fee-for-service has been lowered due to increased competition, and thus only potentially breaking even when factoring in the cost of the vaccine itself; and wound care products used as part of wound care services as well as VLCD products/meal replacements for weight management, as a few examples presented by participants.

Although the financial value of the service may be limited with respect to pharmacy profits, from the pharmacists' perspective, CPS such as flu vaccinations had high value due to their impact on the broader community. It is positive to note that the perceived consumer benefits of CPS from the pharmacists' perspectives are also shared by consumers. A recent online survey of 1000 Australians between the ages of 18 and 64 years indicated that *"the majority (93 per cent) of Australian adults recognise the benefits of flu vaccination in pharmacy, citing access, cost and convenience as the biggest motivators for protecting against seasonal influenza."*[23] This finding highlights the value placed by consumers on pharmacist-led vaccination services, as one exemplar service that has been recently introduced into practice. As a more recently implemented CPS in comparison to other established CPS, the receptivity and uptake of vaccination services, as well as the value and professional satisfaction derived from providing this service, as expressed by participants in the present study, highlights that there is ongoing potential to increase the work value of community pharmacists as HCPs via increasing their existing scope of practice and establishing pathways for the completion of appropriate training to facilitate the delivery of high quality CPS. Considering that one way in which pharmacies can differentiate themselves in a competitive environment is via implementing CPS,[24] which was also raised by participants in the present study and in previous research,[3] it is evident that CPS provision alongside the quality of their delivery in satisfactorily meeting patients' needs is imperative to continually demonstrating the work value of community pharmacists.

However, there are inevitably ongoing challenges. The perceived barriers for CPS provision and potential expansion of CPS identified in the present study, such as the financial viability of CPS provision, economic pressures, the increased resources required e.g. need for increased staff to support CPS delivery, restrictions on available space necessary to provide CPS in the pharmacy i.e. layout-related, have been echoed in previous research that explored screening in the community pharmacy setting.[20] Changes in the profession via increased competition and revenue changes (for instance, accelerated price disclosure) coupled with increased CPS have contributed to an ongoing struggle between the professional and business aspects of pharmacy that must be reconciled to promote the value of CPS for all parties involved. Similarly, as the concept of value is fluid and perspective-dependent, it is important that the government's perception of the value of CPS is in alignment with the views of the profession as well as patients in order to enable ongoing, expanded CPS funding to improve the financial viability of providing CPS and importantly, patient health outcomes.

Remuneration at a pharmacy level and pharmacist level for the provision of CPS

The findings of the present study reinforced that remuneration at a pharmacy level for the provision of CPS was derived from either 6CPA funding or via user-pay models (excluding any indirect revenue earned from the supply of medicines and/or sale of other goods in the pharmacy). This is not dissimilar to what has been observed within an international context. When examining how CPS are remunerated globally, the majority of CPS are funded via user-pay models or CPS delivery costs are borne by the pharmacy itself.[21]

Among participants, remuneration at both a pharmacy level as well as a pharmacist level for providing CPS was currently regarded as suboptimal. Where some participants felt undervalued by their employer (as reflected by their wage level), others felt that negotiation with employers and demonstrating the pharmacist's individual work value was seen as the responsibility of the individual pharmacist. Participants raised a number of concerns about remuneration of CPS, for instance that CPS may be provided with little to no direct profits, and the lack of transparency in 6CPA funding received for DAAs. Moreover, both employee and employer pharmacists acknowledged that many services (including both 6CPA and non-

6CPA CPS) are not being appropriately reimbursed. This mirrors previous findings, where the Pharmacy Services Expectations report stated that *"the pharmacy network offers a range of professional services to patients, often free of charge or below cost."*[19(p1)]

At a pharmacist level, wages represented the broad remuneration received for their accountabilities held as a community pharmacist, inclusive of CPS. Several pharmacists perceived that the onus for demonstration of work value lay with the individual pharmacist themselves, which led to the adoption of a proactive view and approach to wage levels and their negotiation. This indicates that increases to the minimum wage may have less of a protective effect for pharmacists who are confident in negotiating with their employer regarding their own value in terms of wage level. However, minimum wage levels will likely be imperative to help safeguard wage levels received by employee pharmacists working in pharmacies that are more inclined to pay the minimum wage and/or early career pharmacists with limited work experience and who may have difficulty negotiating their salaries. For instance, the recently released Early Career Pharmacists White Paper 2017 stated that *"more than 80% of survey respondents indicated that they believed that remuneration for early career pharmacists could be improved by re-negotiation of Pharmacy Industry Award rates."*[25(p10)] Similar to the sentiments of several participants, dissatisfaction with present levels of remuneration has been a recent topic of discussion within the Australian pharmacist community.[26, 27] Furthermore, acknowledgement of this issue has been embedded in the recently published Early Career Pharmacist White Paper released by the Pharmaceutical Society of Australia,[25] whereby Recommendations 2 and 3 are of particular relevance to pharmacist remuneration:

- *"Recommendation 2: The profession should negotiate to raise the Pharmacy Industry Awards"*[25(p10)]; and
- *"Recommendation 3: The profession needs to advocate for, and pursue alternative remuneration models for pharmacy services."*[25(p11)]

In accordance with the issues raised by the participants, the profession itself is cognizant of the factors that have influenced the level of remuneration and viability of community pharmacy, such as the emergence of discount models of pharmacy and other reforms. Suboptimal remuneration continues to be a problem as perceived by members of the profession.[3, 25] In particular, Hermansyah et al.[3] noted that *"the declining wages in tandem with the increasing pressures in the working environment have been a source of growing dissatisfaction for employee pharmacists."*[3(p732)] Evidently, on the whole, as wage levels have not proportionally increased alongside the increased provision of CPS by pharmacists over the years, this has contributed to increased work-related responsibilities for community pharmacists with the same financial incentive received (if not less, in some cases). Furthermore, within an international context, Australia has limited established government and/or third party payer systems of remuneration for the provision of CPS in comparison to other countries/regions of the world.[28] As HCPs delivering a range of CPS to the patient populations serviced by their community pharmacy, improved remuneration in the short term, as well as systems to support ongoing improved levels of remuneration in the long term, are important to establish and maintain to support and collectively invest in increasing the work value of community pharmacists and their contributions to providing collaborative, patient-centred health care.

Since the completion of many of the study interviews, a number of changes to 6CPA funding available to reimburse CPS provision were subsequently announced. These included incentives to collect data to facilitate the evaluation of certain CPS, an increase in the cap for MedsChecks to 20 that can be claimed per calendar month (from the previous cap of 10) as well as fixed incentives for DAAs i.e. $6/eligible patient/week.[29] As participants flagged that pharmacies may operate at a loss in providing certain CPS, these changes are a positive step towards addressing some of these remuneration concerns. The increased funding available as part of the allocation for these services and increased capacity/measures to support their sustainability is promising. It also follows on with the trend of increasing CPS funding over the years, considering that limited remuneration for pharmacy services was reportedly received by pharmacies in 2002,[30] and the increased funding available under the existing 6CPA for CPS at present in comparison to previous CPAs.[5]

Considering that additional reimbursement specifically for delivering CPS was generally not received by employee pharmacists, in moving forward, with increased government funding made available to pharmacies, increased incentives should also be provided to the pharmacists who are actually delivering these services. Further to 6CPA funding, alternative funding pathways such as the introduction of MBS payments for pharmacists' time and supplementary funding given by private health insurance companies for CPS delivered by pharmacists may improve the level of reimbursement for pharmacists and associated level of satisfaction. This may then in turn contribute to an improvement in perceived professional satisfaction derived from practice. MBS payments for pharmacist consultations have been discussed among members of the profession in recent times,[31] and is a preferred approach to remunerating the advice provided by individual pharmacists.[22] In particular, 80% of early career pharmacist survey respondents felt that pharmacists should be remunerated via MBS payments.[25] A higher proportion of employee pharmacists have expressed support for reimbursement to be received for CPS via the MBS (rather than via the Community Pharmacy Agreement) in comparison to the proportion of pharmacist proprietors[9]; this trend of employee pharmacists preferring MBS payments was also seen in relation to the preferred system for allocation of funding for reimbursement.[22] Together, these findings indicate that remuneration of the individual pharmacist delivering a service to a patient is coveted by members of the profession, and may reflect its absence in current systems of pharmacist remuneration within the Australian context.

4.1 Study limitations

The two-pronged approach to recruitment helped to capture pharmacists both within the research team's networks who are engaged in CPS but also via the PPA membership network. However, there was a limited response rate from the PPA mail-out. There may be self-selection bias for participation in the study as there were no reimbursements provided for time and/or travel associated with participation. Voluntary participation and the study aims may have influenced the sample demographics and willingness to participate. There was a slight skew in the overall sample towards younger participants (despite pharmacists of a wide range of ages being approached) with the majority of pharmacists having less than 10 years of experience. However, data saturation was achieved, and the range of CPS covered were similar to those reported in the literature.[7, 11, 12, 19]

Whilst generalisability was not the aim of this qualitative study, the study findings may not be representative of other pharmacy settings or community pharmacy practice in Australia. The focus of the interview discussions was not on dispensing-related duties but on CPS. Thus, this study did not capture the full spectrum of the work value of a community pharmacist but a subset of the tasks and responsibilities inherent within the community pharmacist's role. Furthermore, some services may not be offered on a routine basis and thus may have been inadvertently forgotten by the participant and not mentioned during the interview. Consequently, there is likely to be under-reporting of the services being offered in pharmacies as a result.

5. Conclusions

Pharmacists are offering a broad range of CPS within the community pharmacy setting, both via 6CPA-funded initiatives as well as non-6CPA CPS. Almost all participants reported that their pharmacy provided 6CPA-initiatives such as DAAs, clinical interventions, MedsChecks/Diabetes MedsChecks, and HMRs. User-pay services being offered included pharmacist-led flu vaccinations, opioid substitution therapy (OST), diagnostic testing for sleep apnoea, and absence from work certificates, among other services. However, despite the user-pay model implemented in practice, limited profits were reportedly earned as a result of the provision of these CPS by community pharmacies.

The provision of CPS was regarded by pharmacists as having a number of positive impacts at both a patient and health care system level. Pharmacists perceive their work value within the community pharmacy setting as enabling timely and convenient access to health care for patients, as well as facilitating QUM through multi-faceted means such as addressing medication-related problems and patient education, which then in turn also had some positive impact on the community pharmacy entity as a business.

Overall, it was reported that there has been a prominent shift where professional services have become the status quo for the practice of the profession. This change indicates that there has also been a likely shift in the work value of community pharmacists.

Equally, pharmacists recognised that there were a number of drivers which have led to increased pressures in the industry and thus have indirectly resulted in the need for the expansion of services. These have notably included reforms such as accelerated price disclosure along with the proliferation of discount models of pharmacy within the sector. Despite the increasing provision of services and the integration of CPS delivery within the community pharmacist's role, in most cases there was no additional reimbursement received by the employee pharmacists to deliver services specifically, other than the level of wages received. Pharmacists are cognizant of the complexities inherent within the impact of community pharmacy sector reforms, CPS provision, changes in revenue and level of financial reimbursement received, and viability of the community pharmacy sector as a whole. However, there is a need to ensure that pharmacists are further recognised

professionally and financially for their contributions as HCPs within the broader health care system to ensure the continued viability of the profession, incentivisation of the expanding scope of practice and competencies of pharmacists, with a view towards enhancing the viability of the profession and the resultant positive impacts of the CPS provided by community pharmacists in Australia.

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Appendices

Appendix 1. Recruitment letter sent by PPA

Appendix 2. Participant Information Statement

Appendix 3. Consent form

Appendix 4. Subject demographic survey

Appendix 1. Recruitment letter sent by PPA

THE UNIVERSITY OF SYDNEY

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Work value of a community pharmacist

Date

Dear XX,

We invite you to participate in a study entitled **"Work value of a community pharmacist".** This study is funded through the Professional Pharmacists Australia (PPA), and is being conducted by the Faculty of Pharmacy, University of Sydney. The researchers involved are Professor Parisa Aslani, Professor Ines Krass and Ms Vivien Tong.

Professional Pharmacists Australia (PPA) is a Division of Professionals Australia. Professionals Australia (PA) is an organisation registered as the Association of Professional Engineers, Scientists and Managers Australia under the *Fair Work (Registered Organisations) Act 2009*. They represent a network of over 25,000 professionals including non owner pharmacists who work in community pharmacies nationally.

What is the study about?
The roles and responsibilities of community pharmacists have changed significantly in the last two decades. Namely, there has been a shift towards patient-centred care with increased delivery of cognitive pharmaceutical services, which include medication related services such as advanced counselling practices, adherence monitoring and support, and medication management reviews. This study aims to investigate changes in the work value of a community pharmacist, comparing the data collected in this study with similar work conducted in 1998, and investigate changes over the past 2 decades.

Why have you been invited?
You have been contacted because of your experience as a community pharmacist and because you provide cognitive pharmaceutical services, which may or may not include more advanced services.

What does the study involve?
This study will involve an interview (face-to-face, telephone or Skype) with you at your convenience. The interview will take approximately 30 – 60 minutes. With your permission, an audio-recorder will be used during the interview. All information collected during this study will be confidential, and only de-identified, group data will be reported.

Your participation in this study will be on a voluntary basis and you can withdraw at any time. Please find attached a more detailed Participant Information Statement.

Please contact Ms Vivien Tong (vivien.tong@sydney.edu.au or (02) 9036 7270) if you are interested in participating, an appointment will be made for an interview.

Kind regards
The Research Team

Appendix 2. Participant Information Statement

Faculty of Pharmacy

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Work value of a community pharmacist

PARTICIPANT INFORMATION STATEMENT

(1) What is the study about?

The roles and responsibilities of community pharmacists have changed significantly in the last two decades. Namely, there has been a shift towards patient-centred care with increased delivery of cognitive pharmaceutical services, which include medication related services such as advanced counselling practices, adherence monitoring and support, Medication Management reviews (Home Medicines Review (HMR) and Residential Medication Management Review (RMMR). Pharmacists also provide a range of primary/secondary prevention services including screening health checks, weight management, smoking cessation support and emergency contraception etc.

This study aims to investigate changes in the work value of a community pharmacist, comparing the data collected in this study with similar work conducted in 1998, and investigate changes over the past 2 decades.

The study will firstly determine the health and medication related services delivered by community pharmacists and the "nature" of their current work and work environment; and secondly, determine the level of skills, expertise and responsibility involved in delivering such services in community pharmacy practice. An assessment of the work environment and the work itself, together with the skills required will enable a determination of the work value and a basis for justifying new rates of pay for community pharmacists.

(2) Why have I been invited?

You have been contacted because of your experience as a community pharmacist and because you provide cognitive pharmaceutical services, which may or may not include more advanced services.

This Participant Information Statement tells you about the research study. Knowing what is involved will help you decide if you want to take part in the research. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary.

By giving your consent to take part in this study you are telling us that you:

- Understand what you have read.
- Agree to take part in the research study as outlined below.
- Agree to the use of your personal information as described.

You will be given a copy of this Participant Information Statement to keep

(3) Who is carrying out the study?

This study is funded through the Professional Pharmacists Australia (PPA), and is being conducted by the Faculty of Pharmacy, University of Sydney. The researchers involved are Professor Parisa Aslani, Professor Ines Krass and Ms Vivien Tong.

Professional Pharmacists Australia (PPA) is a Division of Professionals Australia. Professionals Australia (PA) is an organisation registered as the Association of Professional Engineers, Scientists and Managers Australia under *the Fair Work (Registered Organisations) Act 2009*. They represent a network of over 25,000 professionals including non owner pharmacists who work in community pharmacies nationally.

(4) What does the study involve?

This study will involve an interview (either face-to-face, telephone or Skype) with you at your convenience. The interview will take approximately 30 – 60 minutes. With your permission, an audio-recorder will be used during the interview. Additional notes may also be taken during the interview.

All information collected during this study will be confidential, and only de-identified, group data will be reported.

(5) Do I have to be in this study? Can I withdraw from the study?

Being in this study is completely voluntary - you are not under any obligation to consent and – if you do consent – you can withdraw at any time without affecting your relationship with any of the researchers, and Professionals Pharmacists Australia.

You may stop being part of the interview at any time if you do not wish to continue. The information that you provide will be deleted.

(6) Will anyone else know the results?

All aspects of the study, including results, will be strictly confidential and only the researchers will have access to information on participants. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

(7) Will the study benefit me?

We cannot and do not guarantee or promise that you will receive any direct benefits from the study.

(8) Are there any risks or costs associated with being in the study?

There are no foreseeable risks or costs associated with being in this study.

(9) What will happen to information about me that is collected during the study?

By providing your consent, you are agreeing to us collecting personal information about you for the purposes of this research study. Your information will only be used for the purposes outlined in this Participant Information Statement, unless you consent otherwise. Your information will be stored securely and your identity/information will be kept strictly confidential, except as required by law. Study findings may be published, but you will not be individually identifiable in these publications.

(10) Can I tell other people about the study?

Yes, you can tell other people about this study.

(11) What if I require further information about the study or my involvement in it?

If you like more information about the study, please contact Ms Vivien Tong by email: vivien.tong@sydney.edu.au; or Prof Parisa Aslani: parisa.aslani@sydney.edu.au.

(12) Will I be told the results of the study?

You have a right to receive feedback about the overall results of this study. You can tell us that you wish to receive feedback by ticking the relevant box and providing us with your email address on the Consent Form. This feedback will be in the form of a brief summary of the findings. You will receive this feedback after the study is finished

(13) What if I have a complaint or any concerns?

Any person with concerns or complaints about the conduct of a research study can contact The Manager, Human Ethics Administration, University of Sydney on +61 2 8627 8176 (Telephone); +61 2 8627 8177 (Facsimile) or ro.humanethics@sydney.edu.au (Email).

Kind regards

The Research Team

This information sheet is for you to keep

Appendix 3. Consent form

THE UNIVERSITY OF SYDNEY

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PARTICIPANT CONSENT FORM

I, ...[PRINT NAME], give consent to my participation in the research project:

TITLE: Work value of a community pharmacist

In giving my consent I acknowledge that:

1. The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.

2. I have read the Participant Information Statement and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.

3. I understand that being in this study is completely voluntary – I am not under any obligation to consent.

4. I understand that my involvement is strictly confidential. I understand that any research data gathered from the results of the study may be published however no information about me will be used in any way that is identifiable.

5. I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher(s) or the University of Sydney now or in the future.

6. I understand that I can stop my participation in the interview at any time if I do not wish to continue; and that my individual data will be deleted.

7. I consent to: Audio-recording YES ☐ NO ☐

8. I consent to receiving a summary of the study findings at the end of the report, by email.

Email address .....

....
Signature Please PRINT name

Date .....

Appendix 4. Subject demographic survey

Subject Demographic Survey

TITLE: Work value of a community pharmacist

1. Gender: Male ❒ Female ❒

2. Year of Birth: _____

3. Country of Birth: Australia ❒ Overseas ❒ Please specify _____

4. Main language spoken at home: English ❒ Other ❒ Please specify _____

5. What is your highest level of education?

6. What is your primary job? (Please include hours per week)

7. What is the setting of your primary job?

8. What is your secondary job? (Please include hours per week)

9. What is the setting of your secondary job?

10. What is your number of years of practice as a pharmacist? _____