FAIR WORK COMMISSION

4 Yearly Review of Modern Awards

Matter No.: AM2014/209

Pharmacy Industry Award 2010

Outline of Submissions

on

APESMA Claim to Increase Pharmacist Minimum Rates of Pay

for Work Value Reasons

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

DATE: **3 November 2016**

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INTRODUCTION

1. These outline of submissions are filed by the Association of Professional Engineers, Scientists and Managers, Australia (***APESMA***) in accordance with the Directions issued by His Honour Justice Ross on 21 September 2016.

CHANGES SOUGHT

2. APESMA is seeking a variation to Clause 17 Minimum Weekly Wages of the Pharmacy Industry Award 2010 [MA000012] (***PIA***) to reflect the work value changes of the following classifications in the following terms:

> An employer must pay adult employees the following minimum wages for ordinary hours worked by the employee:

Employee classification	**Minimum weekly rate** **$**	**Minimum hourly rate** **$**	**Casual hourly rate** **$**
Pharmacy Interns			
First Half of Training	994.37	26.17	32.71
Second half of training	1013.49	26.67	33.34
Pharmacist	1032.61	27.17	33.97
Experienced Pharmacist	1147.35	30.19	37.74
Pharmacist in Charge	1376.82	36.23	45.29
Accredited Pharmacist	1606.29	42.27	52.84
Pharmacist Manager	1606.29	42.27	52.84

> By including a new clause A.10 and renumbering clause A.10 to A.11 in Schedule A – Classification Definitions of the Pharmacy Industry Award 2014 Exposure Draft (9 October 2015 version) as follows:
>
> **Schedule A – Classification Definitions**
>
> **A.10 Accredited Pharmacist** is a pharmacist who is the holder of an Accredited Pharmacist qualification who undertakes professional services requiring pharmacist accreditation or credentialing

A.11 Pharmacist Manager is a pharmacist who is responsible to the proprietor for all aspects of the business.

3. This variation seeks an increase in the minimum weekly rates of pay for the Pharmacist classifications covered by the PIA because we claim there has been a significant increase in the work value of these classifications since the work value of these classifications was last considered.

4. We are also seeking the introduction of a new classification of Accredited Pharmacist. This is the reflect a higher-level qualification that has been introduced reflecting the higher level of clinical knowledge, skills and responsibility required and the growing number of these accredited pharmacists practicing within the industry.

THE CLAIM

5. APESMA believes that there have been such significant changes in the work done by pharmacists employed in community pharmacies since their work value was last considered by the Fair Work Commission (***FWC*** or ***Commission***) that an increase in the award minimum rates of pay is warranted.

6. We believe that we will be able to show that our application to increase these rates of pay is warranted for work value reasons and that it satisfies all of the other various requirements specified in the Fair Work Act (***FW Act***) that must be met on order for such a variation to a modern award to succeed.

7. We specifically clam 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 PIA and that there is a need to create a new classification of Accredited Pharmacist. We say that the significant new increases in the work done by these classifications falls into five main categories:

    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.

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

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

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

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

LEGISLATIVE FRAMEWORK

8. The proposed variations are sought as part of the 4 Yearly Review (***4 Yearly Review***) of modern awards arising from s. 156 of the FW Act. APESMA is seeking the variations pursuant to ss. 156(2), (3) and (4) of the FW Act and the discretion available to the Commission under those and various other provisions of the FW Act to make variations to modern awards.

9. Section 156 (1) of the FW Act provides that the Commission must conduct a four yearly review of modern awards.

10. In conducting the 4 yearly review of modern awards, the task of the Commission is to conduct this review in accordance with the provisions of s.156 (2) of the FW Act which sets out the requirement to conduct the review.

11. Section 156(2) deals with what must be done and what the Commission may do when conducting the review:

> (2) In a four yearly review of modern awards, the FWC:
>
> (a) must review all modern awards; and
>
> (b) may make:
>
> (i) one or more determinations varying modern awards; and
>
> (ii) one or more modern awards; and
>
> (iii) one or more determinations revoking modern awards.
>
> (c) must not review, or make a determination to vary, a default fund term of a modern award.

12. In Re Four Yearly Review of Modern Awards – Preliminary Jurisdictional Issues[1] (***Preliminary Jurisdictional Issues Decision***), the Full Bench indicated that in conducting a 4 yearly review the Commission will also have regard to the historical

[1] [2014] FWCFB 1788

context applicable to each modern award,[2] and previous decisions relevant to any contested issue. They also indicated that previous Full Bench decisions should generally be followed, in the absence of cogent reasons for not doing so.[3]

13. In the Preliminary Jurisdictional Issues Decision, the Full Bench identified that, in addition to s 156, a range of other provisions in the FW Act are relevant to the review. Those provisions included the objects of the Act (s 3), the interaction with the NES (s 55) and those provisions providing for the performance of functions and exercise of powers by the Commission (ss 577 and 578).

14. In the Preliminary Jurisdictional Issues Decision, the Full Bench confirmed that they are required to ensure that modern awards, together with the NES, provide a fair and relevant minimum safety net of terms and conditions, taking into account the modern awards objective[4].

15. The modern awards objective is detailed at s.134 (1) of the Act:

> (1) The FWC must ensure that modern awards, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions, taking into account:
>
> (a) relative living standards and the needs of the low paid; and
>
> (b) the need to encourage collective bargaining; and
>
> (c) the need to promote social inclusion through increased workforce participation; and
>
> (d) the need to promote flexible modern work practices and the efficient and productive performance of work; and
>
> (da) the need to provide additional remuneration for:

[2] Ibid [24]
[3] Ibid [27]
[4] Ibid [23]

(i) employees working overtime; or

(ii) employees working unsocial, irregular or unpredictable hours; or

(iii) employees working on weekends or public holidays; or

(iv) employees working shifts; and

(e) the principle of equal remuneration for work of equal or comparable value; and

(f) the likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden; and

(g) the need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards; and

(h) the likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy.

This is the ***modern awards objective***.

16. When considering the relevance of s. 134 the Full Bench in the Preliminary Jurisdictional Issues Decision stated that:

> 'No particular primacy is attached to any of the s.134 considerations and not all of the matters identified will necessarily be relevant in the context of a particular proposal to vary a modern award'[5].'

[5] [2014] FWCFB 1788 [32]

17. Further they went on to indicate that:

> 'the Commission's task is to balance the various considerations and ensure that modern awards, together with the NES, provide a fair and relevant minimum safety net of terms and conditions.[6]'

18. In performing functions or exercising powers, the Commission must take into account the objects of the FW Act including, "*ensuring a guaranteed safety net of fair, relevant and enforceable minimum terms and conditions*" including through modern awards[7]

19. Section 134 of the FW Act provides for modern awards, together with the National Employment Standards, to provide a fair and relevant minimum safety net of terms and conditions but this is tempered by Section 138 which indicates that modern awards may only include terms that are required to achieve the modern awards objective. It is expressed as follows:

> A modern award may include terms that it is permitted to include, and must include terms that it is required to include, only to the extent necessary to achieve the modern awards objective and (to the extent applicable) the minimum wages objective.

20. Tracey J[8] Tracey J in *Shop Distributive and Allied Employees Association v National Retail Association No.2)* when considering s 138 of the FW Act observed that:

> ".. a distinction must be drawn between what is necessary and that which is desirable. That which is necessary must be done. That which is desirable does not carry the same imperative for action."

21. Various Decisions of the Commission have subsequently applied and agreed with this observation of Tracey J. For example, in their Decision on the scope of the 2012 modern awards review the Full Bench[9] said:

> **[33]** We are satisfied that s.138 is relevant to the Review. The section deals with the content of modern awards and for the reasons given at paragraph [25]

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[6] Ibid [33]
[7] Explanatory Memorandum, Fair Work Bill 2008, r 105
[8] [2012] FCA 480
[9] [2012] FWAFB 5600

> of our decision it is a factor to be considered in any variation to a modern award arising from the Review. We also accept that the observations of Tracey J in SDAEA v NRA (No.2), as to the distinction between that which is "necessary" and that which is merely desirable, albeit in a different context, are apposite to any consideration of s.138.

22. In the Preliminary Jurisdictional Issues Decision, the Full Bench confirm the relevance of s 138 in the four yearly review of modern awards and they indicate that any variations made to modern awards during this process must be necessary to achieve the modern awards objective. In this Decision they say:[10]

> **[39]** We are satisfied that s.138 is relevant to the Review. We also accept that the observations of Tracey J in *SDA v NRA (No.2)*, as to the distinction between that which is "necessary" and that which is merely desirable, albeit in a different context, are apposite to any consideration of s.138.

23. The Full Bench, in the Preliminary Jurisdictional Issues Decision make it clear that if a party seeks a significant change to a provision in a modern award that it must be supported by a submission which addresses the relevant legislative provisions and be accompanied by probative evidence properly directed to demonstrating the facts supporting the proposed variation[11].

24. As part of the four yearly review of modern awards APESMA is seeking a variation to in the minimum wages applicable to the pharmacist classifications contained in the Pharmacy Industry Award 2010. We are also seeking the inclusion of a new classification of Accredited Pharmacist. We are seeking these changes because we believe they are warranted for work value reasons.

25. When setting, varying or revoking a modern award minimum wages the Commission is also required to take into account the minimum wages objective which is set out in s. 284 of the FW Act in the following terms:

> *What is the minimum wages objective?*

[10] [2014] FWCFB 1788
[11] Ibid [23]

(i) The FWC must establish and maintain a safety net of fair minimum wages, taking into account:

(a) the performance and competitiveness of the national economy, including productivity, business competitiveness and viability, inflation and employment growth; and

(b) promoting social inclusion through increased workforce participation; and

(c) relative living standards and the needs of the low paid; and

(d) the principle of equal remuneration for work of equal or comparable value; and

(e) providing a comprehensive range of fair minimum wages to junior employees, employees to whom training arrangements apply and employees with a disability.

This is the ***minimum wages objective***.

26. Section 284 (2) outlines when this Section of the FW Act applies.

When does the minimum wages objective apply?

(2) The minimum wages objective applies to the performance or exercise of:

(a) the FWC's functions or powers under this Part; and

(b) the FWC's functions or powers under Part 2-3, so far as they relate to setting, varying or revoking modern award minimum wages.

Note: The FWC must also take into account the objects of this Act and any other applicable provisions. For example, if the FWC is setting, varying or revoking modern award minimum wages, the modern awards objective also applies (see s. 134).

27. At s. 284 (3) the FW Act defines modern award minimum wages:

Meaning of ***modern award minimum wages***

(3) ***Modern award minimum wages*** are the rates of minimum wages in modern awards, including:

(a) wage rates for junior employees, employees to whom training arrangements apply and employees with a disability; and

(b) casual loadings; and

(c) piece rates.

28. Section 284 (4) of the FW Act then defines what is meant by the term 'setting and varying modern award minimum wages':

Meaning of ***setting*** *and* ***varying*** *modern award minimum wages*

(4) ***Setting*** modern award minimum wages is the initial setting of one or more new modern award minimum wages in a modern award, either in the award as originally made or by a later variation of the award. ***Varying*** modern award minimum wages is varying the current rate of one or more modern award minimum wages.

29. Because APESMA is seeking to 'vary' the minimum wages for pharmacists covered by the modern Pharmacy Industry Award this provision of the FW Act must also be taken into consideration.

30. We are seeking to vary the modern award minimum wages applicable to pharmacists covered by the Pharmacy Industry Award as part of the four yearly review of modern

awards because we believe such a variation is justified for work value reasons. Sections 156 (3) and (4) are particularly relevant to this Application.

31. Section 156 (3) provides that in a four yearly review of modern awards the Commission may vary modern awards minimum wages if it is justified for 'work value reasons':

> (3) In a four yearly review of modern awards, the FWC may make a determination varying modern award minimum wages only if the FWC is satisfied that the variation of modern award minimum wages is justified by work value reasons.

32. Section 156 (4) defines what constitutes work value reasons for the purposes of this review:

> ***(4) Work value reasons*** are reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to any of the following:
>
> (a) the nature of the work;
>
> (b) the level of skill or responsibility involved in doing the work;
>
> (c) the conditions under which the work is done.

33. The APESMA proposed variation to the minimum wages of pharmacist classifications contained in the Pharmacy Industry Award 2010 constitutes significant change to the existing minimum award wages and consequently in accordance with the provisions of the FW Act and the Jurisdictional Issues Decision it must be supported by a cogent merit argument supported by probative evidence properly directed to demonstrating the facts supporting the proposed variation.

34. The various sections of the FW Act, outlined above, that are relevant to the APESMA application contain a number of requirements that must be satisfied. There is some overlap in these requirements and some of the requirements are not relevant.

35. In the Preliminary Jurisdictional Issues Decision, the Full Bench acknowledges that not all of the matters identified in s. 134 (1) of the FW Act will necessarily be relevant in the context of a particular proposal to vary a modern award[12].

36. If APESMAs claim to vary the minimum award rates for pharmacists covered by the Pharmacy Industry Award 2010 is to be successful it must provide cogent merit argument and probative evidence that demonstrates how this claim is justified and how it properly satisfies the relevant requirements of the various sections of the FW Act.

Work Value Reasons

37. In order to achieve a variation of the modern Pharmacy Industry Award minimum rates of pay for work value reasons as part of the four yearly review of modern awards APESMA is required to satisfy all of the relevant modern award provisions of the FW Act. However, s. 156 (3) and (4) of the FW Act are of particular relevance.

38. In order to determine what level and type of evidence will be required to satisfy the Commission that the APESMA application satisfies the work value reasons requirement of the FW Act it will be necessary to explore in further detail what is meant by this provision and what evidence is required for such a claim to be successful.

39. Sections 156 (3) and (4) of the FW Act provides for the Commission to vary modern award minimum wages as part of the four yearly review of modern awards if it is satisfied that such a variation is warranted for work value reasons. The Act defines work value reasons as matters relating to the nature of the work; the level of skill or responsibility involved in doing the work; and the conditions under which the work is done.

40. The Fair Work Bill 2008 Explanatory Memorandum briefly addressed ss. 156(3) and (4). In doing so the Explanatory Memorandum indicated that the Commission could only vary wages as part of a four yearly modern award review if it was satisfied that the variation was justified for work value reasons[13].

41. The work value reasons defined in s 156 (4) are very similar to the 'work value' provisions that have been applied by the Commission and its predecessors for a number

[12] [2014] FWCFB 1788 [32]
[13] Fair Work Bill 2009 – Fair Work Bill 2008 Explanatory Memorandum paras 605 and 606

of years. Consequently, previous Decisions will provide an indication of what an applicant is required to satisfy in order to achieve a work value increase in minimum wages.

42. The Commission has previously acknowledged that work value assessments call for the exercise of broad judgement when determining such a matter. Munro J observed in AMWU and HPM Industries:[14]

> 'experience of work value cases suggests that work value equivalence is a relative measure, sometimes dependent upon an exercise of judgement. A history of such cases would disclose that a number of evaluation techniques have been applied for various purposes and with various outcomes from time to time.'

43. Whilst the Commission has indicated that any work value assessment must depend to some extent on judgment, the factors that constitute work value reasons identified in s. 156(4) are similar to the factors that have historically applied to work value assessments.

44. Historically the Commission has interpreted work value reasons to refer to situations where the nature of the work, skill and responsibility required and the conditions under which the work is performed as being the principal criteria for determining if minimum rates of pay should be varied to take account of work value changes. They have generally determined that there must be a 'significant net addition to work requirements' for such an increase to be warranted.

45. In the May 2004 Safety Net Review – Wages Decision[15] the Commission established principles for varying awards including for work value reasons. In Attachment A – Statement of Principles they defined work value changes as:

> 6. WORK VALUE CHANGES
>
> Changes in work value may arise from changes in the nature of the work, skill and responsibility required or the conditions

[14] Print Q1002, 19 May 1998
[15] Safety Net Review May 2004 PR002004 – 5 May 2004

> under which work is performed. Changes in work by themselves may not lead to a change in wage rates. The strict test for an alteration in wage rates is that the change in the nature of the work should constitute such a significant net addition to work requirements as to warrant the creation of a new classification or upgrading to a higher classification.

46. In *Child Care Industry (Australian Capital Territory) Award 1998*[16] Decision a Full Bench of the then Australian Industrial Relations Commission provided detail on what constituted work value reasons and clarified that there must also be a 'significant net addition to work requirements' for an applicant's work value claim to be granted. In this Decision they traversed previous Decisions of the Commission that outline the requirements for a work value claim to be successful. APESMA believes, because there have been few changes to the 'work value principles' since this time the previous Decisions outlined in this Decision are still relevant to current work value claims.

47. In this Decision the Commission summarised the critical factors that are relevant to a work value assessment. In this Decision they said:

> **[190]** Previous decisions of the Commission suggest that a range of factors may, depending on the circumstances, be relevant to the assessment of whether or not the changes in question constitute the required *"significant net addition to work requirements"*. The following considerations are relevant in this regard:
>
> - Rapidly changing technology, dramatic or unanticipated changes which result in a need for new skills and/or increased responsibility may justify a wage increase on work value grounds.[17] But progressive or evolutionary change is insufficient.[18]

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[16] Australian Liquor, Hospitality and Miscellaneous Workers Union re Child Care Industry (Australian Capital Territory) Award 1998 and Children's Services (Victoria) Award 1998 - re Wage rates - PR954938 [2005] AIRC 28; (13 January 2005)

[17] Graphic Arts Award, (1978) 213 CAR 146; Fire Brigade Employees (ACT) Award (1981) 255 CAR 476; General Motors Holden Ltd (Pt 1) General Award 1982 (1986) 301 CAR 555; Aluminium Industry (Comalco Bell Bay Companies) Award, Print G5474, 15 October 1986 per Leary C.

[18] Graphic Arts Award (1978) 213 CAR 146; General Motors-Holden Ltd (Pt 1) General Award 1982 supra; Municipal Officers (Glenorchy City Council) Award 1981 (1986) 302 CAR 203; Printing and Kindred Industries Union v The Public Service Commissioner for the NT, Print G6607, 5 March 1987 per Palmer C; State Electricity Commission of Victoria v The Federated Ironworkers' Association of Australia, Print G7498, 22 May 1987 per Coldham J, Cohen J and Griffin C.

- An increase in the skills, knowledge or other expertise required to adequately undertake the duties concerned demonstrates an increase in work value.[19]
- The mere introduction of a statutory requirement to hold a certificate of competency does not of itself constitute a significant net addition to work requirements. It must be demonstrated that there has been some change in the work itself or in the skills and/or responsibility required.[20] However, where additional training is required to become certified and hence to fulfil a statutory requirement a wage increase may be warranted.[21]
- A requirement to exercise care and caution is, of itself, insufficient to warrant a work value increase.[22] But an increase in the level of responsibility required to be exercised may warrant a wage increase on work value grounds.[23] Such a change may be demonstrated by a requirement to work with less supervision.[24]
- The requirement to exercise a quality control function may constitute a significant net addition to work requirements when associated with increased accountability.[25]
- The fact that the emphasis on some aspects of the work has changed does not in itself constitute a significant net addition to work requirements.[26]
- The introduction of a new training program or the necessity to undertake additional training is illustrative of the increased level of skill required due to

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[19] Alcoa of Australia (Vic) Award, Print G3738, 15 July 1986 per Boulton J; Brass, Copper and Non-Ferrous Metal Industry Consolidated Award (1986) 302 CAR 568; Austral Pacific Fertilisers Ltd (Agricultural Chemical Industry) Award 1984, Print G6405, 4 February 1987 per Leary C; Australian Public Service Assn v Public Service Commissioner of NT, Print G6934, 1 April 1987 per Griffin C.

[20] The Hydro Electric Commission of Tas v The Australian Workers Union, AIRC, (Boulton J), 9 September 1987, Print G9199; ICI Australia Metal Trades Unions Botany Site Agreement, Print G7632, 29 May 1987 per Paine C.

[21] The National Building Trades Construction Award - Laser Operation Allowance Case, AIRC, (Bennett C), 30 July 1987, Print G8697.

[22] Queensland Alumina Limited Agreement (1976) 175 CAR 894; Aluminium Industry (Commonwealth Aluminium Corporation Ltd - Qld) Award (1978) 207 CAR 852.

[23] Brass, Copper and Non-Ferrous Metals Industry Consolidated Award, Print G5798, 26 November 1986 per Leary C; Austral Pacific Fertilisers Ltd (Agricultural Chemical Industry)Award, Print G6405, 4 February 1987 per Leary C; Aircraft Industry (Domestic Airlines) Award, Print G8270, 3 July 1987 per Paine C; Australian Public Service Assn v Public Service Commission of NT AIRC, Print G6934, 1 April 1987 per Griffin C. Qantas Airways Ltd v Transport Workers' Union of Australia, Print K2423, 24 April 1992 per McDonald C.

[24] Brass, Copper and NonFerrous Metals Industry Consolidated Award (1986) 302 CAR 568.

[25] Vinidex Tubemakers Pty Ltd, Smithfield NSW Industrial Agreement 1981, Print H4342, 2 September 1988 per Munro J.

[26] *Professional Engineers (Local Governing Authorities Tas) Award* (1986) 302 CAR 203.

the change in the nature of the work.[27] But keeping abreast of changes and developments in any trade or profession is part of the requirements of that trade or profession and generally only some basic changes in the educational requirements can be regarded, of itself, as constituting a change in work value.[28]

- Increased workload generally goes to the issue of manning levels not work value.[29] But, where an increase in workload leads to increased pressure on skills and the speed with which vital decisions must be made then it may be a relevant consideration.[30]

48. Since then the Commission has not departed from these requirements.

49. For instance, more recently the Full Bench of the Commission in its Recommendation[31] in the United Voice v Ambulance Victoria dispute concerning the Ambulance Victoria Enterprise Agreement 2015 applied similar provisions to s. 156 (4) of the FW Act and the requirements outlined in the *Child Care Industry (Australian Capital Territory) Award 1998*[32] to determine if it would recommend a 'work value' increase in the rates of pay for various classifications covered by that Agreement. In this Recommendation granting a work value increase in the rates of pay for some classifications covered by the Ambulance Victoria Enterprise Agreement the Commission also provided an analysis of what is required to satisfy a 'significant net addition to work requirements'

> **[17]** Previous decisions of the Commission suggest that a range of factors may, depending on the circumstances, be relevant to the assessment of whether or not the

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[27] *Foreman and Related Supervisory Categories (Australia Public Service) Award 1985* (1986) 301 CAR 82; *Determination No 519 of 1979* (1986) 301 CAR 273; *Gasfitters (Gas and Fuel Corp of Vic) Award 1982* (1986) 301 CAR 539; *Ship Painters and Dockers Award 1969* (1986) 302 CAR 220; *Dispute between Carlton and United Breweries (N.S.W.) Pty Ltd and Federated Clerks Union of Australia*, Print G6216, 18 December 1986 per Nolan C; *Railway Metal Trades Grades Award 1953*, Print G6473, 4 February 1987 per Cross C; *Locomotive Enginemen's Award* (1986) 302 CAR 188; *Tomogo Aluminium Company Pty Ltd Award* (1986) 302 CAR 570; *Alcoa of Australia (WA) Award*, Print G6032, 11 December 1986 per Connell C; *State Rail Authority of NSW v Australian Railways Union*, Print G6666, 20 February 1987 per Riordan DP; *The National Building Trades Construction Award Laser Operation Allowance*, Print G8697, 30 July 1987 per Bennett C.

[28] *Dispute between the Printing and Kindred Industries Union and Nationwide News Pty Ltd* (1986) 301 CAR 221; *State Electricity Commission of Vic v The Australian Institute of Marine and Power Engineers*, Print H1180, 26 February 1988 per Brown C.

[29] *Nursing Staff ACT Rates of Pay Award 1970* (1976) 177 CAR 1141; *Transport Workers (Oil Companies) Award*, Print H3686, 22 July 1988 per Leary C

[30] *Private Hospitals' and Doctors' (ACT) Award* (1977) 198 CAR 379; *Municipal Officers (Clarence Council) Award*, Print G7083, 1 May 1987, per Sheather C.

[31] United Voice v Ambulance Victoria (2015/3378), Recommendation, 23 March 2016

[32] *2005 A.C.T. Child Care Case*, Print 954938, 13 January 2005, op. cit.

changes in question constitute a *'significant net addition to work requirements'*. The following considerations are relevant in this regard:[33]

(i) Rapidly changing technology, dramatic or unanticipated changes which result in a need for new skills and/or increased responsibility may justify a wage increase on work value grounds.[34] But progressive or evolutionary change is insufficient.[35]

(ii) An increase in the skills, knowledge or other expertise required to adequately undertake the duties concerned demonstrates an increase in work value.[36]

(iii) The mere introduction of a statutory requirement to hold a certificate of competency does not of itself constitute a significant net addition to work requirements. It must be demonstrated that there has been some change in the work itself or in the skills and/or responsibility required.[37] However, where additional training is required to become certified and hence to fulfil a statutory requirement a wage increase may be warranted.[38]

(iv) A requirement to exercise care and caution is, of itself, insufficient to warrant a work value increase.[39] But an increase in the level of responsibility required to be exercised may warrant a wage increase on

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[33] Ibid [180]
[34] *Graphic Arts Award*, (1978) 213 CAR 146; *Fire Brigade Employees (ACT) Award (1981)* 255 CAR 476; *General Motors Holden Ltd (Pt 1) General Award 1982* (1986) 301 CAR 555; *Aluminium Industry (Comalco Bell Bay Companies) Award*, Print G5474, 15 October 1986 per Leary C.
[35] *Graphic Arts Award* (1978) 213 CAR 146; *General Motors-Holden Ltd (Pt 1) General Award 1982* supra; *Municipal Officers (Glenorchy City Council) Award 1981* (1986) 302 CAR 203; *Printing and Kindred Industries Union v The Public Service Commissioner for the NT*, Print G6607, March 1987 per Palmer C; *State Electricity Commission of Victoria v The Federated Ironworkers' Association of Australia*, Print G7498, 22 May 1987 per Coldham J, Cohen J and Griffin C.
[36] *Alcoa of Australia (Vic) Award*, Print G3738, 15 July 1986 per Boulton J; *Brass, Copper and Non-Ferrous Metal Industry Consolidated Award* (1986) 302 CAR 568; *Austral Pacific Fertilisers Ltd (Agricultural Chemical Industry) Award 1984*, Print G6405, 4 February 1987 per Leary C; *Australian Public Service Assn v Public Service Commissioner of NT*, Print G6934, 1 April 1987 per Griffin C.
[37] *The Hydro Electric Commission of Tas v The Australian Workers Union*, Print G9199, 9 September 1987; *ICI Australia Metal Trades Unions Botany Site Agreement*, Print G7632, 29 May 1987 per Paine C.
[38] *The National Building Trades Construction Award - Laser Operation Allowance Case*, Print G8697, 30 July 1987.
[39] *Queensland Alumina Limited Agreement* (1976) 175 CAR 894; *Aluminium Industry (Commonwealth Aluminium Corporation Ltd – Qld) Award* (1978) 207 CAR 852.

work value grounds.[40] Such a change may be demonstrated by a requirement to work with less supervision.[41]

(v) The requirement to exercise a quality control function may constitute a significant net addition to work requirements when associated with increased accountability.[42]

(vi) The fact that the emphasis on some aspects of the work has changed does not in itself constitute a significant net addition to work requirements.[43]

(vii) The introduction of a new training program or the necessity to undertake additional training is illustrative of the increased level of skill required due to the change in the nature of the work.[44] But (viii) keeping abreast of changes and developments in any trade or profession is part of the requirements of that trade or profession and generally only some basic changes in the educational requirements can be regarded, of itself, as constituting a change in work value.[45]

(viii) Increased workload generally goes to the issue of manning levels not work value.[46] But, where an increase in workload leads to increased

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[40] *Brass, Copper and Non-Ferrous Metals Industry Consolidated Award*, Print G5798, 26 November 1986 per Leary C; *Austral Pacific Fertilisers Ltd (Agricultural Chemical Industry)Award*, Print G6405, 4 February 1987 per Leary C; *Aircraft Industry (Domestic Airlines) Award*, Print G8270, 3 July 1987 per Paine C; *Australian Public Service Assn v Public Service Commission of NT AIRC*, Print G6934, 1 April 1987 per Griffin C; *Qantas Airways Ltd v Transport Workers' Union of Australia,* Print K2423, 24 April 1992 per McDonald C.
[41] *Brass, Copper and Non Ferrous Metals Industry Consolidated Award* (1986) 302 CAR 568.
[42] *Vinidex Tubemakers Pty Ltd, Smithfield NSW Industrial Agreement 1981*, Print H4342, 2 September 1988 per Munro J.
[43] *Professional Engineers (Local Governing Authorities Tas) Award* (1986) 302 CAR 203.
[44] *Foreman and Related Supervisory Categories (Australia Public Service) Award 1985* (1986) 301 CAR 82; *Determination No 519 of 1979* (1986) 301 CAR 273; *Gasfitters (Gas and Fuel Corp of Vic) Award 1982* (1986) 301 CAR 539; *Ship Painters and Dockers Award 1969* (1986) 302 CAR 220; *Dispute between Carlton and United Breweries (N.S.W.) Pty Ltd and Federated Clerks Union of Australia*, Print G6216, 18 December 1986 per Nolan C; *Railway Metal Trades Grades Award 1953*, Print G6473, 4 February 1987 per Cross C; L*ocomotive Enginemen's Award* (1986) 302 CAR 188; *Tomogo Aluminium Company Pty Ltd Award* (1986) 302 CAR 570; *Alcoa of Australia (WA) Award*, Print G6032, 11 December 1986 per Connell C; *State Rail Authority of NSW v Australian Railways Union*, Print G6666, 20 February 1987 per Riordan DP; *The National Building Trades Construction Award Laser Operation Allowance*, Print G8697, 30 July 1987 per Bennett C.
[45] *Dispute between the Printing and Kindred Industries Union and Nationwide News Pty Ltd* (1986) 301 CAR 221; *State Electricity Commission of Vic v The Australian Institute of Marine and Power Engineers*, Print H1180, 26 February 1988 per Brown C.
[46] *Nursing Staff ACT Rates of Pay Award 1970* (1976) 177 CAR 1141; *Transport Workers (Oil Companies) Award*, Print H3686, 22 July 1988 per Leary C.

pressure on skills and the speed with which vital decisions must be made then it may be a relevant consideration.[47]

50. In this Recommendation the Full Bench determined that their task was to: [48]

(1) Identify the changes in work, skill and responsibility required and the conditions under which work is performed, since early 2005. This requires an analysis of the evidence concerning the work performed by paramedics and related classifications in early 2005 compared with the work performed in 2016.

(2) Consider whether the changes identified constitute a 'significant net addition to work requirements' in relation to the classifications which are the subject of the dispute.

(3) If satisfied that the changes in work value constitute a significant net addition to work requirements then the Commission must assess how that change should be compensated in monetary terms. In this regard clause 4.3(e) states:

'Such assessment should normally be based on the previous work requirements, the wage previously fixed for the work and the nature and extent of the change in work.'

51. It can be seen from this Recommendation that the same tests have been applied to the Ambulance Victoria case as have traditionally been applied in previous Decisions of the Commission.

52. The Commission also followed a similar approach in four yearly modern award review Decision relating to the Pastoral Award 2010 where it decided to include crutching rates for rams in the modern award[49]. In this Decision they indicated that:

'[48] As s.156(4) makes clear, work value reasons are 'reasons justifying the amount that employees should be paid [f]or doing a particular kind of work.'

[47] *Private Hospitals' and Doctors' (ACT) Award* (1977) 198 CAR 379; *Municipal Officers (Clarence Council) Award*, PrintG7083, 1 May 1987, per Sheather C.
[48] United Voice v Ambulance Victoria (2015/3378) Recommendation 23 March 2016 [23]

[49] [2015] FWFB 8810

In this Decision the Full Bench then indicated that they would include these classifications in the Award and that they were:

> "satisfied that the variation proposed is justified for wok value reasons"[50]

53. APESMA believes that it will be able to show that our application to increase minimum rates of pay for the Intern Pharmacist; Pharmacist; Experienced Pharmacist; Pharmacist in Charge; and Pharmacy Manager classifications in the Pharmacy Industry Award 2010 and the addition of a new Accredited Pharmacist classification are justified for the work value reasons specified in s 156 (4) of the FW Act and as previously applied by the Commission.

54. We also believe that we will be able to satisfy the Commission that this application satisfies all of the various requirements that must be met in order for a term in a modern award to be varied.

[50] Ibid [51]

HISTORY OF COMMUNITY PHARMACIES EMPLOYEE PHARMACISTS AWARD REGULATION

FIRST FEDERAL SYSTEM AWARDS

56. Prior to 1994 the terms and conditions of employment of pharmacists employed in community pharmacies were determined by awards of the various state industrial tribunals. There were no awards covering these employees in the federal industrial system.

57. The first Federal system award regulating the terms and conditions of employment of pharmacists employed in community pharmacies was the Community Pharmacy (Victorian) Interim Award 1994. This Award was made by Deputy President (now Senior Deputy President) Drake on 27 May 1994[51]. This first award covered employee pharmacists employed in community pharmacies in Victoria only. It reflected the terms and conditions of employment contained in the Employee Relations Commission of Victoria Chemist Shops Award (Vic) 1987. The Community Pharmacy (Victorian) Interim Award 1994 came about as a result of the decision of the Victorian Government to refer its industrial powers to the Federal system.

58. As a result of a further discussions and a decision of the Commission on 30 May 1995 the Commission made a further interim award on 13 October 1995[52]. This award was known as the Community Pharmacy (Victoria) Interim Award 1995.

59. In 1996 the Community Pharmacy (Victoria) Interim Award 1995 was expanded by consent to cover employee pharmacists employed in community pharmacies in all states and territories across the country. This Award was made by Commissioner O'Shea on 24 December 1996[53] and was known as the Community Pharmacy Award 1996. It contained differing classifications and minimum rates of pay for each state and territory. These different classifications and minimum rates of pay reflected the classifications and minimum rates of pay applying in each state and territory award immediately prior to the making of this Federal System Award.

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[51] Print L4131 [C0597]
[52] Print M6246
[53] Print N7370 [C1790]

AWARD SIMPLIFICATION

60. In 1998 the Community Pharmacy Award 1996 was reviewed as required by the Transitional Provisions of the *Workplace Relations and Other Legislation Amendment Act 1996* (**WROLA Act**). This review involved several components:

- the deletion of provisions which are not allowable pursuant to the various subsections of s.89A of the *Workplace Relations Act 1996*;
- ensuring awards contain properly fixed minimum rates of pay;
- where appropriate, awards were to be reviewed to determine whether or not they met criteria specified in items 51(6) and (7) of the WROLA Act. These criteria included requirements regarding the award being written in plain English and the deletion of provisions which were obsolete, discriminatory, restrict productivity or contain matters of detail best dealt with by agreement at the enterprise or workplace level.

61. During this process the parties to this Award participated in lengthy and detailed discussions and were able to achieve consent on all matters except two – Higher Duties provisions and Meal allowances. The parties were able to achieve agreement on uniformity of all other terms and conditions across all states and territories including new minimum pay rates for the classifications covered by this Award.

62. The new minimum rates agreed between the parties reflected the pay relativities established by the Full Bench of the then Australian Industrial Relations Commission (**AIRC**) during the structural efficiency process established through the August 1989 National Wage Case Decision[54] and evidenced in a Full Bench Decision in relation to an application by APESMA to vary the Professional Scientists Award 1981 and the Professional Engineers (General Industries) Award 1982 that was issued on 26 July 1995.[55]

63. The Community Pharmacy Award 1998 was made by Commissioner Hingley of the then Australian Industrial Relations Commission on 29 June 1998[56]. This Award applied to employee pharmacists, students and interns (then known as trainees) employed in the community pharmacy industry in every state and territory and the pay

[54] M Print H9100
[55] DEC 1718/95 S Print M3882
[56] C1790 Dec 727/98 M Print Q2258

rates adopted by the Commission in making this Award reflected the agreement of the parties to adopt the classification relativities established as a result of the 1989 National Wage Case Decision[57]

64. There were approximately 4000 individually named respondents. This award was also declared as a common rule award for students, interns and pharmacists employed within community pharmacies in the state of Victoria.

65. The Community Pharmacy Award 1998 established one set of minimum pay rates for pharmacists employed in community pharmacies covered by this Award in all states and territories except Western Australia. Separate minimum rates of pay were included for Western Australia and separate classification definitions were retained for each state and territory. This Award standardised most other terms and conditions of employment except for overtime and penalties. The penalties applying in each state and territory award immediately prior to the making of the Community Pharmacy Award 1996 were retained.

66. In his Decision, applying the Award Simplification Decision[58] Commissioner Hingley granted increases in the rates of pay contained in the Community Pharmacy Award 1996. In doing so he[59] said

> 'In respect of this application pursuant to Item 49 of Part 2 of Schedule 5 of the WROLA Act, I am satisfied as to the following matters.
>
> (1) The applicant has made reasonable attempts to reach agreement with the other parties to the award about how the award should be varied and about the treatment of matters that are not allowable matters.
>
> (2) Once varied in accordance with the application before me the award will deal with only allowable award matters.
>
> (3) The application is consistent with the criteria in sub-items 7 and 8 of Item 49 of Part 2 of Schedule 5 of the WROLA Act 1996.

[57] Print H7460 – http://www.airc.gov.au/safetynet_review/decisions/H8200.htm
[58] Print P7500
[59] C1790 Dec 727/98 M Print Q2258

(4) The application is consistent with the award simplification decision principles [Print P7500].

(5) To the extent that the application adopts rates of pay in accordance with the decision in C No. 32994 of 1998 and the Safety Net Review - Wages decision [Print Q1998] it is consistent with those principles and the award simplification principles.'

VARIATIONS BETWEEN 1998 AND 2010

67. Various Roping-in of new respondents' awards; the Community Pharmacy Victorian Common Rule Declaration 2005[60]; variations to student minimum rates of pay; National Wage Case Safety Net Adjustments; and incorporation of Test Case Decisions were the only variations made to the Community Pharmacy Award 1998 from its making in 1998 until the new modern award was created in January 2010. There were no work value variations made to pharmacist minimum rates of pay between 1998 and the making of the new modern award in January 2010.

68. In January 2010 the then Fair Work Australia made the new modern Award known as the Pharmacy Industry Award 2010 (**PIA**). This Award superseded the Community Pharmacy Award 1998 and a number of other awards applying in the community pharmacy industry.

THE AWARD MODERNISATION PROCESS

69. The Pharmacy Industry Award 2010 came about as a result of Matter Number AM2008/10 – Retail Industry of the priority industry/occupations proceedings of the award modernisation process in 2008/9.

70. As part of the priority industry/occupations proceedings the then Australian Industrial Relations Commission proposed that the community pharmacy industry be included in the modern General Retail Industry Award but after hearing submissions from interested parties determined to create a separate modern award for the community pharmacy industry[61].

[60] Commissioner Smith, 18 November 2004, PR953309
[61] [2008] AIRCFB 1000 [284]

71. In handing down its Decision on 19 December 2008 the Full Bench considered all of the provisions that would apply in the priority industry/occupations awards including minimum wages where they said[62]:

> **Minimum wages**
>
> **[63]** As indicated in our statement of 12 September 2008, the minimum wages in the modern awards include the increases in pay scales and minimum rates in transitional awards operative generally from October 2008. Minimum wages will require further adjustment should there be a general increase in pay scales before January 2010. It is convenient to deal with a number of other matters related to wages.
>
> **[64]** In many cases there will be changes in award classification structures applying to employees. We are aware that decisions will have to be made as to the classification and level that employees should be placed in and the potential for issues to arise in that respect. Those issues are capable of being dealt with through the dispute resolution procedure. It should be pointed out, however, that the ability to determine such issues through that procedure, taking into account the terms of the Fair Work Bill, will be very limited.
>
> **[65]** In the case of a number of modern awards issues arose concerning the manner of expression of minimum wages. We have set out hourly rates in addition to weekly rates in some awards. Some awards also contain annual salaries.

72. In this Decision the Full Bench turned their attention to a wide range of award provisions, but they did not consider the work value of any employment group that was to be covered by any of the priority stage award, including the work value of pharmacists[63].

73. The interested parties involved during the process of developing the modern Pharmacy Industry Award 2010 addressed most of their attention to providing submissions as to whether community pharmacy should be included in the General Retail Industry Award

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[62] Ibid
[63] [2008] AIRCFB 717

or there should be a separate stand-alone Pharmacy Industry Award. However, a number of other issues associated with the proposed award were also agitated by various parties. The most prominent of issues were those raised by the PGA and these were associated with the proposed creation of a single scheme of penalty rates applying across the country and an increase in the casual loading for some states. The PGA also had significant concerns about transitional provisions.

74. A review of submissions and transcript reveals that at no stage during the process of the development of the modern Pharmacy Industry Award 2010 that any consideration was given to the work value of pharmacists covered by the Award.

75. In fact, the new Pharmacy Industry Award 2010 adopted the existing classifications and rates of pay contained in the Community Pharmacy Award 1998. The only changes were that the additional increments available to Pharmacists in Charge and Pharmacy Managers under the Community Pharmacy Award 1998 were removed and Western Australian pharmacists had some of their pay rates changed to bring them in line with those applicable for the rest of the country. (It should be noted that the majority of pharmacists employed in community pharmacies in Western Australia are not covered by the federal system. They are covered by awards of the Western Australian Industrial Relations Commission.) Pharmacy Student rates of pay were changed to bring them in line with pharmacy assistant rates of pay but the pay for the qualified pharmacist classifications was not varied.

VARIATIONS AFTER THE MAKING OF THE PHARMACY INDUSTRY AWARD IN 2010

76. After the making of the modern Pharmacy Industry Award 2010 and prior to the 2012 Modern Awards Review there were a number of corrections made to the Award and variations, such as Part Day Public Holidays and amendments to Transitional provisions that were applicable to all modern awards.

77. On 28 October 2009 a joint application by PGA, SDA and APESMA was lodged seeking a number of agreed changes to the Pharmacy Industry Award 2010. This joint application included amongst other things a claim to change Student Pharmacist and Trainee Pharmacist rates of pay to bring them in line with Pharmacy Assistant rates of pay and to ensure that junior rates of pay only apply to Pharmacy Assistant

classifications and not to the pharmacy student and pharmacy trainee rates of pay. The application also sought to change the name of a Trainee Pharmacist to an Intern Pharmacist. This application was granted by the Full Bench on 22 December 2009[64]. In handing down this Decision the Full Bench said:

> **[9]** The applicants submit that cl 18 of the modern award requires amendment to reflect that junior rates of pay apply only to pharmacy assistant classifications.[65]

78. Other than Annual Wage Review variations there have been no other variations made to the Clause 17 Minimum Weekly Wages of this Award since it was first made in 1 January 2010.

79. APESMA asserts that the above history of the regulation of pharmacist rates of pay and classifications contained in the Pharmacy Industry Award 2010 shows that the work value of Pharmacist classifications contained in Clause 17 of the Pharmacy Industry Award 2010 have not been considered at any time since they were considered by Commissioner Hingley when he made the Community Pharmacy Award 1998 on 29 June 1998[66].

80. We assert that the Commission is now free to consider the work value changes that have occurred to the work done by pharmacists covered by this award since their work value was last considered in 1998.

[64] [2009] AIRCFB 978
[65] Ibid
[66] C1790 Dec 727/98 M Print Q2258

THE COMMUNITY PHARMACY INDUSTRY

81. Community pharmacies provide a general service to all members of the public and are the main providers of prescription medicines, 'pharmacist only' medicines and 'over the counter' medicines to the general public, in conjunction with the appropriate counselling and advice.

82. Community pharmacies operate under strict rules governing ownership and the dispensing and supply of medicines. These rules are contained in the various State and Territory Pharmacy Acts and the Drugs, Poisons and Controlled Substances Acts.

83. The various Federal, State and Territory legislation regulating pharmacies requires that all pharmacies must be owned by a registered pharmacist. The various state and territory pharmacy acts restrict the number of pharmacies any one pharmacist can own from between four to six pharmacies depending on the state/territory. The only exceptions to these legislative requirements for ownership of pharmacies is for 'friendly societies' where there are no such legislative limits on the number of pharmacies that can be owned.

84. Furthermore, community pharmacies are also regulated by the National Health Act and regulations. This legislation regulates the Commonwealth-funded Pharmaceutical Benefits Scheme (***PBS***) which allows community pharmacies to dispense medications listed on the PBS and to be paid by the Commonwealth for dispensing those medicines.

85. In addition the various federal state and territory legislation and regulations controlling the operation of pharmacies and pharmacists any pharmacy who wishes to dispense medicines under the PBS must be authorised to do so by the PBS and they are required to agree to comply with the rules for dispensing PBS medicines established and varied from time to time by the Minister for Health in accordance with the National Health (Pharmaceutical Benefits) (Conditions of approval for approved pharmacists) Determination 2007[67] .

[67] *National Health (Pharmaceutical Benefits) (Conditions of approval for approved pharmacists) Determination 2007* (the Conditions of Approval).

86. As at 30 June 2015, there were 5,511 pharmacies in Australia.[68] According to the Pharmacy Guild of Australia (***PGA***) there were 4942 registered pharmacies in 2000[69]. This equates to approximately an 11.5% increase in the number of registered pharmacies operating within Australia in the period between 2000 and 2016.

87. The PGA in the Executive Summary of their annual review of the community pharmacy industry – titled the Guild Digest[70] - for the financial year 2014/15 reported an annual turnover of $15.46billion. In an earlier submission to the Productivity Commission on Review of Pharmacy in 1999 the PGA reported an annual turnover in community pharmacies of $6 billion in the year 1996[71]. This equates to approximately a 155% increase in annual turnover. According to ABS figures general retail turnover has increased in the same period of time by approximately 100%[72].

88. Pharmacies in Australia are primarily health care providers but they also operate as retail outlets for many non medicines such as perfumes and cosmetics. In the Department of Health Discussion Paper into the review of pharmacy remuneration and regulation[73] they reported that data from the April 2016 IBISWorld report on the pharmacy sector in Australia illustrates the proportion of income pharmacy received from prescriptions as opposed to non-prescription business (Figure 1). Further they indicated that the ratio of revenue from 'front of shop' and prescription medicines varies greatly across pharmacy business models.

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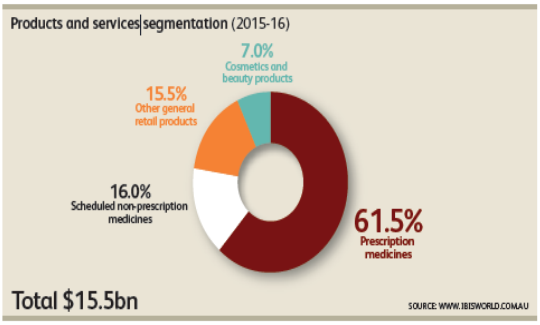
[68] Department of Health - Review of Pharmacy Remuneration and Regulation – Discussion Paper – July 2016, p 11
[69] Substance Abuse in Australian Communities – Submission by Pharmacy Guild of Australia – June 2000, p 7
[70] http://www.guild.org.au/docs/default-source/public-documents/Business-Support/guild-digest-2016---executive-summary.pdf?sfvrsn=0
[71] PGA Submission to the Productivity Commission National Review of Pharmacy - November 1999, P5
[72] 8501.0 - Retail Trade, Australia - http://www.abs.gov.au/ausstats/abs@.nsf/mf/8501.0
[73] Review of Pharmacy Remuneration and Regulation – Discussion Paper – July 2016, p 15

Figure 1



89. However, these statistics indicate that the significant proportion of income in pharmacies is derived from the provision of prescriptions. The above Figure also indicates that the next largest source of income (16%) in community pharmacies is from the sale of scheduled and other non-prescription.

90. The Australian National Audit Office undertook a review of the operation of the Fifth Community Pharmacy Agreement in 2015 and their Report confirms that the majority of income in community pharmacies is derived from prescription and pharmacist only and other pharmacy only medicines.[74]

91. With approximately 61% of income derived from dispensing of prescription medicines the statistics provided by the PBS on the expenditure on prescription medicines provides a good indicator of income in community pharmacies. The PBS statistics on Expenditure and Prescriptions[75] between 1998 and the end of June 2104 shows approximately a 157% increase in expenditure by the federal government under the PBS for the category of prescription medicines most related to PBS expenditure in community pharmacies.

92. The Federal, State and Territory legislation governing the sale of prescription medicines and pharmacist only medicines requires that, not only do owners of pharmacies need to be a currently registered pharmacists, but that these medicines be only dispensed under the authority of a currently registered pharmacist. Consequently pharmacy owners need to employ pharmacists in order to meet these and other requirements regulating the operation of pharmacies.

[74] https://www.anao.gov.au/sites/g/files/net1661/f/ANAO_Report_2014-2015_25.pdf
[75] https://www.pbs.gov.au/info/browse/statistics#Expenditure

PHARMACISTS – WHAT THEY DO

93. Pharmacists dispense prescriptions, provide advice on drug selection and usage to doctors and other health professionals, primary healthcare advice and support, and educate patients on health promotion, disease prevention and the proper use of medicines.

94. They use their expertise in medicines to optimise health outcomes and minimise medication misadventure. They apply their knowledge of medicines to promote their safe use and avoid harm to users and others in the community.

95. A pharmacist is required to ensure the safe custody, preparation, dispensing and provision of medicines. Their role is to provide health advice and to counsel patients on the best use of medicines, providing advice on symptoms, the management of common ailments, preparing and formulating medications, possible medication side-effects and drug interactions, and providing health education.

96. Pharmacists provide primary healthcare including education and advice to promote good health and to reduce the incidence of illness.

97. Many pharmacists work in community pharmacies, with some owning their own pharmacy or partnership, but the vast majority are employees. Pharmacists also work in public and private hospitals and related services.

98. Pharmacists also can be accredited to provide medication management review (***MMR***) services to consumers in their home and in residential aged care facilities. Some of these accredited MMR pharmacists work independently, others work within a community or hospital pharmacy.

99. Pharmacists also work in primary care settings such as medical centres, Aboriginal health services etc.

100. In addition, some pharmacists are employed by pharmaceutical companies in drug research and regulatory activities, governments and the military, professional organisations, or by universities and TAFE institutes.

101. Pharmacy is a registered health profession under the National Registration and Accreditation Scheme (***NRAS***).

PHARMACISTS EDUCATIONAL, TRAINING AND REGISTRATION REQUIRMENTS

102. Under the various Federal, State and Territory legislation governing the operation of pharmacists a person must be registered with the Pharmacy Board of Australia to practice as a pharmacist.

103. The Pharmacy Board of Australia is an arm of the Australian Health Practitioners Regulation Agency (***AHPRA***). AHPRA's operations are governed by the Health Practitioner Regulation National Law, as in force in each state and territory (***the National Law***), which came into effect on 1 July 2010.

104. The functions of the Pharmacy Board of Australia include:

- Registering pharmacists and students
- developing standards, codes and guidelines for the pharmacy profession
- handling notifications, complaints, investigations and disciplinary hearings
- assessing overseas trained practitioners who wish to practice in Australia
- approving accreditation standards and accredited courses of study.

105. To become a pharmacist who is registered to practice a person must:

- Complete program of study at university which has been accredited by the Australian Pharmacy Council (***APC***). These courses are of at least four years' full time equivalent duration
- Obtain Provisional Registration (known as an Intern) with the Pharmacy Board of Australia.
- Enrol in and complete an accredited intern training program and obtain an intern position. Intern training programs are also accredited by the APC.
- Complete a year (1824 hours) of supervised practice.

- Pass extensive oral and written examinations.

106. In order to gain General Registration and to be able to work independently as a pharmacist a person who has been granted Provisional Registration must have completed their Internship and passed the oral and written examinations must also provide evidence of:

    - Completion of their accredited undergraduate degree;
    - Completion of an accredited Intern training program
    - Successful completion of oral and written examinations undertaken by the Pharmacy Board of Australia
    - Completion of 1824 hours of approved supervised practice
    - Satisfied a criminal history check; and
    - Provided evidence of being covered by Professional Indemnity Insurance

107. To maintain registration a Registered Pharmacist must provide evidence of compliance with the registration standards which include criminal history, professional indemnity insurance, recency of practice and undertake continuing professional development (***CPD***) in accordance with the Pharmacy Board of Australia's requirements.

CPD

108. The Pharmacy Board of Australia's minimum requirements for CPD[76] for pharmacists is aimed at ensuring pharmacists can competently and safely provide pharmacist services to the public.

109. To meet this registration standard pharmacists must complete CPD activities that have an aggregate value of 40 or more CPD credits during each 12- month CPD period ending 30 September. They are required, at the commencement of each CPD year, to plan their CPD activities against the current *National Competency Standards*

[76] http://www.pharmacyboard.gov.au/News/2015-10-30-registration-standards.aspx

Framework for Pharmacists in Australia to identify relevant competencies and to identify their professional development needs against the relevant competencies.

PHARMACIST DEMOGRAPHICS

110. The Pharmacy Board of Australia reported in their 2015 Annual Report[77] that there were 29, 014 registered pharmacists in Australia on 30 June 2015.

111. Health Workforce Australia (HWA), an arm of the Federal Department of Health published a report of the Pharmacist Workforce in March 2015[78]. This is the most recent report on Pharmacists that they have undertaken. In this report they indicated that 63.1% of Registered Pharmacists are working in community pharmacies – either as owners or employees. It is estimated that around 15,000 of the pharmacists working in community pharmacies are employees.

112. This Report also indicated that approximately 58% of pharmacists are female and that the average age of pharmacists is 39.7 years.

[77] http://www.pharmacyboard.gov.au/News/2015-11-06-annual-report.aspx
[78] http://pandora.nla.gov.au/pan/133228/20150419-0017/www.hwa.gov.au/sites/default/files/HWA_Australia-Health-Workforce-Series_Pharmacists%20in%20focus_vF_LR.pdf

THE ROLE OF PHARMACISTS WITHIN COMMUNITY PHARMACIES

113. The PGA in its submission to the Productivity Commission's Competition Policy Review (known as the 'Harper Review')[79] provides an excellent summary of the role of pharmacists working in community pharmacies across Australia. They say:

> In addition to the role of pharmacies in distributing scheduled medicines, community pharmacies also provide important services. These services differ from pharmacy to pharmacy in response to local needs, and to fill gaps in the health system. They include:
>
> - Aboriginal and Torres Strait Islander Quality Use of Medicines (QUM) support
> - Asthma management support
> - Mother and Infant services
> - Blood pressure monitoring
> - Bone density testing
> - Chemotherapy preparation
> - Cholesterol testing
> - Chronic Obstructive Pulmonary Disease (COPD) risk-assessment and self-management support
> - Community health education/promotion (structured)
> - Complementary health therapies
> - Compounding services (extemporaneous dispensing)

[79] https://www.guild.org.au/docs/default-source/public-documents/news-and-events/media-releases/2014/pgoa-submission-to-the-competition-policy-review-june-2014_573492_3.pdf?sfvrsn=2, p 18 & 19

- Continence support
- Diabetes risk assessment and self-management support (including Diabetes MedsCheck)
- Dose Administration Aids (i.e. Blister Packs)
- Health aids and equipment
- Home delivery services
- Home Medicines Reviews (HMRs)
- Immunisation services
- Medication reconciliation post-discharge from hospital
- MedsCheck and Diabetes MedsCheck
- Mental Health Support
- Minor Ailments support
- National Diabetes Services Scheme (NDSS) Access Point
- Needle and Syringe Program (NSP)
- Opioid Dependence Treatment (ODT) services
- Product recalls and safety alert information and co-ordination
- QUM support for residential aged care facilities
- Residential Medication Management Reviews (RMMRs)
- Return of unwanted medicines for destruction
- Sexual health services
- Sleep apnoea support

- Smoking cessation support
- Staged supply (e.g. daily dispensing intervals at the request of a doctor)
- Vascular Disease Support
- Wound management support
- Weight management support

114. APESMA claims that any of these service to patients have been introduced since employee pharmacists work value was last considered by the Commission and that many of these services require pharmacists to obtain skills that they were not required to have in 1998.

THE WORK VALUE CHANGES

115. APESMA asserts that there have been significant changes in the work done by employee pharmacists since their work value was last considered by the Commission when the Community Pharmacy Award 1998 was made by Commissioner Hingley on 29 June 1998[80].

116. We specifically claim that there have been a significant net increases in the work requirements for all the Pharmacy Intern, Pharmacist, Experienced Pharmacist, Pharmacist in Charge and Pharmacist Manager classifications currently contained in the Pharmacy Industry Award 2010 (**PIA**) and that there is a need to create a new classification of Accredited Pharmacist to take account of new qualifications and work being done by Accredited Pharmacists within the community pharmacy industry. We say that the significant new increases in the work done by these classifications falls into five main categories:

- 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.
- The introduction of additional training so a pharmacist can become and retain registration under the legislative requirements for registration of a pharmacist.
- The introduction of new work that requires additional skills, knowledge and training
- The introduction of new work that has resulted in an increase in responsibility and accountability
- An increase in workload and an increase in pressure and on skills and the speed with which vital decisions need to be made.

[80] C1790 Dec 727/98 M Print Q2258

117. APESMA will lead expert and lay evidence to support the work value changes we believe have resulted in a significant net increase in the work value of the work done by pharmacists employed in community pharmacies across the country. This expert and lay evidence will support the work value changes we outline in this submission.

118. These changes, we say, have led to an increase in the work value of the work done by pharmacists.

119. The majority if these changes in the work done by pharmacists have occurred mainly because of changes in government health and medicines policy and industry initiatives designed to respond to these changes in government policy and to patient needs.

120. The key Federal Government policy changes that have resulted in a significant change in the role of the pharmacist are the:

- Introduction of the Quality Use of Medicines (**QUM**) into the National Medicines Policy
- Medical practitioner shortages, particularly in rural and regional areas
- Escalating cost to the Australian tax payer of providing a high quality medical service and medicines to the Australian community.
- Increasing number of patients with multiple chronic diseases requiring complex treatment
- Introduction of many new highly specialised medicines to the Australian market and the extra knowledge required to minimise drug interactions and adverse effects with patients
- Increasing number of medicines being downscheduled from prescription only status to pharmacist-only and pharmacy-only status, and the extra knowledge/skills required to safely provide these medicines to the public without a doctors' review

121. The changes in the work done by pharmacists are contained in government legislation, regulations and policy. For example, the introduction of QUM into the National Medicines Policy in 1999 has had a major impact on the role of a pharmacist. This

change has been the main instigator of the change in the role of the pharmacist and in the work they do. The inclusion of QUM into the National Medicines Policy has changed the role of a pharmacist from someone who was responsible for safely storing and dispensing medicines to a professional playing an increasing role as part of a multidisciplinary primary health care team who provides a wide range of preventative and primary health care services.

122. The Community Pharmacy Agreements (CPA), negotiated every five years between the PGA and the federal government, also detail changes to the work done within community pharmacies. These agreements outline the income pharmacies will receive from the federal government for dispensing prescription medicines. They also detail the professional or cognitive health care services that the federal government is requiring pharmacists within the community pharmacy sector to undertake and the funding the government will provide for undertaking these services. These various CPAs entered into between 1998 until today outline the increasing number and variety of services provided by pharmacists. Changes introduced as part of these agreements include the introduction of Home Medicine Reviews (HMR); Residential Medication Management Reviews (RMMR), Medschecks, asthma management, diabetes management etc. There have been five Community Pharmacy Agreements implemented since 1998. They are:

- The Second Community Pharmacy Agreement (1995 – 2000)[81]
- The Third Community Pharmacy Agreement (2000 – 2005)[82]
- The Fourth Community Pharmacy Agreement (2005 – 2010)[83]
- The Fifth Community Pharmacy Agreement (2010 – 2015)[84]
- The Sixth Community Pharmacy Agreement (2015 – 2020)[85]

[81] https://www.guild.org.au/docs/default-source/public-documents/tab---the-guild/Community-Pharmacy-Agreements/19950424-second-agreement.pdf?sfvrsn=0
[82] https://www.guild.org.au/docs/default-source/public-documents/tab---the-guild/Community-Pharmacy-Agreements/third-community-pharmacy-agreement-(2000-2005).pdf?sfvrsn=0
[83] https://www.guild.org.au/docs/default-source/public-documents/tab---the-guild/Community-Pharmacy-Agreements/fourth-community-pharmacy-agreement-(2005-2010).pdf?sfvrsn=0
[84] https://www.guild.org.au/docs/default-source/public-documents/tab---the-guild/Community-Pharmacy-Agreements/fifth-community-pharmacy-agreement.pdf?sfvrsn=0

123. Other changes to the work done by pharmacists are documented in changes to various pieces of legislation and regulations. These changes include the addition to the Fair Work Act of pharmacists as people authorised to sign medical certificates; the addition to the list of professions authorised to undertake inoculations.

124. In order to undertake these expanded services pharmacists must now possess an extensive number of skills that were not required of them in 1998. These skills include skills in diagnosis of various illnesses and disease, skills in the most appropriate way to treat these diseases and illnesses. They have also now need to possess skills in communication, counselling and in how to educate patients.

125. APESMA will lead extensive expert and lay evidence of these changes and the new skills required to undertake this new work. We will also provide extensive legislative and regulatory evidence of these changes.

Changes in Educational and Registration requirements

126. There have been a large and significant number of changes in the educational requirements and the registration requirements for pharmacists since 1998. Whilst these changes in isolation do not necessarily lead to a conclusion that there has been a significant work value increase in the work done by pharmacists we believe they are indicative of an increase in the skills, knowledge or other expertise required to adequately undertake the duties performed by pharmacists.

Cessation of Three Year Degree Option

127. From 2000 the option of undertaking a three year degree was progressively phased out. The accreditation body ceased to accredit three year pharmacy undergraduate degrees because it was deemed that a three year undergraduate degree would not be able to provide pharmacists with sufficient training to undertake all of the duties required of a pharmacist. Since then the minimum accredited pharmacy undergraduate degree is of four years fulltime equivalent duration with some academic institutions offering 4.5 and 5 year fulltime equivalent undergraduate degree options.

Introduction of Extended Undergraduate Degrees

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[85] https://www.guild.org.au/docs/default-source/public-documents/tab---the-guild/Community-Pharmacy-Agreements/6cpa---final-24-may-201558b59133c06d6d6b9691ff000026bd16.pdf?sfvrsn=2

128. From around 2010 the Australian Pharmacy Council[86] has accredited a number of undergraduate degrees of more than the usual four year degree. These undergraduate degrees provide student pharmacists with access to extended and more intensive undergraduate training. The reason for introduction of these extended undergraduate degrees was to provide student pharmacists with a greater understanding and knowledge of the work they will be required to undertake when they become registered pharmacists.

New Areas of Training Covered in Undergraduate Degrees

129. In 1998 students undertaking an undergraduate degree in pharmacy did not receive any training in counselling and education of patients. Pharmacy students now receive extensive training in education and counselling of patients all through their undergraduate degrees. Education and counselling of patients is now seen as a core skill requirement for pharmacists where it was not considered to be a role of the pharmacist in 1998. In 1998 counselling and educating patients on the use of medicines was the role of a doctor and was not considered to be a part of a pharmacist's role. In 1998 the training on education and counselling consisted of training on relaying the dosage directions of the prescribing doctor rather than counselling and educating the patient on the diagnosis, the reasons for prescribing, and the safe and effective use of the prescribed medicine(s) including any adverse effects related to the medicine(s) that is expected of a pharmacist today.

130. This change in focus of the work done by pharmacists and the need for them to be trained in education and counselling arose mainly as a response to the inclusion of the Quality Use of Medicines (QUM) policy into the Federal Government's National Medicines Policy. Prior to the introduction of QUM into the National Medicines Policy undergraduate pharmacy students courses mainly centred on issues such as pharmacology and anatomy. Now undergraduate pharmacy degrees still address pharmacology and anatomy etc. but they also have changed their focus from an emphasis on science to, in addition to continuing to provide skills in anatomy and pharmacology to including a focus on the patient and communication and education of the patient.

[86] The Australian Pharmacy Council is the accreditation authority responsible for accrediting education providers and programs of study for the pharmacy profession.

Introduction of Accredited Pharmacist Qualification

131. The accreditation of the new higher qualification of Accredited Pharmacist was formally recognised in 2010.

132. Pharmacists who are the holders of this qualification undertake a higher course of study. Only pharmacists who are the holders of an accredited pharmacy undergraduate degree who are also Registered Pharmacists are eligible to enrol in this higher level qualification.

133. Pharmacists who successfully complete this higher level qualification are known as 'Accredited Pharmacists' and they are specially qualified to undertake Home Medicines Reviews and the like.

Changes in Registration Requirements

134. Since mid-1998 there have been significant changes in the registration requirements of pharmacists[87]. APESMA believes that these changes have been implemented in order to ensure that pharmacists are capable of performing the more complex and higher level duties that are now requirement of them.

Increased Training and Skill Requirements for Intern Pharmacists

135. In recent years the Pharmacy Board of Australia[88] introduced new requirements for intern pharmacists to obtain full registration as a pharmacist.

136. These new requirements increased the training prerequisites intern pharmacists must complete before they can gain full registration as a pharmacist.

137. In 1998 the only requirement for an intern pharmacist to gain full registration as a pharmacist was for them to have completed 1824 hours of supervised practice. Now intern pharmacists have, in addition to completing 1824 hours of supervised practice, been required to undertake further study conducted by an approved provider and to

[87] The various national and state and territory legislation governing the operation of pharmacy require that pharmacists must be currently registered as pharmacists in order to practice as pharmacists.
[88] The Pharmacy Board of Australia is the authority responsible for registering pharmacists, developing standards and codes of practice, handling and investigating complaints and for approving accreditation standards. They are a wing of the Australian Health Practitioner Regulation Agency (AHPRA) and are governed by the Health Practitioner Regulation law from each of the states and territories

undertake an oral examination and a written examination conducted by the Pharmacy Board of Australia.

Introduction of Compulsory Professional Development as Registration Requirement

138. When Pharmacists registration was referred from the states to the Federal Government it became the responsibility of the national Pharmacy Board of Australia. When the national Pharmacy Board was created in 2010 one of its first tasks was to develop new registration standards for pharmacists. As part of this process the requirement for pharmacists to have completed the required amount of Compulsory Professional Development (CPD) in order to retain their registration as pharmacists.

139. Since this requirement was introduced the accredited CPD options pharmacists can undertake has been varied and increased to include options to undertake new training that was not available when CPD was first introduced. For example, when CPD was first introduced there were no options to undertake training in inoculations, Home Medicines Reviews, Medschecks, Medical Certificates and the like as there are now.

Introduction and Changes in Competency Standards

140. In 1999 various pharmacy organisations including the Pharmaceutical Society of Australia (***PSA***) [the professional association], the Pharmacy Guild of Australia [the employer association] and APESMA [the union representing pharmacists] reached agreement on the first set of national competency standards for pharmacists. These competency standards covered in detail the safe dispensing of medicine requirements of pharmacists and a number of other 'technical' aspects of the work done by pharmacists but they did not cover any of the cognitive and other professional services pharmacists now provide to patients. For example there were no competency standards for conducting inoculations, signing medical certificates, undertaking Home Medicines Reviews and Medschecks and the like.

141. Until 2010 undertaking CPD was voluntary in most states. It wasn't until the creation of the national Pharmacy Board of Australia that undertaking CPD became a mandatory requirement to remain registered as a pharmacist.

142. The most recent version of the Competency Standards for pharmacists was recently released and they contain significantly changed standards from those released in 1999. These competency standards now contain standards for inoculations, medical certificates, Home Medicine Reviews and the like. They also place an emphasis on the role of the pharmacist in educating and counselling patients which was not emphasised in the 1999 version of the Pharmacist Competency Standards.

Changes In Government Policy

143. There have been several changes in the federal Government National medicines and health policies that have had a major impact on the work done by pharmacists. These changes include:

Quality Use of Medicines (QUM)

144. In December 1999, the federal government introduced the QUM into the National Medicines Policy. This change has had the most significant impact on the changes to the work done by pharmacists than anything else[89].

145. QUM is one of the central objectives of Australia's National Medicines Policy[90] and it requires pharmacists, doctors and other medical professionals to:

- Select management options wisely;
- Choose suitable medicines if a medicine is considered necessary; and
- Use medicines safely and effectively.

146. QUM, along with the whole of the National Medicines Policy is aimed at ensuring better health outcomes for all Australians, focusing especially on people's access to, and wise use of, medicines.

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[89] http://www.ebay.com.au/?ul_ref=http%253A%252F%252Frover.ebay.com%252Frover%252F1%252F705-142447-44013-1%252F4%253Fnull%2526srcrot%253D705-142447-44013-1%2526rvr_id%253D1113753326536
http://www.ebay.com.au/?ul_ref=http%253A%252F%252Frover.ebay.com%252Frover%252F1%252F705-142447-44013-1%252F4%253Fnull%2526srcrot%253D705-142447-44013-1%2526rvr_id%253D1113753326536

[90] http://www.health.gov.au/internet/main/publishing.nsf/Content/B2FFBF72029EEAC8CA257BF0001BAF3F/$File/NMP2000.pdf

147. The definition of QUM applies equally to decisions about medicine use by individuals and decisions that affect the health of the population. The term 'medicine' includes prescription, non-prescription and complementary medicines. The goal of the National Strategy for QUM is to make the best possible use of medicines to improve health outcomes for all Australians.

148. The QUM appears as follows in the National Medicines Policy as follows:

> *The partners recognise that Australia has an established and well accepted national policy on the quality use of medicines.*
>
> *The partners consider that all medicines should be used:*
>
> - *judiciously - medicines, whether prescribed, recommended, and/or self-selected should be used only when appropriate, with non-medicinal alternatives considered as needed;*
> - *appropriately - choosing the most appropriate medicine, taking into account factors such as the clinical condition being treated, the potential risks and benefits of treatment, dosage, length of treatment, and cost;*
> - *safely - misuse, including overuse and underuse, should be minimised; and*
> - *efficaciously - the medicines must achieve the goals of therapy by delivering beneficial changes in actual health outcomes.*
>
> *To achieve quality use of medicines, people must be provided with the most appropriate treatment, and have the knowledge and skills to use medicines to their best effect. Health practitioners have a particularly important role to play in promoting the quality use of medicines, through good treatment choices, good communication with consumers, collaboration with other health practitioners, including across professional boundaries, the development and implementation of models of best practice, and maximising professional roles to provide optimal contribution from the various health practitioners.*
>
> *To achieve optimum use of medicines:*
>
> - *consumers and health practitioners should have timely access to accurate information and education about medicines and their use;*
> - *public health and health education programs, and other programs relating to quality use of medicines (eg development and implementation of guidelines, implementation of schemes for the disposal of unwanted medicines) should be coordinated between the Commonwealth Government and State/Territory Governments as well as others in this partnership;*
> - *industry and health practitioners should contribute through appropriate information, education and promotion activities; and*

- *issues relating to use of medicines should be reported accurately and responsibly by the media.*

Quality use of medicines depends on committed teamwork between all members of the partnership on behalf of the Australian community. It follows that all members must be committed to ensuring exchange of relevant information between involved groups and members of the community to ensure they are able to make informed decisions.[91]

149. QUM requires pharmacists and other medical health practitioners when managing medical conditions to, amongst other things, identify and implement:

- Methods to select and communicate the most appropriate medicine or non-medicine option from all available prevention and treatment options, so that the individual gains optimal, cost effective health outcomes; and

- Methods to monitor the outcome of the selected treatment option, to allow rapid modification according to response, so that optimal health outcomes are maintained over time.

150. QUM also requires:

- Pharmacists and other health practitioners to provide patients/consumers with information and counselling to promote quality use of medicines;

- Health educators, to promote these ideas in public education programs;

- Pharmacists and other Health practitioners, to educate their peers and the adoption of appropriate standards and models of practice;

- Regulatory agencies, to encourage use of modern communication principles in provision of Consumer Medicine Information, label information, etc.;

- Industry, by ensuring truthful, balanced and understandable information is provided to health practitioners and consumers about medicines;

[91]http://www.health.gov.au/internet/main/publishing.nsf/Content/B2FFBF72029EEAC8CA257BF0001BAF3F/$File/NMP2000.pdf

- Media, in relation to the responsible reporting of medicines issues;
- Patients/Consumers, by taking responsibility for good health outcomes;
- Government, by coordinating and funding efforts to promote quality use of medicines, including public information campaigns.

151. The introduction of QUM into the National Medicines Policy has had a major impact on the work done by pharmacists. This can be seen through the various Community Pharmacy Agreements between the PGA and the federal government[92] These Agreements document many of the new initiatives introduced in response to QUM that have been introduced into pharmacies and the work done by pharmacists,

152. The Initiatives implemented as a response to the introduction of QUM, known as cognitive services, were previously the sole domain of medical practitioners. These initiatives include initiatives such as Home Medicines Reviews (HMR), Residential Medication Management Reviews (RMMR), Medschecks, asthma management, diabetes management etc. They were previously not part of the pharmacist's role in the supply of medications to consumers as they are now.

153. The introduction of these initiatives in response to QUM has resulted in the increased requirement for pharmacists to educate and counsel patients on the safe and correct use of medicines. This change has now become a significant component of the work done by pharmacists. Educating and counselling patients on the safe use of medicines was previously the sole domain of medical practitioners,

Down Scheduling and other pharmacist only medicines

154. Since 1998 the federal government has removed many medicines from the prescription only category to the pharmacist only category. Medicines that no longer require a prescription are known pharmacist only medicines. These medicines include medicines such as Chloramphenicol eye drops (for bacterial conjunctivitis), emergency contraception and higher-strength codeine-containing combination analgesics, Ventolin and the like no longer require a prescription and they are now pharmacist only medicines. These medicines can only be supplied by a registered pharmacist. They are not available in supermarkets and the like and a pharmacist must be directly involved in the supply of these medicines.

155. These changes have had the impact of requiring pharmacists to now diagnose minor illnesses to ensure that the patient requesting the medicines actually needs them and to then determine the appropriate medicine for their illness. Prior to dispensing a pharmacist only medicine pharmacists also need to determine if dispensing a suitable pharmacist only medicine is appropriate or if the patient needs to be referred to a medical practitioner for a diagnosis.

156. The number and variety of pharmacist only medicines have increased significantly since 1998. For example, Gauld et al (2012)[93] reported 33 medicines were switched by authorities in Australia between 2000 and 2011.

157. This has increased the responsibility of the pharmacist to correctly diagnose a patient's illness; determine the appropriate course of action; determine if the patient needs to attend a medical practitioner; determine if the patient requires any medicines at all and if so to then to dispense the appropriate pharmacist only and/or complementary medicines for the illness presented. The pharmacist is also required to counsel the patient regarding their illness and to educate them on the appropriate use of the medicine they are dispensing.

158. Some pharmacist only medicines such as pseudoephedrine and codeine based medicines can be abused by some patients. Various state governments have introduced

[93] Natalie Gauld, Fiona Kelly, Lynne Bremmerton, Linda Bryant, Stephen Beutow. Innovations from 'Down Under'; A focus on prescription to non-prescription medicine reclassification in New Zealand and Australia. SelfCare 2012;3(5):88-107

regulations requiring pharmacists to record who they dispensed these medicines to and for them to refuse to dispense these medicines if the pharmacist believes that the parent requesting them is abusing these medicines. For example, pseudoephedrine, can be used by people to make amphetamine that is then sold illegally. Pharmacists are required to refuse the sale of these medicines to people they believe may be using these drugs for illegal purposes. If a pharmacist dispenses these medicines to people, they know or suspect are using them for illegal purposes the pharmacist can be deregistered and charged and found guilty of a criminal offence. It is not unheard of for pharmacists found guilty of dispensing these medicines to people who are using them for illegal purposes to be jailed for a period of time. These additional requirements via the Pharmacy Guild of Australia run "Project Stop" that have been imposed on pharmacists, while in the best interests of the community and endorsed by the Pharmacy Board of Australia [3] in their Guidelines for Practice Specific Issues, have placed an additional burden and skill requirement on pharmacists. Pharmacists now require skills of what could be considered as cross-examination etc. to determine if the person requesting these medicines is actually requesting them because of a need or if they are seeking the medicines for inappropriate reasons. If the pharmacist determines that the patient is abusing one of these pharmacist only medicines they are required to refer the person to appropriate counselling.

Introduction of Generic Medicines

159. To assist with slowing down the increase in the cost of Pharmaceutical Benefits Scheme (PBS) the federal government introduced generic medicines into the NPS. In April 2012, the federal government introduced Price Disclosure in an attempt to reign in the cost of the PBS and this resulted in pharmacies increased use of generic medicines. Price disclosure requires pharmaceutical companies to tell the Government the actual price at which medicines are supplied to pharmacies. So instead of subsidising generic medicines based on the labelled prices, the Government reimburses pharmacies the discounted wholesale price that pharmacies are actually paying for buying medicines in bulk. This initiative has encouraged pharmacies to place a heavier reliance on the use of generic medicines in order to keep their costs down.

[3] http://www.pharmacyboard.gov.au/Codes-Guidelines.aspx

160. With the large number of generic-producing manufacturers and the continual ignorance of the guidelines to produce generic products without brand names, there has also been an increase in risk of dispensing errors and drug misadventure by patients, with pharmacists being burdened with the responsibility of reducing risk by ensuring accuracy and compliance. Risk management of generics has added a complicated layer to dispensing in all areas.

161. The federal government decision to allow generic medicines to be available under the PBS has increased the number of medicines registered under the NPS by around half. The number of medicines registered under the PBS has increased from around 1,000 in 1998 to around 3,500 at the start of 2016. This increase is significantly attributable to the introduction of generic medicines.

New Work Done by Pharmacists

162. There are many new functions that pharmacists perform since their work value was last assessed in 1998. These functions all require additional skills and result in increased responsibility. These new functions are:

Home Medicines Reviews (HMR)

163. An HMR accredited pharmacist undertakes an HMR upon a referral from a medical practitioner. The pharmacist usually conducts the review in the patient's home and then writes a report to go back to the medical practitioner. In conducting these reviews the pharmacist reviews what prescription, non-prescription and complementary medicines, including vitamins, a patient is taking and makes recommendations for the pharmacist or their medical practitioner to discuss with the patient which may include:

- showing the patient how to take their medicines correctly
- explaining why and when to take them
- explaining where they should be stored
- what to expect when taking them
- what problems they should report to their medical practitioner

- checking that prescription medicines, over-the-counter medicines and vitamins are appropriate to take together
- clarifying any confusion with generic medicines
- giving the patient some help so they can remember to take their medicines
- changing a patient's medicines.

164. HMRs were introduced as part of the 3rd Community Pharmacy Agreement which commenced in July 2001 as a response to the large number of people being hospitalized because of medicines mismanagement. Each year more than 140,000 Australians are hospitalized with problems caused by their medicine. It has been shown that in up to 69% of these cases the problem can be avoided. Older people are particularly at risk

165. To undertake this function a pharmacist must be the holder of the higher Accredited Pharmacist qualification.

Residential Medication Management Reviews (RMMR)

166. A RMMR is like an HMR except it is provided to a permanent resident of an Australian Government-funded aged care facility. It also can only be conducted by an accredited pharmacist when requested by a resident's medical practitioner and undertaken in collaboration with appropriate members of the resident's healthcare team. A comprehensive assessment is undertaken to identify, resolve and prevent medication related problems and is provided to the resident's medical practitioner.

167. This service, like that for HMRs, was introduced as part of the 3rd Community Pharmacy Agreement which commenced in July 2001 and is also aimed at reducing medical mismanagement related hospital admissions.

MedsChecks and Diabetes Medschecks (Medicines Use Review)

168. MedsCheck and Diabetes Medscheck are new programs introduced to community pharmacies under the 5th Community Pharmacy Agreement which commenced operation in 2010. These services involve a structured in-pharmacy review of a patient's medicines by a pharmacist, with a focus on education and self-management.

The MedsCheck and Diabetes Medscheck services must take place in a private consultation area of a community pharmacy and should take approximately 30 minutes to complete. This service, which commenced in July 2012 aims to:

- help patients learn more about their medicines including how medicines affect medical conditions;
- identify problems that a patient may be experiencing with their medicines;
- improve the quality use of medicines by patients; and
- educate patients about how to best use and store their medicines.

169. A pharmacist who conducts Medschecks and Diabetes Medschecks must be appropriately trained in how to undertake these services. The PSA recommends that pharmacists who undertake these services should have obtained additional competencies in Fundamental Pharmacy Practice, Counselling and in Medication Review. Their guidelines for Pharmacists providing these services outlines these recommendations[94]

Dose Administration Aids

170. A Dose Administration Aid is an adherence device developed to assist medication management for a consumer by having medicines divided into individual doses and arranged according to the dose schedule throughout the day. It can either be a unit dose (one single type of medicine per compartment) or multi-dose pack (different types for medicines per compartment).

171. Since the introduction of the 5th Community Pharmacy Agreement in July 2010 pharmacists have formally provided Dose Administration Aids to patients to assist patients to better manage their medicines, with the objective of avoiding medication misadventure and improving medication compliance. This service is provided by pharmacists to patients with sight or other issues with managing their own medicines. This service is most often used by elderly patients or patients with impaired sight.

172. This service requires the pharmacist to pack the patient's medicines into a specially provide bag. This bag divides up into pockets for the times of the day and days when

[94] http://www.psa.org.au/downloads/ent/uploads/filebase/guidelines/3612-medscheck-guidelines-c.pdf

medicines must be taken. When preparing these packs, the pharmacist must ensure that each medicine is correctly included in the appropriate pouches. If this is not done the result can be a medical misadventure including admission to hospital or even worse. When preparing these packs, the pharmacist becomes liable for any errors.

Diabetes Management

173. The National Diabetes Services Scheme (NDSS) is an initiative of the Australian Government which has been administered by Diabetes Australia through registered pharmacies.

174. The aim of the NDSS is to enhance the capacity of over one million Australians with type 1, type 2, gestational and other diabetes to understand and manage their life with diabetes. The NDSS aims to ensure people have timely, reliable and affordable access to the supplies and services they require to effectively self-manage their diabetes.

175. In order to manage the heath of patients who have diabetes pharmacists must have additional knowledge and skills in management of diabetes. This is usually undertaken by completing an appropriate course undertaken by an accredited training organisation.

176. The pharmacist's role is to provide patients with the equipment and medicines they need to manage their medicines as well as educating and counselling them on initiatives they can take that may reduce or eliminate their diabetes. Such methods could include counselling and educating them on how to eat healthier food; to reduce weight and to become more active.

Asthma Management

177. Like the NDSS pharmacies have also been charged with providing asthma management services to patients with asthma. The aim of this initiative, which was formally implemented in 1999, is to educate patients on the proper use of their inhaler device and to assist them to develop an asthma management plan,

178. To provide this service pharmacists must obtain specialised training in the disease and how to treat it so they can provide this service. This training usually takes the form of a course provided by an accredited training organisation.

Clinical Interventions

179. A Clinical Intervention is a professional activity undertaken by a pharmacist directed towards improving quality use of medicines and resulting in a recommendation for a change in the patient's medication therapy, means of administration or medication taking behaviour. It is the process of a pharmacist identifying, and making a recommendation, usually to the patient's medical practitioner, to prevent or resolve a drug-related problem. The pharmacist recommendation may be for a change in the patient's medication therapy, means of administration or medication-taking behaviour.

180. To undertake this important service, which was introduced as part of the 5th Community Pharmacy Agreement in 2010, a pharmacist must have undertaken relevant training in the quality provision of clinical interventions. The Pharmaceutical Society of Australia's Guidelines on Clinical Interventions detail the training requirement required to undertake this service[95]

Staged Supply of Medicines

181. In some cases it may be worthwhile for consumers to collect their medicines in stages rather than all at once. Under this federal government Department of Health program, pharmacists are encouraged to dispense PBS medicines in instalments, this may be daily, weekly, fortnightly. A request for staged supply of medicines is usually provided by a doctor, but can be initiated by the patient. It may assist patients with mental illness, drug addiction or who are otherwise unable to manage medications safely.

182. In providing this service which was also introduced as part of the 5th Community Pharmacy Agreement in 2010 pharmacists should have obtained additional skills in:

- building knowledge about mental illness;
- building knowledge about drug dependency and drug seeking behaviours;
- improving skills for interacting with and responding to the
- therapeutic concerns of clients; and enhancing understanding of, and responsiveness to, the needs of clients of the service.

[95] http://www.psa.org.au/downloads/practice-guidelines/pharmacists-performing-clinical-interventions-guideline.pdf

- The PSA's Guidelines for Pharmacists Providing a Staged Supply service outlines these skill requirements.[96]

Certificates for Absence from Work

183. Since the Fair Work Act 2009 came into force pharmacists have been able to sign certificates for absence from work for people who are unable to attend work because of personal illness or because they have to care for a family member with an illness. They are only able to sign a certificate within an area of practice they are registered for.

184. Pharmacists who undertake this service must also undertake a detailed consultation with the patient to determine the nature of their illness and if and how long they will be unable to attend work

185. Because of these limitations, pharmacists will need to carefully consider whether the illness or injury that is the subject of the certificate is within their recognised area of practice. Before signing a certificate, pharmacists must also determine if the illness of the patient requires them to see a medical practitioner. If so, they must not sign the certificate and they must refer the patient to a medical practitioner.

186. Pharmacists are subject to professional discipline and can be deregistered for issuing false, back dated or negligent certificates.

187. The Pharmaceutical Society of Australia's Guidelines on the signing of certificates for absence from work outlines the responsibilities of a pharmacist when providing this service.[97]

188. In order to undertake this service pharmacists must have extensive counselling skills and they should have undertaken additional training in counselling in order to undertake this service.

[96] http://www.psa.org.au/downloads/practice-guidelines/staged-supply-guideline.pdf
[97] http://www.psa.org.au/download/ent/uploads/filebase/guidelines/joint-psa-guild-guidelines-on-absence-certificates.pdf

Inoculations

189. In December 2013 the Pharmacy Board of Australia announced that pharmacists have been authorised to undertake vaccinations if they have obtained suitable additional training to enable them to do so. Since then each of the states has enacted legislation enabling pharmacists to undertake this service to the community.

190. To undertake this service pharmacists must:

- have completed a further approved course of study and maintained authority to immunise. Example of such a course of study is the PSA's course on Immunisation or the Pharmacy Guild's course on Vaccinations.
- hold a current statement of proficiency in cardiopulmonary resuscitation (CPR) and first aid including anaphylaxis training
- is permitted under State or Territory legislation to administer vaccines [98]

191. A pharmacist that signs a medical certificate must keep a record of the certificate they signed and sufficient details of the reasons why they signed the certificate in case there is follow up from an employer or from an industrial tribunal or the like.

192. In addition to having undertaken an approved course and holding a current certificate in CPR a pharmacist should have completed additional training in counselling in order to undertake this service.

Increased Use of Complimentary Medicines and Vitamins

193. In recent years, the usage and range of complimentary medicines and vitamins has increased significantly.

194. This increase in use and range has resulted in pharmacists needing to have knowledge of these products and particularly how they affect various illnesses and diseases. It is also essential for pharmacists to know if these products can cause any negative effects if taken in conjunction with prescription medicines.

195. These products are also widely available through other places such as supermarkets and health stores. But, unlike supermarket and health store employees, pharmacists can be found liable for any ill effects dispensing of these medicines have on patient. They can

[98] http://www.psa.org.au/download/practice-guidelines/immunisation-guidelines.pdf

even be deregistered if they sell one of these products to a patient without educating and counselling the patient on the proper use of the product or if they sell a product to a patient that they know will have an adverse impact on them.

196. The Pharmaceutical Society of Australia and the PGA both recommend that pharmacists should receive additional training in the sale of complementary medicines if this was not covered in their undergraduate degrees.

More Complex Work Environment

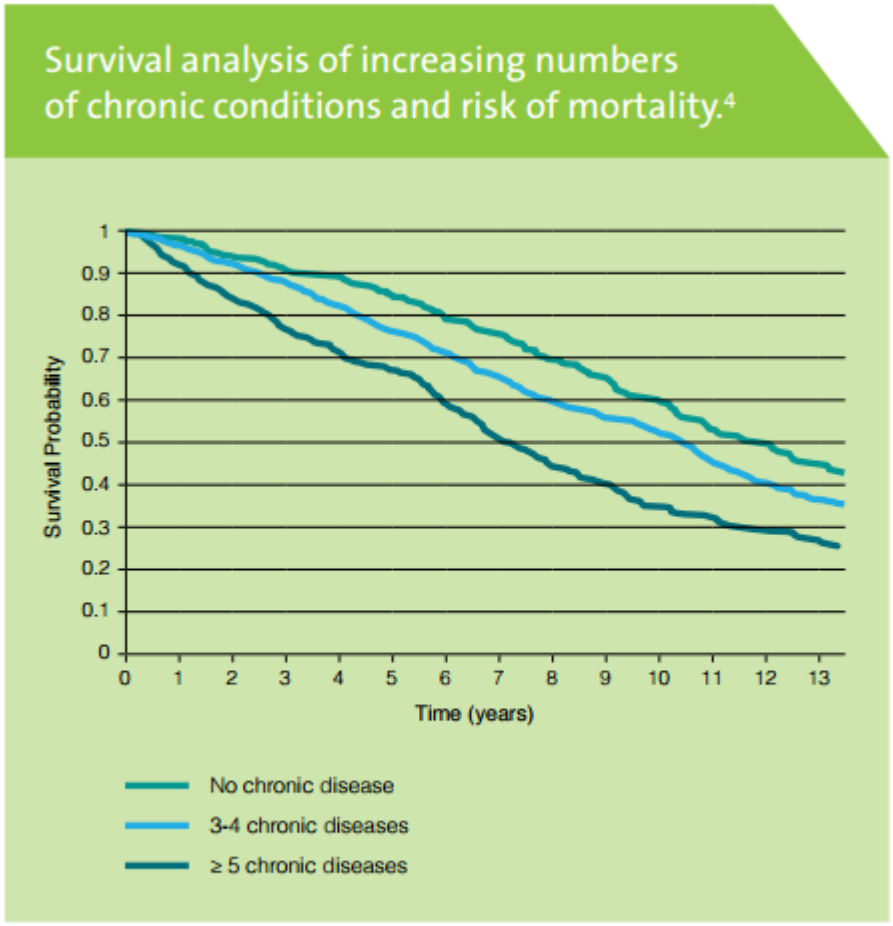
197. Chronic Diseases

198. Chronic diseases have a range of potential impacts on a person's individual circumstances, including quality of life and broader social and economic effects. Chronic diseases are the leading causes of fatal burden of disease (the amount of life lost due to people dying early) in most age and sex groups and are the leading cause of illness, disability and death in Australia, accounting for 90% of all deaths in 2011.

199. The term chronic disease applies to a group of diseases that tend to be long lasting and have persistent effects. Common chronic diseases include arthritis, asthma, back problems, cancer, chronic obstructive pulmonary disease, cardiovascular disease, diabetes and mental health conditions. Around 46% of Australians have at least one of these chronic diseases, and nearly 4 in 10 Australians (39%) aged 45 and over have at least 2 of the 8 selected chronic diseases. Comorbidity becomes more common as people get older. Some combinations of comorbidity have particularly high impacts on the complexity of clinical management and health service use. For example, people hospitalised with both cardiovascular disease and chronic kidney disease record an average length of stay of 10.8 days, compared with 5.4 days for people hospitalised with cardiovascular disease only and 4.9 days for people hospitalised with chronic kidney disease only[99]. The following figure[100] describes the effect of increased

[99] Australian Institute of Health and Welfare. Chronic disease comorbidity. http://www.aihw.gov.au/chronic-diseases/comorbidity/ [cited 3rd May 2016]
[100] Multiple chronic health conditions in older people: Implications for health policy planning, practitioners and patients. University of SA, The University of Adelaide, Flinders University; May 2013. https://www.unisa.edu.au/Global/Health/Sansom/Documents/QUMPRC/Multiple-Chronic-Health-Conditions.pdf [Cited 3rd May, 2016]

comorbidities on longevity.



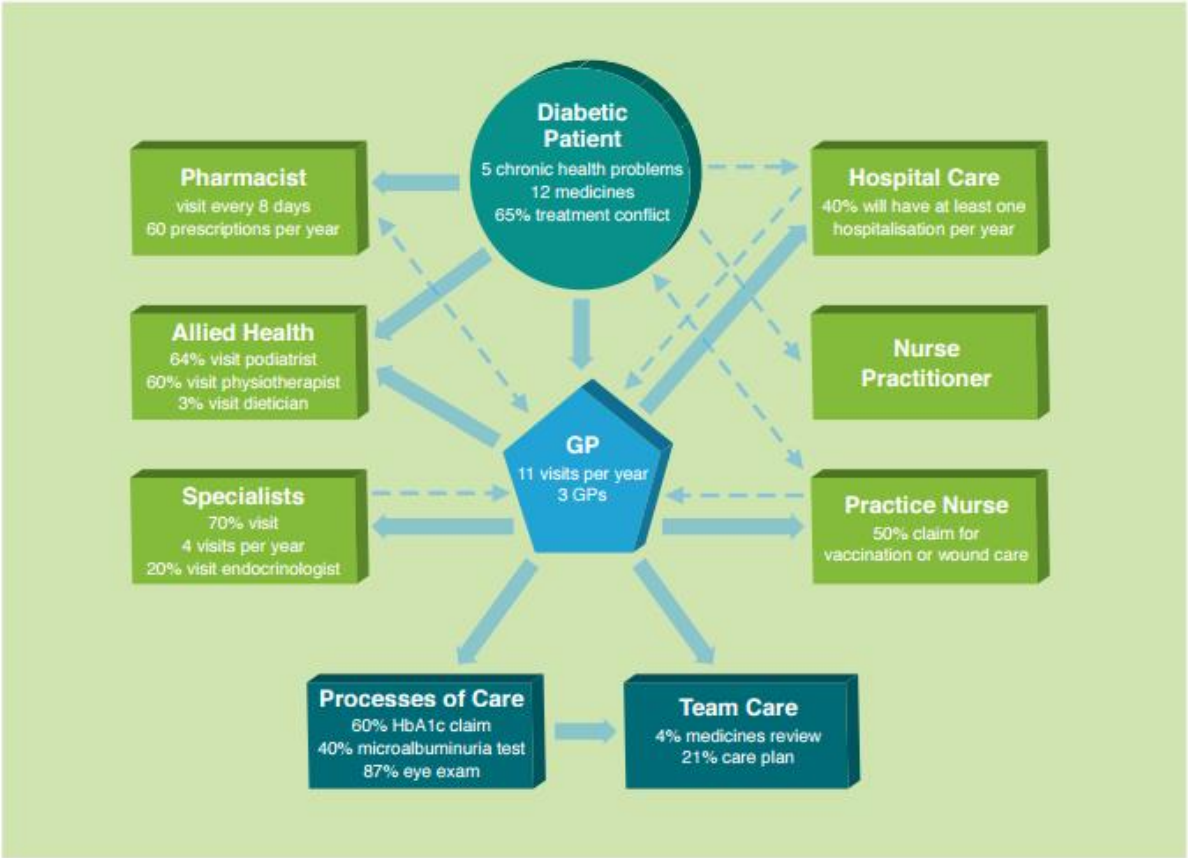
Adapted from Journal of Epidemiology and Community Health, 2010;64(12):1036-42 with permission of BMJ Publishing Group Ltd.[4]
Data source: Australian Longitudinal Study of Ageing.

200. People living with multiple chronic conditions report more difficulties with daily activities of living, hospitalisations, psychological distress and death[101].

201. The following diagram [102]provides insight into the complexity of managing a person with multiple comorbidities.

[101] Marengoni et al. Ageing with multimorbidity: A systematic review of the literature. Ageing Res Rev 2011;10(4):430-9

[102] Multiple chronic health conditions in older people: Implications for health policy planning, practitioners and patients. University of SA, The University of Adelaide, Flinders University; May 2013. https://www.unisa.edu.au/Global/Health/Sansom/Documents/QUMPRC/Multiple-Chronic-Health-Conditions.pdf [Cited 3rd May, 2016]



Adapted from Aging Health, 2011;7(5):695-705 with permission of Future Medicine Ltd.[5]
Data source: Department of Veterans' Affairs health administrative database.

202. This highlights the complexity of multiple comorbidities. They are high users of the health system. They will see a doctor every month and a pharmacist every eight days. Most will visit a specialist up to five times a year, most will claim about 11 pathology services per year, and around 5 radiologist services per year. A majority will see allied health professionals and around 40% will be hospitalised within the year. Half of all patients with multiple comorbidities will have conditions that will result in a treatment conflict and make management difficult. In the "Diabetic Patient" circle, note that there is on average 5 co-morbidities, consumption of 12 medicines and 65% treatment conflict. This latter term relates to the situation where the management options chosen to treat a particular condition will conflict with the management principles of other co-existing conditions. Disease management guidelines currently do not address condition conflicts. An example of condition conflict is provided in the following table

Risk Population	Prevalence	Treatment Conflict	Reason for Treatment Conflict
Diabetes			
Diabetes and Arthritis	20-50%	NSAIDs	Impair renal function, increase fluid retention and may exacerbate hypertension.[79]
Diabetes and COPD	20%	Corticosteroids	Can increase blood glucose potentially increasing risk of hyperglycaemia[80] but are part of treatment recommendations for chronic airways disease.[81]
		ß-blockers	Can increase blood glucose potentially increasing risk of hyperglycaemia[80] but are part of treatment recommendations for chronic airways disease.[81]
Diabetes and Gout	13%	NSAIDs Corticosteroids	Both NSAIDs and corticosteroids can increase blood glucose potentially increasing risk of hyperglycaemia[80] but are part of treatment recommendations for gout.
Diabetes and Inflammatory diseases (ie RA, psoriasis)	5-10%	Corticosteroids	Can increase blood glucose potentially increasing risk of hyperglycaemia.[80]
Diabetes and Heart Failure	20%	Thiazolidinediones	Increased fluid retention and expansion of plasma volume leading to peripheral and pulmonary oedema.[82]
		NSAIDs	Increased risk of fluid retention with both NSAIDs and thiazolidinediones in an already at risk population.

Explanatory notes

Risk population relates to the interaction for diabetes and a second disease. Treatment conflict relates to the medicine that is the cause of the problem which is then explained in the last column.

COPD = Chronic obstructive pulmonary disease

NSAID = non steroidal anti-inflammatory drug (examples include Voltaren, Nurofen)

Corticosteroids – class of drugs that include cortisone, prednisolone

Hyperglycaemia = high, uncontrolled blood glucose ("sugar") levels which will worsen diabetes and the long term effects of poorly controlled diabetes (blindness, loss of sexual function, loss of lower limbs due to gangrene etc)

RA = rheumatoid arthritis

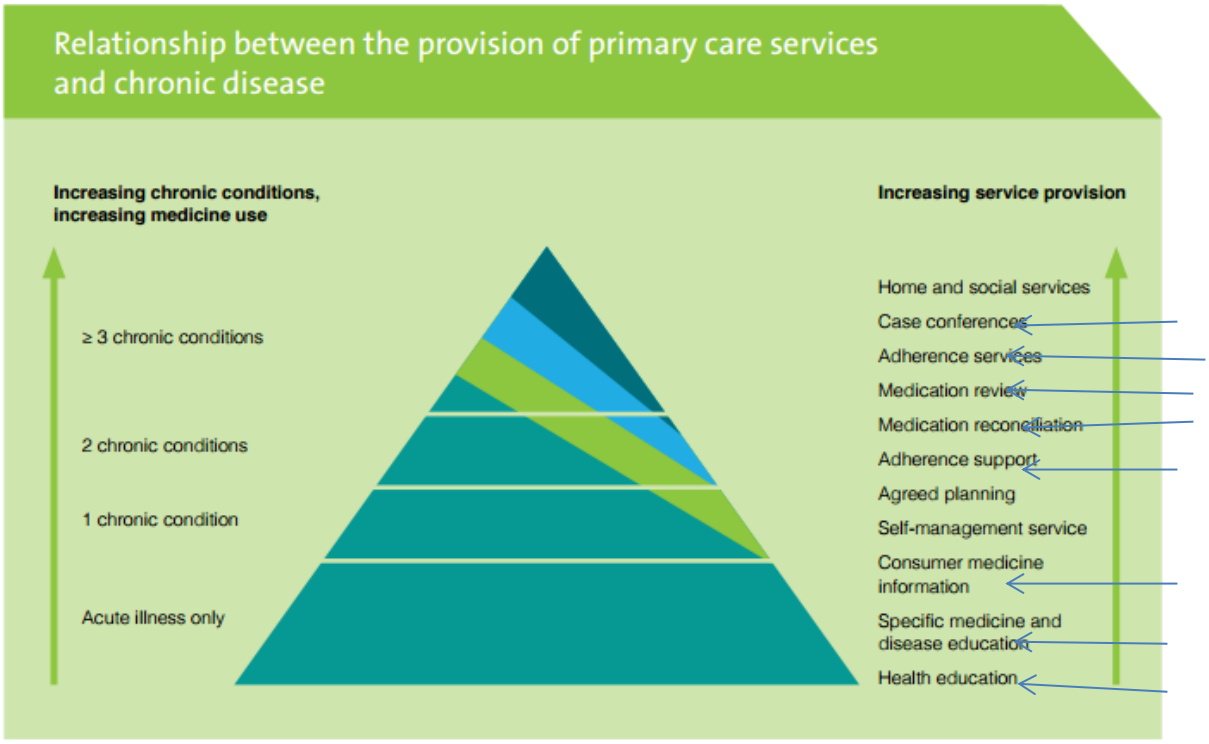
Oedema = fluid retention which is a bad outcome for someone with heart failure where the heart is damaged to such an extent it has trouble pumping blood throughout the body. Increased fluid retention damages the heart even more.

203. This practice of multidisciplinary patient centred care encompasses the many providers, the many diseases, the many medicines, the many non-pharmaceutical treatments and the many preferences involved in achieving holistic care for people living with multiple chronic health conditions.

204. The figure below[103] described in part the services that a pharmacist can provide to the care of such complex cases (indicated by the blue arrows). As can be seen, the

[103] Multiple chronic health conditions in older people: Implications for health policy planning, practitioners and patients. *ibid*

pharmacist is no longer just a supplier of medicines; this is seen as a given, but in light of increasing number of chronic medical conditions and increasing number of medicines used to manage these conditions, there is the need to assist people to get the best out of their medicines and to manage these conditions effectively. Pharmacists have a role in most of the services that are required to ensure people do achieve their health goals as indicated by the blue arrow. These services require of a pharmacist a specific set of clinical knowledge and skills that were not used back in 1998 In 1998, there was no expectation for a pharmacist to be involved at this level; consequently there was no provision for pharmacists to be involved in or provide such services, there was no training available, there were no standards of practice devised and consequently there was no remuneration allocated to pharmacists for the provision of such services..



Adapted from Aging Health, 2011;7(5):695-705 with permission of Future Medicine Ltd.[5]

205. Such an approach relies on social pharmacy skills (communication skills, inter-professional collaboration, understanding behaviour, understanding psycho-social attributes) as well as clinical skills. As outlined previously, the pharmacy curriculum has changed to accommodate the new skills set required for a multidisciplinary patient centred approach. Further, the evolution of standards of practice, competency standards

and Pharmacy Board guidelines and requirements reinforce the skills changes of pharmacists in primary care since 1998.

Introduction of Generic Medicines

206. The introduction of generic medicines and Price Disclosure have resulted in increased complexity and difficulty for pharmacists. These initiatives were progressively introduced between 2005 and 2015. A pharmacy now often carries the original of a medicine and at least one generic of the same medicines. They often carry multiple generics of the more frequently used medicines. Usually these medicines are often in very similar packages and at very differing prices which can make selection difficult. Explaining the options to purchase different versions of the same medicines can make the process of explaining and dispensing a prescription medicine to a patient more difficult than it was when there was only one option of a medicine available. Pharmacists must also explain to their patients the federal government's generics policy and how it impacts on the NPS and the patient. They must also explain to the pharmacist how these medicines may affect them and the impact and cost difference they may have on the patent.

207. Pharmacists often work in more than one pharmacy and the pharmacies they work in usually stock different versions of the same medicines. This makes their job of ensuring that they don't make a dispensing error even more difficult.

Quality Care Pharmacy Program

208. The Pharmacy Guild of Australia's Quality Care Pharmacy Program (QCPP) is a quality assurance program for community pharmacy, and provides support and guidance on professional health services and pharmacy business operations. It was implemented in 2000 and aims to ensure that community pharmacies provide quality professional services and customer care and is in operation in a large number of community pharmacies. It has been operating for 15 years.

209. Pharmacy staff, including pharmacists, employed in QCPP accredited pharmacies, who supply Pharmacy Medicines and Pharmacist Only Medicines, must complete:

- Mandatory initial training via a Recognised Course in the supply of these products.
- Ongoing Refresher Training: at least three hours per year.
- Ensuring all staff undergo regular training as listed above
- Ensure appropriate policies and procedures are in place and that they are being followed correctly
- Ensuring there is evidence that the pharmacy in practicing according to QCPP standards
- Ensuring the pharmacy is prepared for re-assessment every 2 years

210. Many pharmacists, particularly Pharmacy Mangers have responsibility for ensuring that their pharmacy meets all the requirements to gain and retain their QCCP registration. This has added significant work requirements to those who have responsibility for ensuring their pharmacy meets all the QCCP registration requirements. Examples of work that now has to be done in order to meet QCCP requirements are:

- Reviewing each individual standard, procedure, template etc contained in the QCPP standards and adapting them to the specific practice of that pharmacy,
- Ongoing monitoring of fridge temperatures, incident reports, equipment maintenance, daily/monthly checks of the pharmacy premises.

Forward Pharmacy Model of Practice

211. Prior to 1998 almost all community pharmacies adopted the traditional model of practice where the pharmacist's role was to dispense and safely store medicines. The pharmacist very rarely had any interaction with patients. Since the introduction of QUM and a variety of other initiatives almost all pharmacies have adopted what is known as the Forward Pharmacy Model of Practice which takes the pharmacist from behind the counter to being the main point of contact with patients.[104]

[104] https://www.guild.org.au/nsw_branch/professional-services/quality-care-pharmacy-program

212. This change in practice has along with all of the other changes outlined in this submission has significantly changed the role of the pharmacist from someone who is responsible for dispensing medicines and safely storing them had little or no contact with patients to a professional who still dispenses and ensures that medicines are safely stored but who also provides a wide range of health services and who's role also encompasses education and counselling patients on the proper use of medicines.

213. These changes have resulted in pharmacists now requiring additional communication, counselling, and dealing with customer skills that were not previously required of them.

Workloads

214. With the significant increase in the number of duties undertaken by pharmacists and the increase in the number and variety of medicines dispensed by pharmacists the roles of a pharmacist has become increasingly complex and difficult. Some of these new and increased roles and responsibilities are outlined in this submission.

215. There has also been a significant increase in the number of PBS prescriptions dispensed within community pharmacies since 1998 without a commensurate increase in the number of pharmacies. The PBS statistics on the expenditure and number of prescription dispensed under the PBS[105] show that there has been a 68% increase in the number of PBS medicines dispensed since 1998 and only a 8.4%[106] increase in the number of registered community pharmacies in approximately the same period of time.

216. The PBS indicates that over the last 10 to 15 years, the cost of the PBS grew by nearly 13 per cent each year[107]. According to them the increased cost relates to several factors, including newly-developed expensive medicines, new medicines, over prescribing, an ageing population and increased patient awareness and expectations.

217. The increase in the number and usage of medicines; the ageing of the Australian population and the consequential increase in the number of patients taking multiple medicines; the increase in the number and variety of services provided by pharmacists

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[105] https://www.pbs.gov.au/info/browse/statistics#Expenditure (
[106] Figures obtained from Pharmacy Guild of Australia submissions to various Productivity Commission inquiries (e.g. the Competition Policy Review – Report published March 2015)
[107] http://www.pbs.gov.au/info/about-the-pbs

without a consequential increase in the number of community pharmacies has all contributed to an increasing workload and complexity of work for pharmacists. The knowledge and skills now required of pharmacists has increased significantly since 1998 mainly because of the new work done by pharmacists. The introduction of QUM and Forward Pharmacy model of practice which has been adopted in all pharmacies has resulted in pharmacists now needing highly developed skills in education and counselling which were not requirements in 1998.

Summary of Changes

218. The following table outlines the changes that have occurred to the work done by pharmacists since the work value of pharmacists covered by the Community Pharmacy Agreement was last considered by the commission in 1998; when these changes were introduced and the nature of the change.

Change	**When Implemented**	**Nature of Change**
Cessation of Three Year Degree	Phased out from 2000	Educational change
Introduction of Extended Undergraduate Degrees	Commenced around 2010	Educational Change
New Areas of Training in Undergraduate Degrees	Mid 2000s	Educational change, increased training included
Introduction of Accredited Pharmacist Qualification	2010	New Higher Qualification
Increased Training and Skill Requirements for Intern Pharmacists	2010	Increased Registration Standard

Introduction of CPD as registration requirement	2010	Increased Registration standard
Additions to Competency Standards	Since 1999 to present day	Indicative of new Skill Requirements
Quality Use of Medicines (QUM)	1999	New work and increased skill; increased responsibility; new additional qualifications
Down Scheduling and other pharmacist only medicines	Around 2000 and extensive additions since	Additional skills; knowledge and responsibility
Introduction of Generic Medicines	Around 2000 and extensive additions since	Additional skills; knowledge and responsibility
Home Medicines Reviews (HMR)	2001	New Work requiring additional skills and qualifications
Residential Medication Management Reviews (RMMR)	2001	New Work requiring additional skills and qualifications

MedsChecks and Diabetes Medschecks (Medicines Use Review)	2010	New Work requiring additional skills and training
Dose Administration Aids	2010	New Work requiring additional skills and training
Diabetes Management	Early 2000s	New Work requiring additional skills and training
Asthma Management	Early 2000s	New Work requiring additional skills and training
Clinical Interventions	2010	New Work requiring additional skills and training
Staged Supply of Medicines	2010	New Work requiring additional skills and training
Certificates for Absence from Work	2009	New Work requiring additional skills and training
Inoculations	2013	New Work requiring additional skills and training
Increased Use of	Evolving during period	New work and additional

Complimentary Medicines and Vitamins		skill requirements
Chronic Diseases	Evolving during period	More Complex working environment – increased skills and knowledge
Introduction of Generic Medicines / Price Disclosure	From to 2005 to present	More Complex working environment – increased skills and knowledge
Quality Care Pharmacy Program	2000	More Complex working Environment
Forward Pharmacy Model of Practice	From 2000 and various changes since	More Complex working Environment
Workloads	1999 and continuing between 1999 and the present time	More complex working Environment

EVIDENCE

219. APESMA believes that the expert and lay evidence we will lead will show that there has been such a significant change in the role of a pharmacist and in the work they do that a work value increase in the minimum wages of the pharmacist classifications contained in the Pharmacy Industry Award 2010 is warranted and that the introduction of a new classification of an Accredited Pharmacist is also warranted.

220. The evidence we will lead will include government and regulatory legislation requirements evidencing change in the work done by pharmacists; government detailing these changes; documents from the Pharmacy Board of Australia detailing changes in accreditation and registration requirements; details of changes to the Competency Standards for Pharmacists; evidence from experts on the changes to the work done by pharmacists; and evidence from pharmacists from all classifications contained in the PIA on the work they do and changes to that work.

221. Once we have led this evidence we will also provide further submissions outlining how these changes impact on the skill and work requirements for pharmacists. We will also provide submissions on how this claim meets the various requirements before a modern award may be varied.

Expert Evidence

222. Experts who will provide evidence are:

223. Professor Ines Krass, Professor of Pharmacy Practice University of Sydney

Professor Krass will provide expert evidence on the changes in community pharmacy practice and on the changes to undergraduate degrees over the last twenty years

Biographical details:

Ines Krass joined the Faculty of Pharmacy at the University of Sydney as a lecturer in 1993 and is now Professor in Pharmacy Practice. In 20 years in academia, she has built a strong national and international reputation in health services research in community pharmacy, as evidenced through her 126 refereed publications, visiting professorships, invitations to speak at national and international conferences,

contributions to subject reviews and positions within international research organisations and journal editorial boards. Professor Krass has supervised 19 higher degree students to completion of their higher degree (12 PhDs, seven Master of Pharmacy/Clinical Pharmacy students) and is currently supervising six higher degree students.

Link to further information on Professor Krass

http://sydney.edu.au/pharmacy/about/people/profiles/ines.krass.php

224. Associate Professor Parisa Aslani, Associate Professor of Pharmacy Practice, University of Sydney

Associate Professor Aslani will provide evidence on research being conducted for APESMA on changes in community pharmacy practice. This research includes a literature review and the outcome of interviews with currently practicing community pharmacists

Biographical Details:

Associate Professor Parisa Aslani's research addresses areas of fundamental significance: the design of Consumer Medicine Information (CMI); and issues that impact the Quality Use of Medicines (QUM). Associate Professor Aslani's profound long-term goal is to determine how consumers evaluate medicine information, enabling the profession to enhance patient access to, and understanding of, medicines. This is a critical step towards promoting adherence, concordance and compliance within various Australian communities. As well as being an active researcher - where research teams of which she is a member have received $2.68 million in grants - Associate Professor Aslani has supervised to completion: six doctoral, five masters by research, five masters by coursework with a research component (Master of Pharmacy) and 19 honours students (Bachelor of Pharmacy).

Link to further information on Associate Professor Aslani:

http://sydney.edu.au/pharmacy/about/people/profiles/parisa.aslani.php

225. Dr. Lance Emerson, Chief Executive Officer, Pharmaceutical Society of Australia and/or representatives of the PSA

Dr. Emerson and/or other representatives of the PSA will provide evidence on the Pharmacist Competency standards, particularly on the new additions and changes in these competency standards. Evidence will also be provided on Pharmacist Practice Notes and Guidelines particularly as to new additions and changes in these Practice Notes and Guidelines.

Organisation Details:

PSA is the peak national professional pharmacy organisation representing Australia's 29,000 pharmacists working in all sectors and across all locations.

The core business of PSA is practice improvement in pharmacy by providing continuing professional development and practice support, in order to improve the health of Australians. They are responsible for developing practice standards and procedures for the pharmacy industry and in developing and publishing competency standards in consultation with industry.

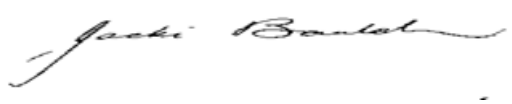
PSA provides an extensive program of education and professional development activities across Australia, including the PSA Intern Training Program.

Link to PSA Website:

https://www.psa.org.au/

Lay evidence

226. A number of pharmacists will provide evidence on the work they do and the changes and increased skill requirements to perform that work



Jacki Baulch
Senior Industrial Officer, APESMA