The Pharmacy Guild of Australia

Submission to the

Post Market Review of Products Used in the Management of Diabetes – Stage 1 Review of Blood Glucose Test Strips

November 2012

1. Terms of Reference

- Describe the utilisation and patterns of use of self-monitoring of blood glucose (SMBG) for people with type 2 diabetes
- Determine the clinical outcomes and benefits (e.g. HbA1C) of self-monitoring of blood glucose (SMBG) relative to HbA1C monitoring alone for people with type 2 diabetes not treated with insulin
- Consider the clinical criteria for eligibility for subsidised access to blood glucose test strips under the PBS and NDSS, accounting for clinical benefits offered through SMBG compared to regular HbA1C monitoring

2. Introduction

The Pharmacy Guild of Australia (the Guild) is the national peak pharmacy organisation representing community pharmacy. It strives to promote, maintain and support community pharmacies as the most appropriate primary providers of health care to the community through optimum therapeutic use of medicines, medicines management and related services. The Guild welcomes the opportunity to comment on the benefits of self-monitoring of blood glucose (SMBG) for people with type 2 diabetes not treated with insulin.

The Guild highlights that Australia's 5,200 community pharmacies operate in a highly regulated environment to provide the highest quality of care in delivering cost-effective, safely dispensed medicines under the Pharmaceutical Benefits Scheme (PBS) as well as other therapeutic goods and Quality Use of Medicines (QUM) advice. This infrastructure includes 20% of community pharmacies in rural and remote locations[1], where the rates of mortality due to diabetes are two and four times higher in remote and very remote areas[2].

The established network of over 5,000 community pharmacies in Australia provides a national, equitable-access platform, complete with highly qualified health professionals providing a very effective infrastructure that is unparalleled in any other part of the health system. Each man, woman and child visits a community pharmacy 14 times each year. This equates to an average of 320 million occasions each year on which pharmacists and pharmacy assistants are able to provide professional advice and services.

Community pharmacy also maintains a high standard of patient care with the Quality Care Pharmacy Program (QCPP) which is recognised as the Australian Standard for service provision within the community pharmacy sector. The QCPP is a quality assurance program aimed at raising the standards of pharmacy services, ensuring community pharmacies provide a uniformed

[1] According to the Pharmacy Access/Remoteness Index of Australia (PhARIA).
[2] *Fact sheet 21 Diabetes in Rural Australia* (November 2011) National Rural Health Alliance

approach when delivering professional services and customer care. As of October 2012, approximately 91% of Australian community pharmacies are QCPP accredited.

In the 12 months to June 2012, community pharmacies provided approximately 12 million diabetes-related prescriptions[3] in addition to local screening, education and medication assistance services. In a recent published health survey, the overwhelming majority (94 per cent) of Australians reported using a pharmacy with 89 per cent expressing satisfaction with the service, the highest of all the major health care providers.[4]

As the prevalence of diabetes is anticipated to increase to up to 3 million Australians over the age of 25 years by 2025[5], the Guild believes the importance of access to *effective* SMBG programs and support will be essential, through a structured program with an emphasis on quality, rather than testing quantity. This is supported by the International Diabetes Federations (IDF) Guideline on Self-monitoring of Blood Glucose in Non-Insulin Treated Type 2[6], which recommends that SMBG 'should be considered as part of ongoing diabetes self-management education to assist people with diabetes to better understand their disease and provide a means to actively and effectively participate in its control and treatment, modifying behavioural and pharmacological interventions as needed, in consultation with their healthcare provider.'

According to the Australian Bureau of Statistics, about 6% of Aboriginal and Torres Strait Islander people are reported to have diabetes as a long-term health condition. Indigenous people living in remote areas have higher rates of diabetes (9%) than those living in non-remote areas (5%), such as major cities and towns. The prevalence of diabetes increases with age. Of Indigenous people aged 65 years and over, 36% had diabetes. Given the spread and location of community pharmacies in rural and remote areas, the opportunity is evident for early detection, intervention and diabetes and lifestyle management within the Aboriginal and Torres Strait Islander populations.

Non-insulin dependent type 2 diabetes is managed through the monitoring of blood glucose levels, medicines, diet and exercise, as well as a frequent requirement to lower cholesterol and blood pressure levels[7]. Community pharmacy already plays a key role in supporting people with type-2 diabetes through the National Diabetes Services Scheme (NDSS), Diabetes MedsCheck and related services such as weight loss programs and the monitoring of blood glucose, cholesterol and blood pressure. Further, it is recognised that appropriate use of SMBG can enhance patient understanding, facilitate self-management, and support healthcare providers to individualise recommendations regarding lifestyle and medications[8].

The Guild draws to the attention of the Committee a recent review of structured SMBG studies that were conducted between January 2010 and May 2011[9]. This review highlights that of the nine most recent studies in the published literature; only one reported no benefit from structured SMBG. As such, to assist the Review in this first stage of the consultation process, the Guild highlights a number of issues that have potential to impact on future SMBG for type-2 diabetes, with an emphasis on how community pharmacy could be utilised to deliver programs that target all phases of the Diabetes spectrum.

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[3] Official PBS data supplied by the Department of Health and Ageing; and Drug Utilisation Sub-Committee (DUSC) data.
[4] The Menzies-Nous Australian Health Survey 2012, 18 October 2012, 25
[5] *Diabetes: the silent pandemic and its impact on Australia* (2012) Baker IDI Heart and Diabetes Institute, Diabetes Australia and Juvenile Diabetes Research Foundation (JDRF).
[6] *'Guideline on Self-monitoring of Blood Glucose in Non-Insulin Treated Type 2'* (2009) International Diabetes Federations http://www.idf.org/webdata/docs/SMBG_EN2.pdf
[7] *Ibid*
[8] Christopher G. Parkin et al (2012) ' Results that matter: Structured vs. unstructured self-monitoring of blood glucose in type 2 diabetes' *Diabetes Research and Clinical Practice* Vol. 97:6-15 [accessed 08/11/2012]
[9] *Ibid*

This could include a pre-diabetes program, the current Diabetes MedsCheck program, a structured SMBG program, and the supply of products through the NDSS.

3. Community Pharmacy Role in Diabetes Risk Assessment (pre-diabetes)

An estimated 2.45 million Australians have pre-diabetes[10]. Early detection is important as diabetes can remain asymptomatic for many years which may result in significant diabetes-related complications becoming established before diagnosis[11]. A key focus is the identification of Impaired Fasting Glucose (IFG) or Impaired Glucose Tolerance (IGT), collectively described as pre-diabetes, which is associated with a highly increased risk of progression to clinical diabetes, incident CVD and cardiovascular mortality[12]. Moreover, 60% of people diagnosed with diabetes have been found to have had pre-diabetes 5 years before diagnosis[13].

Further supporting the case for early detection is irrefutable evidence of available, cost effective interventions for preventing and controlling type 2 diabetes. Well-designed randomised controlled trials (RCT) have shown that diabetes related complications can be prevented or minimised in people with type 2 diabetes by improving metabolic control[14].

A consequence of screening for undiagnosed type 2 diabetes is the detection of people with pre-diabetes. RCTs have shown that progression to type 2 diabetes can be prevented or delayed by lifestyle changes and pharmacotherapy[15].

The two trials[16,17] that used intensive individualised diet and exercise interventions showed a 58% reduction in the incidence of diabetes while pharmacotherapies such as metformin[18], acarbose and orlistat[19], and rosiglitazone[20] have shown 25-60% reductions in the incidence of diabetes.

Overall, these findings highlight the need for more effective screening of the general population to facilitate increased risk identification and earlier interventions to prevent the development of diabetes and its complications. Of the three approaches to screening in the general community (opportunistic, population-based, and selective-screening), opportunistic is considered to be the most efficient and effective[21].

Opportunistic risk identification involves screening individuals during routine encounters with the health care system[22]. Although various health care settings have been trialled, no single setting can capture the entire "at risk" population. However, community pharmacies are ideally placed and pharmacists well trained and skilled to assist in the detection, education and referral of individuals

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[10] *Diabetes Facts - 2012* (May 2012) Australian Diabetes Council
[11] *National Diabetes Strategy 2000-2004*. Canberra: Commonwealth Department of Health and Aged Care. 1999 www.health.gov.au/pq/diabetes/pubs/nds0004.htm
[12] The Queen Elizabeth Hospital and Health Centre Diabetes Health Centre http://www.diabetes.org.au/d_info.htm
[13] *Ibid*
[14] *Ibid*
[15] Norris SL et al (2006) 'Long term non pharmacological weight loss interventions for adults with pre-diabetes'. The Cochrane Collaboration Volume (1) 2006
[16] Tuomilehto J et al (2001) 'Prevention of type 2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance' .*N Eng J Med* 344(18):1343-50.
[17] Diabetes Prevention Program Research Group (2002) 'Reduction in the Incidence of type 2 Diabetes with Lifestyle Intervention or Metformin' *N Eng J Med* 346(6):393-403
[18] *Op. Cit. (16)*
[19] Unwin N et al (2002) 'Impaired glucose tolerance and impaired fasting glycaemia: the current status on definition and intervention' *Diabet Med* 19:708-23.
[20] *Op. Cit. (16)*
[21] Evans P et al (2008) 'Diagnosing Type 2 diabetes before patients complain of diabetic symptoms—clinical opportunistic screening in a single general practice' *Family Practice* 25(5):376-381
[22] Engelgau M et al (2000) 'Screening for type 2 diabetes' *Diabetes Care* 23(10):1563-1580.

at risk of diabetes[23]. They are freely accessible, widely available and in frequent contact with the public. Individuals who are healthy and unwell visit community pharmacies, providing an opportunity to engage people along the health spectrum and hard-to-reach populations who do not utilise other health services, of increasing importance given workforce shortages, budgetary constraints and changing population demographics.

Recommendation 1

Consideration be given to implementing a remunerated pre-diabetes community pharmacy program based on research conducted under the Third Community Pharmacy Agreement – *Pharmacy Diabetes Care Program.*

The program could involve three-steps that align with the NHMRC Guidelines National Evidence Based Guidelines for the Case Detection and Diagnosis of type 2 Diabetes mellitus:

(a) Risk assessment using a validated tool (AUSDRISK)[24];

(b) Point of care testing (POCT) using capillary blood test in line with professional standards; and

(c) Review of results in line with NHMRC Guidelines with appropriate counselling and follow-through, such as, recommendation for future monitoring for low risk or referral to a GP for high risk.

4. MedsCheck and Diabetes MedsCheck[25]

Funding is provided under the Fifth Community Pharmacy Agreement (5CPA) for the Medicines Use Review Program (known as MedsCheck) and the Diabetes Medication Management Service Program (known as Diabetes MedsCheck). These services provide for an in-pharmacy review of consumers who are taking multiple medications and/or have newly diagnosed or poorly controlled type 2 diabetes, which are aimed at enhancing the quality use of medicines and reducing the number of adverse drug events experienced by consumers.

Specifically, a MedsCheck is not disease specific and is targeted at consumers who are taking five or more prescription medicines or have experienced a recent significant medical event, focusing on education and self-management and aims to:

- Identify problems that the consumer may be experiencing with their medicines;
- Help the consumer learn more about their medicines including how medicines affect medical conditions;
- Improve the effective use of medicines by consumers; and

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[23] *Evaluation of the Diabetes Pilot Program Final Report* (2010) prepared for the Department of Health and Ageing by Health Outcomes International http://www.health.gov.au/internet/main/publishing.nsf/Content/5B1B138DA00BB9C7CA2578150083984E/$File/DMAS%20Stage%202%20Report.pdf

[24] AUSDRISK tool http://www.health.gov.au/internet/main/publishing.nsf/Content/C73A9D4A2E9C684ACA2574730002A31B/$File/Risk_Assessment_Tool.pdf

[25] *Program Specific Guidelines MedsCheck and Diabetes MedsCheck* http://www.5cpa.com.au/iwov-resources/documents/5CPA/Initiatives/Medication_Management/MedsCheck_and_Diabetes_MedsCheck/00266%20MedsCheck%20Program%20Specific%20Guidelines%20v.2.pdf

- Educate consumers about how to best use and store their medicines.

A pharmacy receives a $60 payment for completing this service in line with the Program Guidelines[26], Service Checklist[27] and Professional Guideline.[28]

A Diabetes MedsCheck is specific to type-2 diabetes in recognition of the specific problems that people may have in managing their medicines and also involves the review of clinical measurements such as blood glucose levels and appropriate use of blood glucose monitors[29]. This service is targeted at consumers who have been recently diagnosed (in the last 12 months) or have poorly controlled diabetes and who are unable to gain timely access to other diabetes education or health services in their community and aims to:

- Optimise a consumer's effective use of medicine through improving understanding of, and compliance with, their diabetes medication therapy;
- Improve a consumer's effective use of blood glucose monitoring devices through training and education;
- Improve blood glucose control; and
- Reduce the risk of the consumer developing complications associated with type 2 diabetes.

The pharmacy receives $90 for each Diabetes MedsCheck completed. There is no cost to the consumer for a MedsCheck or a Diabetes MedsCheck service.

Whilst the MedsCheck and Diabetes MedsCheck services will prove to be essential to those requiring minimal intervention, the limitation for a person with type-2 diabetes is that the Diabetes MedsCheck does not allow for a structured SMBG program as it is only able to be utilised once per year. This does not allow for an opportunity for scheduled reviews to monitor progress and testing frequency, reinforce lifestyle and appropriate testing principles or provide basic motivational interviewing or support to consumer identified as requiring structured SMBG to improve their diabetes and reduce the incidence of requiring tertiary care.

Recommendation 2

Consideration be given to developing a more structured SMBG program through community pharmacy. The Diabetes MedsCheck could be the entry point into this SMBG program.

5. A structured SMBG program through community pharmacy

The IDF Guidelines[30] emphasise the need for strong collaboration between patients and their healthcare team in reviewing, interpreting, and appropriately acting upon the data obtained through structured SMBG. The logical choice for such a program is through community pharmacies, whose involvement in the NDSS as 98% of NDSS Access Points (table 1) means that

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[26] *Ibid*

[27] *MedsCheck and Diabetes MedsCheck Service Checklist* (May 2012) http://www.5cpa.com.au/iwov-resources/documents/5CPA/Initiatives/Medication_Management/MedsCheck_and_Diabetes_MedsCheck/MCDMCModel_v0.6_206456_5.PDF

[28] *Guidelines for pharmacists providing medicines use review (MedsCheck) and diabetes medication management (Diabetes MedsCheck) services v1.0* (July 2012) Pharmaceutical Society of Australia http://www.psa.org.au/download/guidelines/3612-medscheck-guidelines-c.pdf

[29] *Ibid*

[30] *Op. Cit (5)*

they are already the main source of supply of testing strips for SMBG. In addition, community pharmacy is well placed to deliver such a program with an established infrastructure of health professionals located within communities across Australia.

Community pharmacies' role in the ongoing monitoring of consumers with type-2 diabetes and the subsequent reduction in blood glucose levels through a structured program has been previously researched,[31] with the finding of this independent research acting as the basis for the Pharmacy Diabetes Care Program (PDCP)[32] commissioned under the Third Community Pharmacy Agreement and the subsequent roll-out of the Diabetes Medication Assistance Service (DMAS) as part of the Diabetes Pilot Program under the Fourth Community Pharmacy Agreement[33].

Overview of the independent evaluation data from the Diabetes Medication Assistance Service (DMAS)[34]

DMAS involved 785 pharmacists who were trained and credentialed in the provision of pharmacy based diabetes services to patients across Australia, who delivered ongoing cycle of assessment, management and review of patients with type-2 diabetes, in collaboration with GPs and members of the diabetes care team. The aim of the program was to assist patient self-management and improve the QUM for people with diabetes through community pharmacy intervention, which included the monitoring of BGL.

An independent evaluation of DMAS was undertaken by the Department of Health and Ageing to assess the cost and affordability of the DMAS, and whether the clinical outcomes achieved through the PDCP could be replicated within the broader community pharmacy setting.

In total, 611 patients participated, with 263 completing 5 consultations within the community pharmacy. It is interesting to note that there was a slightly higher patient participation rates in rural and remote locations (PhARIA 3, 4 and 5) suggesting that the community pharmacy was able to fill the 'gap' created by a lack of other services in these areas.

The outcomes for the 263 patients who completed the program were:

- Decrease in the mean blood glucose level from 9.48 mmol/L to 8.64mmol/L – a reduction of 0.84mmol/L (8.8%);
- Decrease in the mean BMI from 33.1 to 32.9 (-0.2%);
- Decrease in the overall mean Systolic BP pressure by 6.0mmHg and Diastolic by 4.3mmHg;
- Decrease across all forms of medication management problems identified, particularly adherence issues;
- Improved exercise in 41% of patients;

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[31] Krass I, Taylor S.J, McInman A.D & Armour C.L (2004) *An integrated model for disease state management (DSM) in diabetes: collaboration of the community pharmacist and GP in continuity of care- Final Report* for the Pharmacy Guild of Australia Research and Development Program (Third Community Pharmacy Agreement)

[32] Krass I (2005) *Pharmacy DiabetesCare Program Final Report* for the Pharmacy Guild of Australia Research and Development Program (Third Community Pharmacy Agreement)

[33] *Op. Cit. (23)*

[34] *Ibid*

- 23% of patients increased their alcohol-free days per week and 14% of patients reported reducing the average number of drinks they consumed; and

- 38% of patients considered the goals they set were fully met while 49% said they were partially met

In terms of cost effectiveness, the evaluation concluded that most patients would consider their participation in the DMAS to be cost effective, and to represent value for money (90% of patients were charged a co-payment of $5.00 or less per consultation).

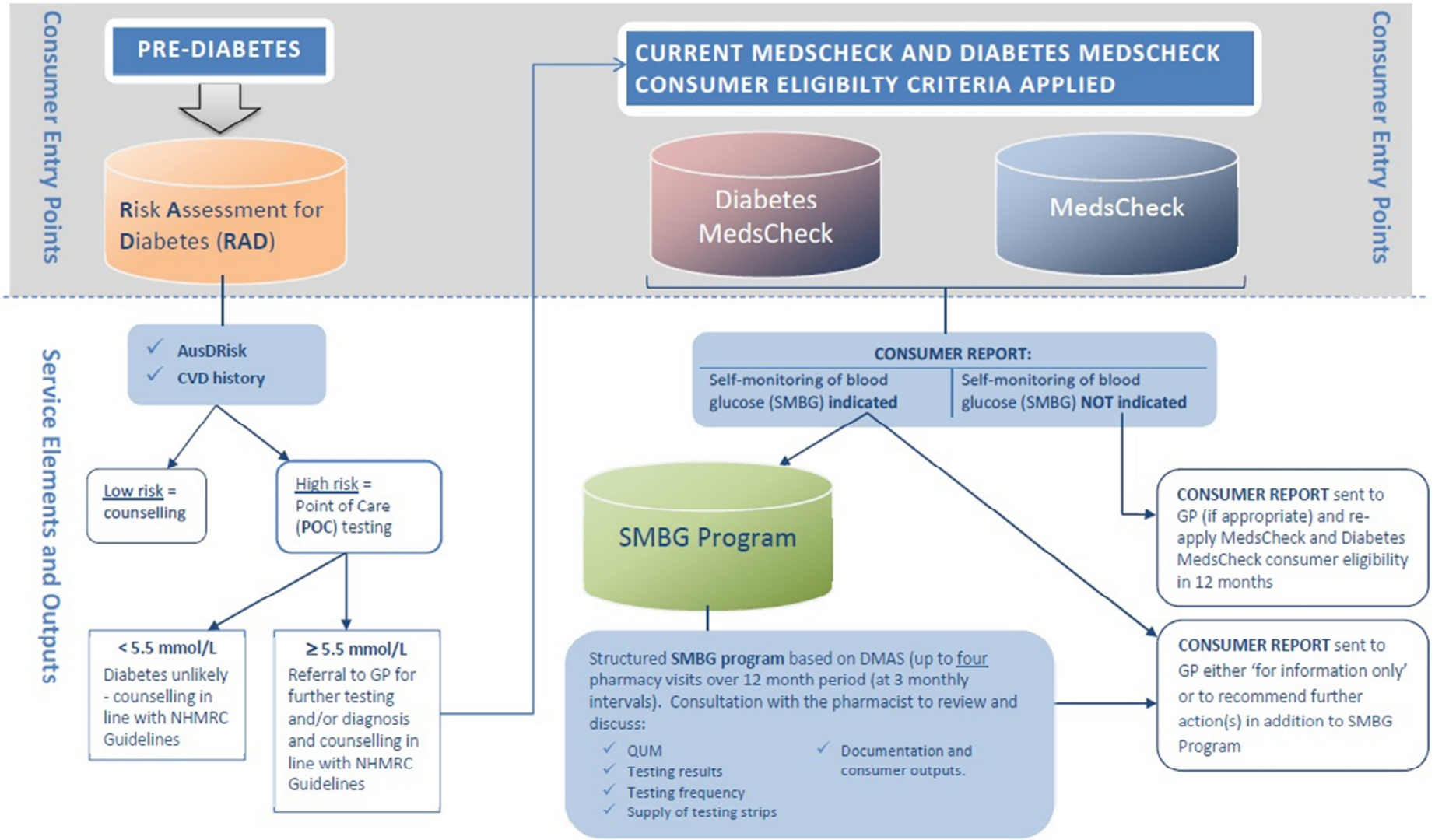
Costing considerations for a structured SMBG program through community pharmacy will include appropriate training, start-up costs (including equipment) and remuneration for time. Costs based on the 2010 DMAS evaluation estimated $660 per participating patient in a structured program with a high participation rate. By way of comparison, the cost of type 2 diabetes to the community for a person with no complications is $9,625 a year and $15,850 for a person with complications[35].

The Guild highlights that the Department and the Guild have to date invested in the foundation for a structured, multi-layered and quality integrated SMBG program within community pharmacy. The key is now to focus on utilising this past investment and the established infrastructure of community pharmacy to invest in a new model of service that provides for a structured SMBG program. The program, when implemented in conjunction with the Diabetes MedsCheck program, has the potential to improve the future health outcomes of people with type 2 diabetes in a cost effective way.

One such model is depicted in figure 1, where a Diabetes MedsCheck becomes the entry point into a more structured SMBG program that allows for scheduled reviews of a developed action plan, and careful monitoring of test strip utilisation over a twelve month period. It would encompass all of the components recommended in the IDF Guidelines, recent research related to the effectiveness of SMBG and testing quality and interpretation, rather than testing frequency, as well as the previously researched and piloted community pharmacy diabetes service programs.

[35] *Op. Cit. (10)*

Figure 1: Pictorial of a Community Pharmacy Diabetes Care Model



6. Community Pharmacy and the NDSS

The Guild draws attention to the NDSS and its implications for the SMBG. This is because 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[36]'. This is largely achieved through a nation-wide network of Access Points from where a Registrant to the Scheme can purchase significantly discounted supplies. Diabetes Australia estimates that the NDSS covers 80%–90% of people with diagnosed diabetes. **As 98% of NDSS Access Points** (table 1)**, community pharmacy plays a key role not only in the NDSS, but is uniquely positioned to assist with early intervention and the ongoing professional management of a person's diabetes.**

Table 1: NDSS Access Points June 2012[37]

	Total Access Points	No. of Community Pharmacy Access Points	No. of Community Pharmacies	Access Point % Penetration of Community Pharmacy Total
QLD	830	824	1078	76%
NSW	1566	1557	1783	87%
ACT	49	48	68	70%
VIC	709	679	1257	54%
TAS	127	125	144	86%
SA	252	251	429	58%
NT	20	18	32	56%
WA	506	476	554	86%
TOTAL	**4059**	**3978 (98%)**	**5345**	**74%**

Community pharmacies' involvement as Access Points is crucial for Registrants to have improved access to NDSS products in their local community because they have, at point of contact, experienced health professionals who are able to provide a service greater than product supply.

The Guild highlights to the Review that Access Points under the NDSS are mandated to provide unremunerated services that 'extend(s) beyond just being a shopfront for NDSS products including to 'provide Registrants with information on diabetes by a person/s engaged or employed by the Access Point who is capable of providing an informed response to Registrant questions[38]'.

A 2011 analysis[39] estimated that based on pharmacy cost and income trends, the financial impact on community pharmacy Access Points is an average loss of $7,481. Despite this, community pharmacies have elected to be involved in the NDSS due to high level of commitment to providing a comprehensive diabetes service to the community as they feel NDSS supports their patients' health and information needs.

It is also important to note that the Access Point role is to increase access to NDSS products, not to increase the number of Registrants to the scheme. The number of Registrants is determined by the number of people eligible for the NDSS and diabetes prevalence. With an estimated 275 new cases of diabetes diagnosed in Australia every day[40], and given the increasing financial losses for

[36] The National Diabetes Services Scheme (NDSS)
[37] Data provided by the Department of Health and Ageing.
[38] Per the *NDSS Access Point Guidelines* (September 2011)
[39] *NDSS Financial Impact Estimates* (February 2011), Medici Capital for the Pharmacy Guild of Australia. Provided to the Department of Health and Ageing in February 2011
[40] Diabetes Australia *'Government must act now to stop diabetes'* Media release (4 April 2012)

community pharmacy to participate in the NDSS, a remuneration arrangement must come into place to ensure the long term viability of access to diabetes products, specifically testing strips and monitors, coupled with a structured SMBG program.

Recommendation 3

Consideration be given to providing remuneration, within the NDSS, for the role of Access Points to enhance the quality and scope of support provided for the SMBG.

6.1 Stock requirement for NDSS Access Points

The Guild estimates the average community pharmacy Access Point is holding $5,000[41] worth of initial stock[42], in addition to any new products they have been required to purchase. Collectively, this amounts to approximately $19,890,000 worth of stock[43] being held by community pharmacy Access Points for the purpose of participating in the NDSS at their own cost and risk[44].

In regard to products that support SMBG, there is a requirement to purchase new stock when products are updated or new products enter the market. The Guild highlights that Registrants have an expectation that their local community pharmacy can supply the full range of monitors and testing strips; however, there is a high level of stock waste at an ultimate cost to the pharmacist to ensure this high level of service is maintained through the current NDSS. This is compounded by Registrant behaviour, with Access Points reporting[45] that the current scheme encourages Registrants to 'stockpile' test strips as they have access to unlimited quantities, which is not cost-effective for the pharmacy, Diabetes Australia, or the Commonwealth.

The Guild draws attention to the complex options that a person has to purchase test strips from a community pharmacy and the variance in cost (table 2).

Table 2: Options currently available for purchasing BGM test strips

Options for purchasing test strip (example of one product for a box of 100 strips)[46]					
Over the Counter	PBS prescription	PBS prescription (Concession)	NDSS (General)	NDSS (HCC)	NDSS (DVA)
$46.00 (approx.)	$35.40	$5.80	$15.20	$2.40	$1.20

Recommendation 4

Consideration be given to the rationalisation of the number of brands of test strips available through the NDSS, with all other brands available if required at subsidised rates through a PBS prescription.

[41] 70.93% of respondents to a January 2011 Guild NDSS survey stated they were required to purchase up to $5,000 of initial stock
[42] Per the *NDSS Access Point Guidelines*, Access Points are required to hold an initial base stock of product to supply Registrant demand
[43] Based on $5,000 x 3,978 sub-agents
[44] Per the *NDSS Access Point Guidelines*, all stock purchased by the Access Point is owned by the Access Point
[45] Pharmacy Guild of Australia submission on the NDSS provided to the Department of Health and Ageing (February 2011)
[46] Prices correct October 2012 based on PBS and NDSS data

This would:

- Involve a smaller range of products required to be held at the Access Point, and the Agents warehousing arrangements, to meet NDSS requirements;
- Access Point staff could be well trained on a smaller number of products, enhancing the effective support available to give to SMBG; and
- Minimise the shelf space required within a community pharmacy Access Point to display NDSS product and minimise the risk associated with the stock-holdings.

Recommendation 5

Consideration be given to placing a limit on the number of test strips a Registrant can receive at any one time.

This would:

- minimise any 'stock piling' behaviour by Registrants;
- Allow the pharmacist to engage and reinforce with the Registrant information regarding appropriate testing frequency;
- Reduce the amount of testing strips required to be held at any one time by the Access point; and
- Allow for enhanced forecasting by the NDSS of test strip requirement.

Recommendation 6

New stock should be provided to the pharmacy as part of the rotating stock process, with adequate training and information provided on the new products to assist pharmacists in providing effective SMBG support to Registrants.

This would:

- Ensure consistency across Access Points;
- Ensure Registrants have equal access to products no matter which Access Point they visit; and
- Minimise waste and further reduce the risk to Access Point for stock holding.

6.2 Supply of NDSS products through the existing pharmacy wholesaler chain

The issue of duplication between the product supply through the NDSS and the distribution of PBS medicines by wholesalers has been raised over a number of years, with the Guild emphasising the issue during the recent NDSS Product Delivery and Supply Review[47] process.

The Guild highlights that the wholesaling network is well established, strong and efficient, ensuring products are delivered in a timely manner so patient access is not put at risk due to the Community Service Obligation for Pharmacy Wholesalers (CSO). The objective of the CSO is to ensure that arrangements are in place to provide all Australians with ongoing and timely access to the full range of PBS Medicines and products via their community pharmacy[48]. Full-line

[47] In accordance with the NDSS Agreement 2011-16 between the Department of Health and Ageing and Diabetes Australia, during the 2011-12 financial year Diabetes Australia must ensure an independent review is undertaken into the product supply and delivery arrangements for the Scheme with a view to seeking efficiencies in this aspect of the Scheme. The NDSS Supply and Delivery Arrangements Review report was scheduled for completion by 30 June 2012.

[48] Department of Health and Ageing. For the purpose of the CSO Funding Pool, 'PBS medicines' means all items listed on the Schedule of Pharmaceutical Benefits and available under Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme arrangements, excluding items that a CSO Distributor cannot supply due to an exclusive supply arrangement, items listed

wholesalers distribute the complete range of PBS listed medicines to all PBS approved pharmacies in Australia, within 24 hours regardless of their geographic location, on a daily and emergency basis, in line with Government's National Medicines Policy commitments.

Recommendation 7

Consideration be given to the transfer of the product supply component of the NDSS to the pharmacy wholesalers delivering PBS medicines, Scheduled medicines and over the counter health related products and devices.

If the current NDSS supply model is to be retained, compliance requirements and service standards for the delivery of NDSS products should be similar to the compliance requirements and service standards of the CSO by the wholesalers.

7. Conclusion

There are an estimated 65 amputations due to diabetes every day in Australia[49]. A structured and effective system in monitoring pre-diabetes and type-2 diabetes through community pharmacy is essential, given there is one person diagnosed in Australia every 5 minutes[50]. This is compounded by the unavailability of other health professions due to geographic distribution and workforce shortages, particularly in rural and remote Australia, where it is reported that almost two-thirds (64 per cent) of people cannot get an appointment with a GP on the same day outside of a capital city.[51] Further, the higher rates of diabetes and associated complications within Aboriginal and Torres Strait Islander populations than other Australians[52] means that consideration should be given to the provision of culturally appropriate and family-centred local care.

The Guild highlights that e-health has an important role to play in the future of diabetes care, where a pharmacist could play an essential role through the Electronic Transfer of Prescriptions (ETP) and the Personally Controlled Electronic Health Record (PCEHR). Any structured SMBG program through community pharmacy would also be enhanced, particularly for rural and remote regions, if the pharmacy was viewed as an 'other health care facility' in which a patient could access telehealth and engage in a video conference with a specialist at another location[53], thus ensuring that there is access to a 'team' of health professionals.

A person with diabetes already recognises their local community pharmacy as a diabetes health destination, given that 98% of NDSS Access Points are community pharmacies. The Guild draws attention to the new NDSS Agreement, which states that it is a requirement for a community pharmacy Access Point to participate in the Diabetes MedsCheck Program. Utilising this established infrastructure is therefore the logical choice to deliver pre-diabetes and structured SMBG care.

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on the Schedule of Pharmaceutical Benefits under Section 100 of the National Health Act 1953, and items listed on the Repatriation Schedule of Pharmaceutical Benefits.

[49] *Op. Cit. (10)*

[50] *Op. Cit. (10)*

[51] The Menzies-Nous Australian Health Survey 2012, 18

[52] Australian Health Ministers' Advisory Council (2012) *Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report*, AHMAC, Canberra.

[53] Comparable to the exemption provided under the telehealth initiative to residential aged care services, Aboriginal Medical Services and Aboriginal Community Controlled Health Service, which are able to provide telehealth consultations without a Medicare provider number.

The Guild highlights that MedsCheck and Diabetes MedsCheck are delivered by Quality Care Pharmacy Program (QCPP) accredited community pharmacies, ensuring that these services are being delivered to a quality Standard.

Further, the Guild believes that any disease screening or condition management service offered through community pharmacy should be established only when there is evidence-based research that has shown an improved outcome for the consumer. In this submission, we have provided evidence of this for diabetes care through community pharmacy.