Dispensing of HIV specialist drugs – community pharmacy pilot – Evaluation report

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table of contents

1.	Nature and purpose of the Pilot Scheme	1
1.1.	Introduction	1
1.2.	Objectives	2
1.3.	Steering Committee	2
1.4.	This evaluation	3
2.	Project Implementation	5
2.1.	Conduct of the pilot	5
2.2.	Information available on clients referred to the pilot	7
3.	Client Responses	11
3.1.	Client survey	11
3.1.1.	Methods	11
3.1.2.	Respondent Characteristics	12
3.1.3.	Registering for the pilot	13
3.1.4.	Advantages and disadvantages of using a community pharmacy	13
3.1.5.	Comparisons of using a hospital/clinic and using a community pharmacy	14
3.1.6.	Compliance	17
3.1.7.	Non-participation in the pilot	17
3.1.8.	Likely future use of a community pharmacy scheme	17
3.1.9.	Summary of survey findings	18
3.2.	Focus group discussion	18
3.2.1.	Recruitment	19
3.2.2.	Focus group findings	19
3.2.3.	Comparison with survey findings	23
4.	Stakeholder Views and Experience	24
4.1.	Introduction	24
4.2.	Access and client satisfaction	25
4.2.1.	Take-up of pilot places	25
4.2.2.	Three months' supply of medication	26
4.3.	Compliance	27
4.4.	Cost issues	28
4.4.1.	Drug costs	28
4.4.2.	Dispensing costs	30
4.5.	Feasibility	30
4.6.	Other issues and impacts	31
4.6.1.	Guidelines and protocols	31
4.6.2	Unplanned impacts	32
4.7	For the future	32
5	Summary and Conclusions	33

1. Nature and Purpose of the Pilot Scheme

1.1. Introduction

Major improvements in the treatment and management of HIV/AIDS have meant that in Australia many HIV-positive people are enjoying better health and living much more 'normal' lives than in the past. Many, for example, are in employment (according to the AIDS Council of NSW, around 35% of HIV-positive people living in inner Sydney are working full-time). In such circumstances there has been considerable interest, among health professionals and within the community, in the possibility of patients obtaining their HIV specialist medication in a community setting (for example at a local pharmacy) rather than having to attend a hospital or special clinic for this purpose. The potential advantages of dispensing through local pharmacies are seen as including access to medication outside normal business hours, access in a less 'medical' environment, and reduced travel and waiting time. The possibility of community dispensing has been a talking point for quite some years. *Reservations* which were sometimes expressed about such a scheme included concerns about the level of HIV medications *knowledge and skill* available in community pharmacies, and concerns that community pharmacies might not provide adequate levels of privacy and confidentiality.

After considerable discussion and negotiation with various relevant parties, the NSW Department of Health in 2001 decided to support a pilot program in the South-East Sydney Area, whereby eligible HIV-positive persons would be able to register through an authorised medical practitioner to obtain their Schedule 100 HIV medication, for a limited period, through one of five designated pharmacies in the Surry Hills/Darlinghurst/Potts Point area.

The pilot scheme commenced operation in early February 2002; it was initially agreed that it would run for a period of three months. Once the pilot was operating in what was seen as a fairly smooth fashion, it was agreed to extend it to 30 September 2002. During September 2002 a further 6-months extension of the pilot was negotiated, so that *existing* clients could continue to have community pharmacy access to medication during the time when an evaluation report was being prepared and State-Commonwealth negotiations on a possible long-term scheme were pursued.

Schedule 100 of the National Health Act currently covers some 50 drugs for the treatment of a number of complex and chronic conditions, of which HIV is one; HIV medications evidently make up about one-third of S100 drugs. In general these are very costly drugs, and regarded as best prescribed by medical specialists rather than general practitioners. In the case of HIV, however, numbers of general practitioners with a significant HIV practice have received authorisation to dispense relevant S100 drugs to their patients.

1.2. Objectives

Before the commencement of the pilot in February 2002, highly specialised drugs (HSDs) for the treatment of HIV had previously been dispensed – like all S100 drugs – almost exclusively through hospital-based pharmacies – including, in Sydney, the Albion Street Centre (ASC) in Surry Hills. A key goal of the pilot scheme was to improve quality of life for HIV-positive people by increasing and facilitating their access to HSDs. The stated objectives of the pilot were to:

- assess the feasibility of community pharmacist dispensing of highly specialised drugs for treatment of HIV;
- improve access to drugs for people with HIV – especially out of regular hospital pharmacy hours;
- improve compliance with drug regimens;
- assess the cost of alternative access arrangements for Areas (ie hospital pharmacies), community pharmacies and general practitioners.

The project was intended to generate evidence as to:

- whether the dispensing of S100 drugs through community pharmacies improves access to treatments for people living with HIV/AIDS and therefore patient satisfaction with dispensing services;
- whether extending the dispensing of s100 drugs through community pharmacies is financially and logistically feasible from the perspective of hospital pharmacies, community pharmacies and clinicians.

1.3. Steering Committee

A Steering Committee which provided advice on the design and conduct of the pilot included representatives of a range of stakeholders including:

NSW Health Department

Albion Street Centre (ASC)

Prince of Wales Hospital

St Vincent's Hospital

Australian Society for HIV Medicine (ASHM)

AIDS Council of NSW (ACON)

PLWHA New South Wales

Prescriber representatives

Community pharmacy representatives

1.4. This evaluation

In February 2002 the Department of Health commissioned Urbis Keys Young to undertake an independent evaluation of the community pharmacy pilot. The steering committee for the pilot requested that the evaluation be undertaken in two stages, involving a preliminary report in May 2002 on initial implementation of the scheme (intended to identify any early problems that needed to be addressed), and a full report to be presented two months after the proposed 30 September completion date – that is, by the end of November 2002.

The issues considered in the evaluation included:

- successes and limitations of the project relative to its stated objectives;
- levels of participation in the pilot and use of the community pharmacy services;
- appropriateness and effectiveness of the pilot guidelines;
- client experience and satisfaction levels;
- the experience of the participating community and hospital pharmacies;
- issues relating to the costs of community pharmacy dispensing;
- apparent strengths and weaknesses of the pilot project; and
- potential development and expansion to community dispensing of HIV HSDs.

The budget available for conduct of the independent evaluation was relatively modest, and the evaluation needed to be carefully designed to obtain best value from the funds available. Main elements of the evaluation included:

- arranging and carrying out consultations with representatives of key stakeholders;
- review of statistical information on the pilot that was made available by ASC;
- survey research involving completion of written questionnaires by patients enrolled in the pilot;

- face-to-face consultation with a number of patients by way of a focus group meeting;
- seeking comment on relevant costs issues from community and hospital pharmacies;
- analysis of findings and preparation of draft and final reports.

An early meeting of the Steering Committee clarified the role of ASC in collecting data to inform the operation of the pilot, and that of Urbis Keys Young in relation to evaluation data.

2. Project Implementation

2.1. Conduct of the pilot

Management and Guidelines

The pilot scheme was managed by the ASC, which is located in Surry Hills and incorporates a satellite pharmacy of the Prince of Wales Hospital, Randwick. Both facilities are part of South Eastern Sydney Area Health Service. Chief investigator for the pilot project was Professor Julian Gold, Director of the Albion Street Centre; Ms Sylvia Bridle, Senior Pharmacist at ASC, was the co-investigator responsible for all technical matters. ASC provided project management support and monitoring. ASC expects to publish a detailed report on the pilot in early 2003.

A detailed Clinical Protocol was developed to cover the various aspects of the pilot project. The intention was that up to 300 patients would be enrolled in the pilot, with an initial recruitment period of three months. The participants were to be people aged 18 or over, who had been clinically stable on their current medication regime for at least 3 months, who felt they could benefit from accessing the nominated pharmacies, and who were willing to participate in monitoring of the project, eg through completing appropriate questionnaires. Patients taking part in clinical drug trials and patients requiring extended supplies of medication were excluded. As regards medical practitioners, the Clinical Protocol for the pilot stated that:

> *As many clinicians as possible will be encouraged to participate to ensure a good distribution of patients and that the workload is distributed across as many practitioners as possible. All metropolitan GPs who are authorised s100 HIV prescribers or medical specialists affiliated with a designated HIV/AIDS unit in South Eastern Sydney Area Health Service will be provided with the opportunity to participate.*

Registration of Participants

Clients wishing to take part in the pilot needed to enrol through a medical practitioner authorised to prescribe S100 HIV medication. The doctor completed an enrolment form with the patient (which included particulars of the medication prescribed), and faxed this, together with a client consent form relating to the pilot, to ASC. Each participant nominated a community pharmacy that s/he would use during the pilot.

Three hundred pilot places were available, but according to ASC's records the actual number of people who enrolled for the pilot was 200. (ASC reports that of the 200 who originally enrolled, eleven never in fact collected from the community pharmacies; a further five people formally discontinued, leaving a maximum of 184 participants.) The fact that not all the pilot places available were taken up is one of the issues considered in later sections of this report.

Role of the Community Pharmacies

The HIV specialist drugs required over the course of the pilot were supplied by Prince of Wales Hospital, through the ASC Pharmacy Department, to the five community pharmacies which took part. These five pharmacies were:

- Serafim Pharmacy, Taylor Square
- Sharpe's Pharmacy, Flinders Street, Surry Hills
- Fullife Pharmacy, Oxford Street, Darlinghurst
- Bill Warner Pharmacy, Victoria Street, Darlinghurst
- Parker's Pharmacy, Darlinghurst Road, Potts Point.

Twelve staff-members from the five community pharmacies attended a special day-long training course (organised by ASHM and held on two occasions in September 2001) to familiarise them with S100 HIV drugs and various issues relating to dispensing these. The course was developed by ASHM in consultation with ASC, and suitable specialists were brought in to provide relevant material. The training was reportedly well received; however, a repeat course originally planned for April 2002 was cancelled for lack of participants. Over the course of the pilot ASHM (which among other things has responsibility for providing ongoing HIV information to the authorised prescribers) supplied the community pharmacies with up-to-date information on HIV medications through a monthly one-page fact sheet, *Community Pharmacy News*.

The participating community pharmacies neither paid for the drugs dispensed under the pilot, nor received any remuneration. Patients presenting their prescription to the community pharmacy, paid the standard hospital patient co-payment of $15.40 (for general patients) or $3.60 (for concessional patients) per script item. The community pharmacies reimbursed the collected co-payments to ASC/ Prince of Wales.

In the case of the client's *first* visit to the community pharmacy there was a short delay (up to 48 hours) while ASC supplied the drug to the community pharmacy. After that ASC systematically supplied the community pharmacy with the necessary drug three weeks after the patient's previous pick-up.

The strict audit provisions relating to S100 drugs required the community pharmacists to provide ASC with full documentation on their dispensing of HIV medication, including returns of the original script or a copy thereof; there was also a monthly community pharmacy dispensing report. The documentation was required to fulfil Commonwealth/State audit requirements. It enabled ASC to prepare an S100 claim and a reconciliation report for each pharmacy.

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* That is, approximately the same as the number of participants who collected medication from the community pharmacies each month – see section 2.1.

ASC figures show that once the pilot was well established the average number of people who collected medication from the community pharmacies was around 130 per month. Discussion with people involved in conducting the pilot suggests that there would have been some pilot participants who from time to time collected their medication elsewhere, and also possibly some who were on 'treatment interruption'. However, it seems clear from these figures that there was some incidence of non-collection of medication in the community pharmacy scheme – just as there reportedly is with hospital-based pharmacies.

2.2. Information available on clients referred to the pilot

As noted above, ASC records show that a total of 200 people registered for the community pharmacy pilot. Further details supplied by ASC are summarised below.

- *Referrals*

  Data collected by ASC show that a total of 21 authorised prescribers, from seven practices, referred patients to the pilot. These 21 doctors represented around two-thirds of the community prescribers within the South Eastern Sydney Area Health Service. However, the numbers of patients referred per practitioner varied greatly, from one to 90. The 90 patients who were referred by a single practitioner represented almost half (45%) of all pilot registrations. There were four prescribers who altogether accounted for 71% of total registrations.

- *Previous collection of S100 HIV medication*

  ASC data show that most of those who registered for the pilot had previously been accustomed to collecting their medication from St Vincent's Hospital. Data available for 176 of the patients who registered for the pilot shows the following distribution:

Formerly collected from St Vincent's	64%
Formerly collected from ASC	25%
Formerly collected from Sydney Hospital	6%
Formerly collected from RPA Hospital	3%
Formerly collected from other hospitals	1%

- *Community pharmacy used*

  Data provided by ASC to Urbis Keys Young to assist in the administration of the client evaluation questionnaire (see section 3.1 of this report) indicated that the distribution of clients across the five community pharmacies was as follows:

Sharpe's	63%
Serafim	18%
Fullife	14%
Parker's	3%
Bill Warner	3%

- *ASC survey data*

  Seventy-nine clients responded to an initial survey questionnaire prepared by ASC and distributed through prescribers. A draft report on that survey prepared by ASC staff shows that:

  – 73% of these survey respondents were in employment – most of them in *full-time* work.

  – 33% indicated that before the pilot they had normally collected their specialist HIV medication during their work hours; the remainder who answered this question normally collected their medication before or after work, on a day when they were not working, or at varying times.

- 61% of the respondents to the ASC questionnaire described the average waiting time to collect their medication at their hospital-based pharmacy, before the pilot, as either *long* or *very long*. A further 28% classified their average waiting time as *acceptable*, while 11% said it was *short* or *very short*.
- 75% of the respondents to the ASC questionnaire described the current opening hours of the hospital-based pharmacies as either *inconvenient* or *very inconvenient*.
- 87% thought that extended opening hours would change the times at which they normally acquired their medication.
- 35% of these ASC respondents described their travelling time to/from their hospital-based pharmacy as *long* or *very long*; a further 44% described their travel time as *acceptable*, and 20% rated it *short* or *very short*.
- 32% of the ASC respondents stated that they usually sought or received from the hospital-based pharmacy information or advice about their medication. (It will be recalled that the pilot eligibility criteria required participants to have been stable on their current medication for three months or more.) Of 25 respondents who said that they did usually seek or receive such information or advice, 19 (76%) said they found this *useful* or *very useful*.

The ASC survey questionnaire also asked respondents what they expected 'the benefits and/or disadvantages' to be in accessing antiretroviral medication from a community-based pharmacy.

Relatively few *disadvantages* were foreseen. The issues that respondents mentioned in this context were the small geographical area covered by the pilot community pharmacies; the short life of the pilot; reservations about confidentiality or privacy; and the fact that participants would be able to obtain only one month's supply at a time.

The likely *advantages* of community pharmacy access as seen by these respondents included the following:

- more convenient/extended opening hours
- more flexible and predictable access
- a more pleasant or normal environment
- more friendly and personalised service
- greater privacy
- more convenient locations or access, including more convenient parking
- simpler process and faster service
- being able to obtain all medication at one location (a 'one-stop-shop')
- simpler tracking of PBS expenditure and Safety Net eligibility
- improved compliance.

- *Time of collection from community pharmacies*

Data collected by ASC show that, in terms of the *time of day* of the first visit which participants made each month to a community pharmacy, around 55% of visits were made at a time when the relevant participant's former hospital-based pharmacy was closed.

3. Client Responses

The evaluation used two methods to seek feedback on the pilot direct from HIV-positive people who had participated in it: a *client survey* which was distributed through the five community pharmacies, and a *focus group discussion* which was conducted with a group of clients in mid-October. Each of these is discussed below.

3.1. Client survey

3.1.1. Methods

A questionnaire for clients was developed by Urbis Keys Young in consultation with representatives of the Department of Health and ASC, with some input also from PLWHA and ACON. The questionnaire was designed to be short and simple and was mostly pre-coded; however it also included some questions inviting respondents to express their views in their own words.

Because there exists no single list of participants' names or contact details, it was not possible for the researchers to have the client questionnaire distributed by post as they had originally intended. Discussion with ASC representatives indicated that the possible ways of getting the questionnaire to clients included working through the prescribing doctors or through the community pharmacies; of these, use of the five pharmacies was seen as likely to be the more practical and effective option. Accordingly, in late August the ASC Senior Pharmacist approached each community pharmacy seeking its agreement to distribute questionnaires to clients during September and to keep a record of the clients who accepted a questionnaire.

All five pharmacies agreed to this course of action. Accordingly, in the second week of September, each pharmacy was given sufficient questionnaires and reply-paid envelopes (addressed to Urbis Keys Young) for all of its clients, together with a list of the relevant client registration codes for that pharmacy. Pharmacists were asked to offer a questionnaire and a return envelope to each client as s/he visited the pharmacy either to collect HIV medication or for other reasons. The pharmacists were also asked to mark off on the list the code number of each client who took a questionnaire, and to write this code number in a space provided on the front page of the questionnaire. Use of the client code in this way was designed, among other things, to avoid any risk of duplicated responses to the survey.

An introductory section of the questionnaire explained the purpose of the client survey, and emphasised that all information provided would be treated in a confidential fashion. Clients were asked to post back the completed questionnaire to Urbis Keys Young by 10 October.

Because some pilot participants had already collected their monthly medication before the questionnaires reached the community pharmacies on 10-11 September, the Health Department placed advertisements in the *Sydney Star Observer* in late September and early October, advising all participants about the client survey and encouraging those who had not received a questionnaire from their pharmacy to collect one – or, if this presented any difficulties for them, to contact the evaluation team direct.

In the event, as noted in section 1.1 of this report, a decision was made *not* to terminate the pilot on 30 September as originally planned, and it remained possible for the participants to collect HIV medication from the community pharmacies beyond that date. The pharmacies agreed to continue to distribute the survey questionnaires, and to advise their clients that responses would now be accepted up until 24 October.

By 28 October Urbis Keys Young had received a total of 91 completed questionnaires, representing almost exactly half of the 184 people who, according to ASC's records, took part in the pilot. Enquiries of the community pharmacies, however, showed that the number of participants who had received a survey questionnaire was in fact less than this; the actual number of questionnaires distributed was approximately 125[*]. The 91 responses received therefore represent some 73% of all possible responses to the survey.

The survey results are discussed below.

3.1.2. Respondent characteristics

Previous collection of HIV drugs

Most of the survey respondents (55 people, or 58%) had previously collected their specialist medication from St Vincent's Hospital. Smaller numbers had formerly collected their medication from ASC (24%), Sydney Hospital (6%) and some other hospitals. The dominance among the survey respondents of former users of the St Vincent's Hospital pharmacy was consistent with the fact that St Vincent's patients made up the largest single group of pilot participants (see section 2.2 of this report).

Community pharmacy used during the pilot

When participants were asked from which community pharmacy they had (mostly) obtained their HIV drugs during the pilot, the responses were as follows:

- Sharpe's 57%
- Serafim 23%
- Fullife 12%
- Parker's 6%

- Bill Warner 2%

The above percentages broadly reflect the numbers of clients registered with the various pharmacies (see section 2.2). For example, some 63% of clients were registered with Sharpe's, and 18% with Serafim.

Employment status

Fifty-nine respondents (65%) stated that they were currently in full time employment, while a further 15 (17%) were employed on a part time or casual basis (total employed: 81%). There were 17 people (19%) who were not in paid work at the time of the survey.

3.1.3. Registering for the pilot

Respondents were asked how simple or otherwise they had found the process of *getting information about the community pharmacy pilot and registering for it*. The responses were as follows:

- *Very simple* 41%
- *Fairly simple* 36%
- *Fairly difficult or cumbersome* 14%
- *Very difficult or cumbersome* 1%
- Not sure / hard to say/ not stated 8%

3.1.4. Advantages and disadvantages of using a community pharmacy

The survey respondents were asked an open-ended question as to what the main *benefits or advantages* for them had been in being able to get their HIV medication from a community pharmacy. Up to four responses per respondent were coded.

In summary the responses were as follows:

- Extended opening hours/after hours access 79% of respondents
- Fast/straightforward/ efficient process 36% of respondents
- Convenient location 27% of respondents
- 'One-stop shop' 22% of respondents
- Good customer service/friendly staff 18% of respondents
- More 'normal' experience, less confronting etc 11% of respondents
- Pharmacist can advise on other medication etc 9% of respondents

- Privacy/confidentiality 7% of respondents
- More payment options 4% of respondents
- Increased ease of compliance 3% of respondents

Similarly, respondents were asked what *problems or disadvantages*, if any, there had been for them in getting their medication from a community pharmacy. Responses were as follows:

- No problems/none stated 77% of respondents
- Initial errors/delays/other teething problems 7% of respondents
- Only receive one month's supply 5% of respondents
- Confidentiality/privacy problem 4% of respondents
- Uncertain length of pilot 2% of respondents
- Obliged to use one pharmacy only 2% of respondents
- System too complicated/involves too much paperwork 2% of respondents
- Occasional prescription errors or oversights 2% of respondents

The survey questionnaire asked two other questions designed to gather information on particular benefits or problems that may have been associated with the community pharmacy pilot.

First, respondents were asked (Q9) whether there had been any benefit for them in *being able to get all (their) medication in one place*. A total of 81 respondents (89%) answered *Yes* to this question, while the remaining 11% answered in the negative or said that this had been not applicable / not important for them.

The questionnaire also asked (Q10) whether it had been a problem for the respondents *to have to go to the same pharmacy each time*. Only seven people (8%) said *Yes*, while 92% said *No*.

3.1.5. Comparisons of using a hospital/clinic and using a community pharmacy

The respondents were asked to compare their *community pharmacy* experience with their former *hospital/clinic* experience in relation to various issues relating to their collection of HIV medication –for example opening hours, waiting time, privacy and confidentiality. In each case they were asked to say whether they had found the hospital/clinic *better* or *much better*, or the community pharmacy *better* or *much better*.

Client responses are summarised in Table 1; they generally reflect a strong endorsement of the service provided by the community pharmacies during the pilot. It is important to note, however, that these responses

should *not* be taken as a definitive comparison of hospital-based and community-based services. This research did not involve any survey of the views of patients who continued to obtain their medication from a hospital-based pharmacy; what we are reporting on here is the experience of a group of patients who foresaw enough merit in the community pharmacy model to register for the pilot.

Table 1: Client Comparisons of Hospital/Clinic and Community Pharmacy Collection (Percentages)

	Hospital/ Clinic Much Better	Hospital/ Clinic Better	Both About the Same	Community Pharmacy Better	Community Pharmacy Much Better
a. Opening hours (ie the times you can go to collect your medication)	-	-	2%	1%	97%
b. Travel time and ease of getting there	-	2%	14%	7%	76%
c. The length of time you had to wait for your medication	-	-	13%	19%	68%
d. Communicating information or advice to you	-	3%	34%	14%	46%
e. Privacy and confidentiality	1%	6%	51%	9%	34%
f. Method(s) of payment available	-	1%	33%	13%	53%
g. Overall quality of service	-	1%	12%	26%	60%

It was in relation to *privacy and confidentiality* (item e. in Table 1) that the highest proportion of respondents saw no significant difference between the hospital/clinic and the community pharmacy; even on this point, however, 43% thought that the community pharmacy was preferable as against 7% who preferred the hospital-based pharmacy. On the other six measures at least 60% of respondents thought the community pharmacy either *better* or *much better*. The percentages *preferring the community pharmacy* in each case were as follows:

- Communicating information and advice 60%
- Methods of payment available 66%
- Travel time and ease of getting there 83%
- Overall quality of service 86%

- Waiting time for medication 87%
- Opening hours 98%

3.1.6. Compliance

Respondents were asked to say whether they had observed any differences in their compliance with their HIV drugs regimen since getting their medication from a community pharmacy.

Most respondents (64%) said that their compliance during the community pharmacy pilot had been *about the same* as before, but 36% said that they believed that their compliance had been *better* since they had been getting their medication from a community pharmacy. None said that compliance had been worse.

3.1.7. Non-participation in the pilot

The respondents were asked whether they had *friends or acquaintances* who used HIV medication but who had chosen *not* to take part in the community pharmacy pilot and, if so, what they thought were the reasons for such non-participation.

Relatively few of the respondents (13 people) stated that they had friends or acquaintances who might have taken part in the pilot but had chosen not to (many were *not sure*). As for possible reasons for non-participation, suggestions made by these 13 respondents were as follows: not all HIV medications were available from community pharmacies; resistance by prescribers to the paperwork required for the pilot; lack of knowledge, eg doctors' not informing patients about the pilot; ineligibility as a result of recent change in medication.

3.1.8. Likely future use of a community pharmacy scheme

Finally the survey asked two questions relating to any possible future scheme for accessing HIV specialist drugs through community pharmacies.

When asked whether they would be likely to take part again if a comparable community pharmacy scheme were established on a permanent basis, the vast majority of participants – 98% – answered that they *would*.

Respondents were also asked whether there was anything that could be done differently in the future to improve the community pharmacy scheme. A total of 53 respondents (58%) offered some reply to this question. In summary the responses were as follows:

- Provide more than one month's supply 12% of respondents
- Simplify system/less red tape 12% of respondents

- Establish as long-term program 11% of respondents
- Better publicity/awareness raising 5% of respondents
- Expand to other areas 2% of respondents
- Improve level of privacy/discretion 2% of respondents
- Offer a choice of pharmacies 2% of respondents
- Establish a shared client database 2% of respondents
- Various other matters 9% of respondents

3.1.9. Summary of survey findings

The survey findings showed a very high level of client acceptance of the community pharmacy pilot scheme, with 98% of respondents saying that they would take part in such a scheme if it were established on a permanent basis.

Key advantages identified by clients included longer opening hours, speed and simplicity of collecting medication, and convenience of locations. Just over a third of respondents reported improved compliance during the pilot; the remainder reported no difference in this regard.

Almost 80% of the respondents reported no problems or disadvantages associated with obtaining their medication from a community pharmacy. However, 15% said they had found the initial process of getting information about the pilot and registering for it *difficult or cumbersome*.

When participants in the pilot were asked to compare their community pharmacy experience with their previous experience in obtaining HIV medication from a hospital-based pharmacy, large majorities preferred the community pharmacy in relation to *opening hours*, *waiting time*, *overall quality of service*, and *travel time/accessibility*. Only in relation to *privacy and confidentiality* did a large number of respondents see little difference between the two settings – and even then almost as many *preferred* the community pharmacy.

Main suggestions for improvement of a future community pharmacy scheme were for *prescribing more than one month's supply* and *simplifying the procedures required*.

3.2. Focus group discussion

The focus group discussion with clients, which was conducted on 17 October, 2003 provided an opportunity to explore various aspects of the pilot scheme in some detail. The intention was to conduct a discussion on

various aspects of the pilot with a group of 8-10 people who had taken part. Among other things this discussion was intended to help shed further light on the survey findings described in section 3.1.

After discussion with ASC staff and representatives of PLWHA, it was decided to hold this focus group in a meeting room at an East Sydney hotel, between the hours of 5.30 pm and 7 pm.

The set of questions which were used as a discussion guide is set out in Appendix C.

3.2.1. Recruitment

The original client questionnaires which were administered by ASC (see section 2.2) had asked people whether they would be willing to take part in later research or discussions relating to the pilot, and were willing to be contacted by ASC for this purpose. Accordingly ASC agreed to try to contact participants who had indicated their willingness to contribute to later research, to ask if they were interested and able to take part in the discussion on 17 October, 2003; the aim was to find about half the focus group participants by this means. PLWHA was requested to identify another five or so participants in the pilot who would make up the balance of the discussion group.

In the event nine people (eight males and one female) took part in the group – five recruited through PLWHA and four by ASC. The participants had previously (before the pilot) obtained their HIV medication from ASC, St Vincent's Hospital, Royal Prince Alfred Hospital or North Shore Hospital. Clients of all of the community pharmacies except Bill Warner were represented. All participants lived in inner city areas – including the inner west and lower North Shore.

3.2.2. Focus group findings

Initial information and responses

People in the group had originally heard about the pilot through press publicity, from their pharmacist, from their doctor, or from ACON.

Their initial reactions had been generally quite positive ('*I couldn't wait'*, said one man). The attractions of the pilot included the prospect of easier access – particularly in terms of *opening hours* and *reliability* (no closures on 'low-activity days' as at the hospital). Some people had expected speedier dispensing/less waiting, or were attracted by the prospect of a 'one-stop-shop'. There were references in the group to the desirability of obtaining medication in a 'more normal' (less institutional) setting, and to the fact that one could expect '*a more personal relationship'* with a local pharmacist.

Registering for the pilot

Those participating in the focus group had generally found the process of registration straightforward, and said that their doctors had been quite positive and helpful. One person said that he had *changed* doctors soon after the pilot started, and that his *new* doctor had informed him about the pilot.

Three people said they had experienced some minor initial problem that took them back to their doctor in the early stages of the pilot – for example, to add a missing drug to the list.

Benefits of community pharmacy dispensing during the pilot

The main benefits which participants reported were as follows:

- *Less waiting time*. People in the group indicated that it had generally been a much quicker process to collect one's medication from a community pharmacy. Some of the hospital-based pharmacies previously used were described as very slow. A 45 minute wait at the hospital was common, it was said ('*They don't understand that I'm in a hurry*'). One person mentioned having had his car towed away from its parking spot while he waited at ASC. Experience was somewhat mixed in this regard, however: some people indicated that they had been able to make arrangements with their hospital or with the ASC pharmacy to obtain their medication promptly and efficiently.
- *More convenient access/longer opening hours*. A combination of central locations and longer hours served to make collection from the community pharmacy simpler and more convenient. One difficulty with using ASC or a hospital pharmacy was that it had often meant a special trip. Going to RPA Hospital, for example, '*takes half a day out of your schedule'*. Climbing the hill from Central Station to Albion Street could be taxing for someone not in good health.
- *One-stop-shop*. The community pharmacist could maintain a complete record of all your medication. ('*I leave all my scrips at the pharmacy'*).Your financial records relating to prescriptions, also, were all in one place; this was preferable to having to keep track of '*two separate cards'*.
- *Less institutional setting/better customer service*. The community pharmacy was said to offer a more 'normal', 'informal' or 'humane' environment than some of the hospital-based pharmacies. Comment was made, for example, on the 'regimented' ticketing and payment system in operation at one hospital. In part such differences were seen as a matter of staff training and attitudes: a commercial pharmacy had an interest in providing efficient and friendly customer service, whereas this was not necessarily true in an institution like a hospital. With the occasional exception, community pharmacy staff were *'a lot friendlier'*, *'much nicer'*; it was '*no trouble'* to them to respond to client questions or requests. Attitudes or demeanour of some hospital staff, on the other hand, had previously left some of the participants feeling embarrassed or uncomfortable.

- *Privacy/discretion*. Some participants thought the community pharmacy superior in terms of privacy. Community pharmacy staff were not likely to call out to a client 'You have to refrigerate the Ritonavir' – as was said to have happened at one hospital. More generally, being seen at a community pharmacy did not carry the same potential stigma or 'label' as attending a specialist health facility. Long *waits* at the hospital were one factor in some people's feeling very visible there.

  As noted below, however, there were a couple of people in the group who felt there had been a lapse in privacy protection at their community pharmacy.

- *Personal relationships*. Several people emphasised that they enjoyed a good personal relationship with their community pharmacist. For example, as noted above, some left all their prescriptions with the pharmacist and relied on him or her to keep an eye on what was needed, and when.
- *Payment methods*. The community pharmacies, unlike ASC or the hospitals, offered EFTPOS and accepted American Express™.
- *Information and advice*. Participants in the focus group expressed the view that one was more likely to get appropriate information and advice from a community pharmacy than a hospital pharmacy. For one thing, they thought, your local pharmacist was likely to have a more complete picture of your circumstances, health and medications (see above) and to be alert to potential drug interactions and the like. One man mentioned having had helpful advice from his community pharmacy, for example, on a suitable antihistamine. Some participants distinguished ASC from other hospital-based pharmacies in this context, seeing ASC as strong on providing information and advice.
- Participants in the group thought that *compliance* was, if anything, likely to be better with community pharmacy dispensing, because pharmacy accessibility reduced the likelihood of 'slip-ups' such as running out of a given drug.

Negatives associated with the pilot

- *Privacy*. Two people in the focus group commented that there had been an occasion when their community pharmacy had left their medication on the counter, visible to others.
- *Teething problems or errors.* There were several reports of initial errors or omissions (eg in completing the paperwork required by the pilot), but these had evidently been atypical.
- *Provision of one month's supply only.* Several people referred to being able to obtain only one month's supply of medication at the community pharmacy, whereas some hospital-based pharmacies had reportedly been fairly flexible about providing three months' supply – especially in holiday periods or when people were travelling. Some participants thought that this could pose a problem for them over the coming Christmas/summer holiday period, for example. One man, however, reported having obtained a

two months' supply from his community pharmacist – while another said that his hospital had 'never' given him more than one month's medication.

Monthly prescriptions were easier to pay for, some said – but one man said that since he was *tested* every three months, three months' dispensing made sense for him.

- *Organisation and communication*. Another concern was poor communication about the community pharmacy pilot; participants commented, for example, that they had not received clear information about changes/timeframe/extensions relating to the pilot.

Limited take-up of pilot places

The participants were asked their views on why all 300 places in the pilot had not been filled (several were surprised to learn that this was the case). The points they made were as follows:

- Some people were excluded by the terms of reference for the pilot, eg the requirement that patients have been stable on their medication for three month, or not be taking part in clinical trials.
- There was also some initial confusion or misunderstanding of the nature and scope of the pilot and about eligibility; for example, some people evidently thought that only persons on a pension were eligible. There was also uncertainty about how long the pilot was going to run.
- Obviously the *locations* of the five community pharmacies limited the geographical scope of the pilot.
- Most importantly, *prescribers*' approaches to the pilot varied, with a number of doctors reportedly 'put off' by the paperwork required of them (with no reimbursement). The doctor was identified as the key 'gatekeeper' for the project.

Overall preferences

All nine of the focus group participants stated that they preferred obtaining their HIV medication from a community pharmacy. People whom they thought were particularly likely to benefit from community pharmacy dispensing included:

- people in employment, for whom quicker and easier access and longer opening hours were very helpful;
- people in poor health or with a mobility problem, who stood to benefit from improved accessibility and flexibility (for example, your community pharmacist might in some circumstances home-deliver your medication).

Issues for the future

Obviously, it was said, a long-term community pharmacy scheme would need to cover more geographical areas. On the other hand several of the participants sounded a warning that '*not just any pharmacy'* should be entitled to take part. Not all would have the professional skills and sensitivity of the five pharmacies included in the pilot, and some appropriate tender or selection process, plus suitable training, would be required to ensure high standards of service. *'I'd want some kind of accreditation'*, said one participant.

There were some reservations about the likelihood of finding suitable community pharmacies in outer metropolitan areas or country towns; *confidentiality* would be a key issue in the country, it was said.

Some in the group were surprised to learn that the community pharmacies had received no dispensing fee during the pilot; this would presumably need to be addressed in the longer term.

Other points made included the following:

- The registration process needs to be simplified
- Doctors need to be more actively brought on board
- Effective and accurate information is required for potential users of the scheme.

3.2.3. Comparison with survey findings

Relative to the client survey, the focus group discussion added some points and clarified others. The thrust of comments made in the focus group was again very positive, and highly consistent with the survey findings. In terms of the benefits or advantages of community pharmacy dispensing, the survey and focus group findings were also broadly consistent with the *expectations* of participants as recorded in the initial ASC survey (see section 2.2)

4. Stakeholder Views and Experience

4.1. Introduction

As earlier sections of this report indicate, a number of different stakeholder groups – for example the participating community pharmacies, relevant hospital pharmacies, Albion Street Centre, ASHM, the prescribing doctors, and community organisations such as ACON and PLWHA – were involved in various ways in the planning and implementation of the pilot. The study team therefore sought information about the experience and opinions of people in these various groups. The information gathered is considered in the following sections, which discuss key issues arising out of the pilot.

It is worth noting at the outset that there was agreement among most of the stakeholders consulted that community pharmacy dispensing was both feasible, and desirable in principle. The particular concerns or priorities of various people or organisations, however, varied considerably.

Some people saw the pilot as representing a breakthrough in the dispensing of S100 drugs generally, as pointing the way towards a stronger relationship between hospital-based and community pharmacies, as a way of improving customer service and also relieving some of the pressure on understaffed hospital pharmacies. Advocacy groups such as ACON and PLWHA were particularly interested the in long-term quality of life benefits of community pharmacy dispensing, and were concerned that the unused places in the pilot not be seen as indicating lack of demand. Representatives of hospital-based pharmacies had two particular concerns about the pilot model –that it involved additional work for their staff, and that the hospital (Prince of Wales in this case) was required to 'sign off' on S100 documentation when it had no control or direct knowledge of what the community pharmacies were doing. The *prescribers* who were interviewed generally saw community pharmacy dispensing as a desirable development (some were emphatically in favour) but were critical of aspects of conduct of the pilot – especially what they saw as the unduly complicated or bureaucratic procedures involved. There was also comment, from various sources, that the prescribers had not been adequately consulted about the pilot or 'brought on board'.

The community pharmacies were for the most part satisfied with the way the pilot had run – subject to the issue of there being appropriately remunerated if the scheme, or something like it, continued in the longer term, and to concerns about having to pay the costs of stocking specialist HIV drugs. Other issues raised by various stakeholders included a view that the need for community pharmacy dispensing was much greater in rural areas than in the inner city.

4.2. Access and client satisfaction

Section 3 of this report indicates that direct feedback from clients who took part in the community pharmacy pilot was for the most part very positive. This was consistent with the perceptions of those stakeholders who felt able to comment on client response to the pilot. Two issues in particular were raised by stakeholders in this context – the take-up of places available in the pilot, and the issue of obtaining one month's, as against three months', supply of medication.

4.2.1. Take-up of pilot places

One or two of the stakeholders who were consulted argued that the shortfall in take-up of places available in the pilot left a question mark over the level of demand for community pharmacy dispensing. Others – including some prescribers, ASHM, ACON and PLWHA – believed that there were several reasons why the pilot had not been fully 'subscribed'. These were as follows:

Prescriber attitudes

Community prescribers, reported not being closely involved in discussions leading to the set-up of the pilot. The idea had 'been on the boil for years', but when it came to the point, 'it all happened in a rush' and with little prescriber involvement. Information about the pilot was just 'dumped' on doctors, said one person. A number of prescribers regarded the procedures required for the pilot as quite onerous and largely unnecessary – perhaps reflecting 'Albion Street' preoccupations rather than what a community dispensing scheme actually required. Further, given that the original timeframe for the pilot was only three months, some prescribers felt it was hardly worth their, or their patients', taking part. One major medical practice with large HIV patient numbers declined to take part in the pilot, apparently because of the requirements it imposed on prescribers.

One prescriber mentioned another practical issue: given the time required to complete the paperwork involved in registration for the pilot, it was only practical to do this, in a long consultation, if there were no other significant matters to be dealt with.

Short timeframe

As noted above, the pilot was originally guaranteed to last only three months. This was too short a period for many clients to think it worthwhile – especially since some were already obtaining a three months' supply of medication from their hospital-based pharmacy.

Inadequate information or publicity

Numbers of people commented that there was limited publicity for the pilot, and that many potential participants were dependent or their doctors for information about it. By the same token, as noted elsewhere, the arrangements for ensuring that doctors were fully informed were not considered adequate.

Further, it was said, there was confusion about the nature of the pilot and eligibility for it. For example, some evidently believed that only people on a pension were eligible to take part. The exclusion of patients who were 'on a clinical trial of antiretroviral medication' was in some cases allegedly misunderstood.

It was also emphasised that publicity and client information about the pilot had been patchy, and that there was continuing uncertainty about how long the pilot would continue. For example, there was no publicity for the fact that the pilot was continuing beyond the original three months. Likewise the message that community pharmacy access would continue past 30 September did not reach all participants (St Vincent's hospital pharmacy reported people 'turning up' there in October with community pharmacy scripts which it could not accept).

Lack of comparability with hospital dispensing

In several respects, it was said, the community pharmacy pilot did not offer the same service as was available from hospital-based pharmacies. In particular, the community pharmacies were expected (as with PBS prescriptions) to dispense only one month's supply at a time, whereas numbers of clients had been able to obtain a three months' supply from their hospital-based pharmacy. Beyond that, the exclusion of people on clinical or observation trials or those not 'stable on medication' for three months was a significant limitation on the scope of the pilot.

Further, participants in the pilot were asked to nominate one community pharmacy they would use, as distinct from being able to visit any hospital-based pharmacy.

Client reaction to the pilot process

Some HIV-positive people, it was said, were confused or put off by the procedures required for registration in the pilot – in particular the consent form. Accustomed to consent forms for clinical drug trials (which might involve, for example, receiving a placebo), they found it hard to understand exactly what they would be 'consenting' to in the case of the community pharmacy pilot.

4.2.2. Three months' supply of medication

The issue of patients being able to obtain one month's or three months' supply of medication came up frequently in discussion of the community pharmacy pilot. As noted in earlier sections, some patients from the

outset saw the fact that only one month's supply would be available from community pharmacies as a disadvantage, and some prescribers saw this as a disincentive to enrolment.

Discussions around this issue revealed varying practices among hospital-based pharmacies. As previously noted, patients' experience of having been able to obtain three months' supply of a drug varied. It appeared, for example, that St Vincent's pharmacy tended to provide a three months' supply more readily than ASC. Some people had the impression that it was easier to obtain three months' supply from a hospital-based pharmacy once the community pharmacy pilot was set up.

If the community pharmacy scheme continued in the long term, said one prescriber, community pharmacies would need to be able to provide a three months' supply of medication.

While numbers of clients regarded it as desirable to be able to obtain a three months' supply – especially if they lived outside Sydney, or when they were on holiday or travelling – some people within the health system raised concerns about this. One month's supply, they emphasised, was the norm for all prescriptions. One significant issue, especially in relation to HIV, was waste and cost if, for whatever reason, a three months' supply of medication was only partly used. Another issue was that it was valuable from a public health perspective for patients to have to come into frequent contact with a doctor or pharmacist; quality of care, it was said, was likely to be better if the patient 'checked in' each month.

4.3. Compliance

Health practitioners see consistent compliance with HIV treatment regimes as an issue of major importance; for example, failures in compliance (eg a 'drug holiday' from time to time) limit the future effectiveness of the medication. One of the reasons that some have advocated community pharmacy dispensing, therefore, is that the limited hours of operation of hospital-based pharmacies can represent a barrier to consistent compliance and lead to involuntary 'drug holidays'. One point made in this context was that *employed* patients may have difficulty with the embarrassment and self-disclosure likely to be involved in having to take time off work to attend a hospital pharmacy.

As indicated in section 2, ASC data on collection of HIV drugs during the pilot suggests that each month something like 70% of participants collected medication from their community pharmacy. Allowing for the fact that some of the other participants might, for example, have collected from the ASC pharmacy instead [2], or returned to their hospital pharmacy because of a change in medication, this would still suggest that a significant minority of participants did not consistently collect their medication. ASC staff who were consulted on this point indicated that this was not surprising, and that non-compliance in the form of non-collection was

[2] According to St Vincent's pharmacy representatives, it was not possible for pilot participants to move back and forth between the hospital and a community pharmacy.

a significant issue for hospital-based pharmacies also. One person suggested that, broadly speaking, around two-thirds of HIV patients complied conscientiously with their treatment regime, while another third were much less reliable; it was said that community pharmacists could usefully focus more on this issue than they had done during the pilot.

As far as participants in the pilot were concerned, the client survey and focus group discussed in section 3 show that clients believed that the community pharmacy pilot had been *either neutral or positive* in relation to compliance. Around one-third of the survey respondents, for example, reported improved compliance, and none reported poorer compliance.

One prescriber who was interviewed for the evaluation expressed strong views on this issue; believing that community pharmacy access made a significant contribution to improved compliance. This was not only because of easier accessibility and extended opening hours (which reduced the possibility of patients running out of a drug), but also because there was often quite a strong three-way relationship between prescriber, patient and pharmacist which meant that – for example – a failure by a patient to collect medication was likely to be brought more quickly to the doctor's notice. The community pharmacist might also be willing to supply a drug on credit for a time if the patient was short of money. This doctor also felt that close community prescriber/ community pharmacist links led to better patient care generally – for example, quicker identification of negative side-effects. The fact that the community pharmacist had a comprehensive view of the client's medications (and even of his or her *recreational* drug use) was also seen as a positive benefit.

The 'one-stop shop' offered by community pharmacy dispensing was thus seen not only as *convenient* for clients, but as offering better health care as the result of the community pharmacist's good overview of the client's situation and medical history, and the potential for direct communication between community prescriber and community pharmacist.

4.4. Cost issues

There are two broad cost issues to consider in relation to the pilot scheme – the costs of the drugs themselves, and the costs of dispensing.

4.4.1. Drug costs

If we assume that levels of patient collection of medication from hospital-based and community pharmacies are approximately equal (no firm evidence appears to be available on this either way), the actual medication costs involved in the two systems will be more or less the same. The difference is in who pays for the drugs, and how.

All the drugs dispensed during the pilot were supplied by the Prince of Wales pharmacy. This meant an increase in monthly costs at Prince of Wales, essentially because it was purchasing drugs that were to be used by former clients of the St Vincent's pharmacy. Even though these costs are ultimately reimbursed by the Commonwealth, the additional expenditure caused inconvenience at Prince of Wales.

Logically we might expect that HIV drug costs at St Vincent's pharmacy would have *decreased* during the pilot. St Vincent's representatives reported, however, that after a significant drop (of around 25%) in the amount of its S100 claim in the first three months period covered by the pilot, their drug costs returned to pre-pilot levels. It is not clear why this was so; the fact that there were major changes affecting the St Vincent's pharmacy over the period of the community pharmacy pilot (including a new location and new procedures) makes it difficult to isolate factors relating directly to the pilot. It is interesting to note that ASC pharmacy staff also commented that 'our GP scripts haven't dropped at all' during the pilot.

If a community pharmacy scheme continues in some form, the *costs of purchasing S100 HIV drugs* is a key issue. Several community pharmacists were reluctant to purchase and be reimbursed for these drugs (as for other drugs subsidised on the Pharmaceutical Benefits Scheme) because the high drug costs (creating outlay and cash-flow issues). In addition frequent developments and changes in prescribing HIV medications potentially result in the pharmacist being left with an unsaleable supply of an expensive drug. (The cost of stocking specialist HIV drugs was of course likely to be *less* of an issue in a situation where a community pharmacy was dealing only with a small number of regular clients.)

From the perspective of most of the community pharmacies, the pilot system whereby a *hospital* pharmacy handled the supply and the cost of the drugs was thus an appropriate one. For the future, as some observers see it, each major hospital could play a similar role in relation to a small number of community pharmacies which effectively provide an extension of its outpatient dispensing service. The viewpoints of hospital pharmacy staff raised questions about this model. Representatives strongly expressed the view that the cost to the hospital of administering a community pharmacy scheme (including additional costs for stock and inventory management) would far outweigh any savings to it in terms of reduced patient numbers. Given that they are reimbursed for the cost of the drug, less the patient co-payment, and no administration fee they felt they could not reasonably be asked to take on this additional task. Their strong preference was for a scheme where the community pharmacists would handle S100 drugs directly, without any hospital involvement. Hospital pharmacists also expressed concerns that the model used in the pilot involved 'an unnecessary layer of complexity' which should be avoided if possible.

Another major hospital reservation about the pilot model was that it required hospital pharmacy staff to take legal responsibility for the 'audit trail' of S100 drugs, when they had no direct knowledge of or control over what happened in the community pharmacies. One stakeholder suggested that an updated system which

provided *online* community pharmacy reporting to the hospital pharmacy should substantially reduce concerns of this kind.

One hospital pharmacist mentioned the new cancer drug *Glivec* as an example of community pharmacies being authorised directly to dispense a costly Special Authority drug.

4.4.2. Dispensing costs

As previously explained, during the pilot the community pharmacies charged the same co-payment amount as is payable at a hospital pharmacy, and passed these moneys back to ASC/Prince of Wales.

4.5. Feasibility

The pilot has in general terms demonstrated the feasibility of community pharmacy dispensing of specialist HIV drugs. Probably the most significant problem raised by any stakeholder in relation to the pilot related to the documentation required for reimbursement.

Various other concerns that had been expressed in advance – for example about whether community pharmacies could develop sufficient expertise in this area, and whether patient privacy could be adequately protected – have not proved to be major problems. Client reaction to the community pharmacy scheme has been essentially positive, and there appear to be few stakeholders who are critical of the *principle* of community pharmacy access. The issues that remain are practical, and in particular financial.

The number of HIV patients handled by the five community pharmacies during the pilot varied greatly, from six to over 120. The pharmacies varied also in their view of the sorts of numbers they could accommodate in the longer term; the two pharmacies with the largest client numbers believed that they could readily make arrangements to handle larger numbers.

As indicated in section 4.4, most of the community pharmacies appear to prefer a system in which – as in the pilot – they act as agents or extensions of a hospital pharmacy. The hospital pharmacies see issues with this in relation to costthe and in relation to their legal responsibilities with respect to S100 prescribing. There is also, as discussed in section 4, the question of how the community pharmacies are to be paid for their work.

If State and Commonwealth health authorities see merit in community pharmacy dispensing and support its continuation, these difficulties need not be insuperable. However there would clearly need to be detailed discussion and negotiation among the various relevant parties in order to reach agreement on the shape of an acceptable future scheme.

4.6. Other issues and impacts

4.6.1. Guidelines and protocols

As previously explained, the guidelines for the pilot *excluded* various groups of patients, including in particular those who had not been clinically stable on their current medication for three months. The rationale for this was that patients who had had recent changes in medication should continue to attend a hospital-based pharmacy in order to obtain appropriate information and advice. Some stakeholders believed that this exclusion reflected a somewhat exaggerated view of the level of information and advice provided at hospital-based pharmacies; one prescriber commented that in such a fast-changing field as HIV medication, 'stable for three months' was a significant limitation on the pilot. Another prescriber said that the pilot guidelines excluded 'half the patients' in his practice who would have been interested. A number of stakeholders believed that, in light of the positive experience of the pilot, future guidelines need not include such limitations. One hospital pharmacist, on the other hand, emphasised that the findings from the pilot were limited by the fact that the community pharmacies had not had to deal with 'more problematic' patients.

Another limitation of the pilot was that clients were asked to stick to one pharmacy for collection of HIV medication. Few of the clients surveyed, however, had found this a problem. Further, some health professionals emphasised the value of patients consistently obtaining medication at a place where they and their medical history were known ('Too much choice would reduce the qualify of care').

ASC representatives reported that the pilot protocols were generally, but not always, followed. In particular, there were evidently some cases where prescriptions were changed but the patient continued in the community pharmacy program.

While the community pharmacists had generally found the information provided to them on HIV medication useful, some made comments to the effect that it had been a little difficult to see the wood for the trees. One, for example, said that the one-day training course organised by ASHM had spent too much time on peripheral matters and not enough on the basic issues that would arise day-to-day. Another said that the Manual he had been given at the outset was excessively detailed and not practical; a five-minute explanation of key reporting issues would have been far more useful.

To some extent, perhaps, it was in the nature of a pilot scheme of this kind that the protocols prescribed should be very detailed and that collection of substantial amounts of data should be required. As we have seen, however, there were complaints (on the part of the community prescribers in particular, and to some extent from the community pharmacists) that the pilot procedures were unnecessarily time-consuming and cumbersome; future simplification would therefore be of key importance.

4.6.2 Unplanned impacts

The stakeholders whom the study team consulted were asked whether they had observed any incidental or unplanned impacts, positive or negative, of the community pharmacy pilot. The main comments made in this context were as follows:

- Several of the community pharmacists, and some of the other parties involved in the pilot, reported having found the experience of the pilot professionally rewarding in terms of new knowledge and insights gained.
- Some community pharmacies noted that the pilot had helped them identify areas in which their customer service could be improved. One pharmacy reported, for example, that in working to cater for the confidentiality requirements of HIV dispensing, it had recognised that there were other clients who would value a system designed to offer greater privacy.
- Some observers believed that some of the hospital-based pharmacies had worked to 'lift their game' since the pilot came on stream, in order to attract or retain clients. This was thought to involve, for example, greater efforts to meet clients' particular needs or circumstances and more effort to provide extended hours of service.
- One community prescriber, in particular, felt that the direct doctor/pharmacist links which characterised the pilot had proved very positive in terms of overall quality of patient care.

4.7 For the future

Preceding sections have referred to a number of key issues which stakeholders raised and which would need to be worked through if the pilot scheme, or a modified version of it, were to continue in the future. These include:

- more effective communication with community prescribers;
- better publicity and clearer information for patients;
- simplification of administrative procedures wherever possible, to minimise any disincentive to participation by doctors and other professionals (for example, 'radical overhaul' of the registration process);
- reconsideration of eligibility guidelines with a view to making community dispensing available to more patients;
- reviewing the future role, if any, of hospital pharmacies in relation to community dispensing;
- paying for the work done by community pharmacies;
- clarifying policies and practice relating to the dispensing of three months' supply of medication;

- the need for an effective and ongoing means of getting relevant information to community pharmacists – for example, by newsletters of the kind distributed by ASHM during the pilot.

There remain the important issues of possible geographical extension of community dispensing of HIV medication, and the potential use of community dispensing for other types of S100 drugs. Some stakeholders referred to these as 'equity' issues.

It was acknowledged that, while it had no doubt been appropriate to focus the pilot in a single geographical area, broader coverage would need to be considered if the scheme continued into the future. Particular areas which various people mentioned in this context were Newtown/Erskineville and the lower North Shore (both in inner Sydney), and the Northern Rivers area – all of which were seen as having significant numbers of HIV-positive people, as well as relevant community information and support structures and the like. One stakeholder emphasised the view that the potential benefits of community pharmacy access were likely to be *particularly valuable in country areas*, where travel distances were generally far greater than in inner Sydney.

Some people saw the pilot as pointing the way towards community pharmacy involvement in dispensing S100 drugs for conditions other than HIV. Some felt that it would be 'only fair' that if certain groups of patients had community pharmacy access, the privilege should be extended to others. On the other hand, there were some characteristics of HIV-positive people which tended to distinguish them from people with other conditions treated by S100 drugs. These included the fact that (as indicated above) there were some clear geographical areas with substantial numbers of people living with HIV, a relevant infrastructure of community organisations or services, and some local pharmacies with close links with this 'community'. The other distinctive factor, of course, was that only in relation to HIV are there 'specialist' general practitioners authorised to prescribe S100 medication. Possible extension of community pharmacy dispensing to other groups of patients, therefore, will need to be considered on its merits in each case.

5 Summary and conclusions

- This pilot has in broad terms demonstrated the feasibility of community pharmacy dispensing of specialist HIV medication. In the view of the participating community pharmacies, prescribers, clients and most other stakeholders, the pilot has generally worked smoothly and satisfactorily, and has shown that in terms of client service and satisfaction community pharmacy dispensing has much to recommend it. Anticipated problems relating to privacy protection and possible lack of pharmacy expertise have not arisen to any significant extent. Some observers believe that the introduction of an element of 'competition' has tended to lift standards of service at hospital-based pharmacies also.

- The responses of HIV-positive people who took part in the community pharmacy pilot have generally been very positive. For example, of 91 people who completed a client questionnaire in September-October 2002, 98% said that they would use such a scheme if it were available in the future. Key advantages which clients identified were extended opening hours, speed and simplicity in collection of medication, and convenient pharmacy locations.

When the survey respondents were asked to compare their community pharmacy experience with their previous experience in obtaining medication from a hospital-based pharmacy, large majorities preferred the community pharmacy in relation to *opening hours*, *waiting time*, *overall quality of service*, and *travel time/accessibility*. Only in relation to *privacy and confidentiality* did a significant number of respondents see little difference between the two settings – and even then almost as many *preferred* the community pharmacy.

Respondents' main suggestions for improvement of a future community pharmacy scheme were for *prescribing more than one month's supply* and *simplifying the procedures required*.

- Issues that were emphasised by people who took part in a client focus group included the closer or more personal relationship that they enjoyed with their community pharmacist, the fact that the community pharmacy offered a convenient 'one-stop shop', and their belief that they benefited from the community pharmacist's better all-round knowledge of their circumstances and of all the drugs they were using. Some also said that the community pharmacy represented a more pleasant and normal environment, and carried no stigma.

- *Out-of-hours access* was seen in advance as a key advantage of the community pharmacy scheme, and was certainly valued by numbers of those who took part in the pilot. However, the percentage of pilot participants who collected their medication outside hospital hours was evidently only around 55%; this would indicate that other factors, such as the availability of a 'one-stop shop' and a closer pharmacist-client relationship, were also significant contributors to client satisfaction with community pharmacy dispensing.

- People who completed the client survey questionnaire and those who took part in the client focus group believed that community pharmacy dispensing had either had no effect, or a positive effect, on *compliance* with their drug regimen. Among the survey participants, 36% reported improved compliance. One *prescriber* in particular saw community pharmacy dispensing as very positive in relation to compliance – because easier access made running out of a drug less likely, and because the three-way prescriber/patient/community pharmacist relationship led to a higher level of patient care and speedy identification of non-compliance or other problems.

On the other hand, pilot data available from ASC appear to indicate that in a given month only about 70% of pilot participants collected their medication from their community pharmacy. While this suggests a significant element of non-compliance, the study team was told that the same issue arises in collection from hospital-based pharmacies.

- The implications of the pilot as to long-term demand for community pharmacy dispensing are not completely clear. On the one hand only 184 people participated in the pilot, as against the 300 places available. On the other hand, both stakeholders and participants themselves believed that this relatively low take-up was explained by such factors as the short and uncertain duration of the pilot, limited publicity, restrictive eligibility criteria, and the reluctance of some prescribers to support what they saw as cumbersome and unjustified pilot procedures. The fact that one prescriber alone referred 90 patients to the pilot would suggest that the potential demand for community pharmacy dispensing is substantial; this was certainly the view of people representing ACON and PLWHA, for example, as well as several prescribers who were interviewed.

  Several of the participating pharmacies indicated that they believed that they could serve larger numbers of clients in the future.

- In terms of *geographical* expansion of community pharmacy dispensing of S100 HIV drugs, stakeholders suggested consideration of various areas in New South Wales known to have substantial numbers of HIV-positive people, such as the Newtown/Erskineville area, the area serviced by Royal North Shore Hospital, and the Northern Rivers area. Some people envisaged a community pharmacy system based around a series of teaching hospitals, each having links with a number of local pharmacies. There were some suggestions that the community pharmacy model was potentially valuable in *country* areas in particular, because of the long distances country people might need to travel to hospitals. (There were some *clients*, however, who felt that privacy and confidentiality could be significant problems in country towns.)

  Pilot participants and some stakeholders emphasised that, if new areas were to be included, *careful selection and suitable training of community pharmacies* would be essential in achieving appropriate levels of service. Some stakeholders envisaged an accreditation system comparable with the process of authorising community prescribers.

- As for introducing community pharmacy dispensing for other groups of S100 drugs, some stakeholders believed that the successful experience of the HIV pilot demonstrated that this could certainly be considered. Each illness or condition, however, might need to be considered separately. There were some distinctive characteristics of HIV-positive patients which perhaps made community pharmacy dispensing particularly appropriate or effective. These included the fact that there existed geographical

and social communities of gay men, including HIV-positive men, and that there were authorised community prescribers and particular local pharmacies which already served substantial numbers of these people.

- Stakeholders who have been involved in the community pharmacy pilot appear to see two broad possibilities for an ongoing scheme: one in which community pharmacies operate as extensions of an existing hospital service, and one in which community pharmacies operate independently. *Cost* issues are central to people's views of these possibilities.

  Independent operation would presumably mean – unless the Health Department was willing to underwrite the scheme in some way - that community pharmacies would have to purchase the relevant HIV drugs; some pharmacists are concerned at the large amount of money they would have to find to do this, and also at the financial risk (in a field where new drugs and drug combinations are relatively common) of being left with costly drugs on the shelves for which there is little demand. On the other hand, hospital pharmacies which had an involvement in the pilot tend to say that for them to liaise with and supply S100 drugs to community pharmacies would in itself be quite costly (more costly than themselves dispensing the drugs to patients) and that they are concerned at the prospect of being asked to do this without additional funding.

  A further reason why hospitals might favour an independent community pharmacy system is that there are difficulties in their accepting legal responsibility for compliance with the National Health Act in circumstances where they do not have direct control.

  Whether a future scheme involved a 'satellite' or an independent community pharmacy system, the issue of payment for the community pharmacy's services would need to be addressed. Probably this would be more simply dealt with in an 'independent' scheme.

- In the light of the experience of the pilot it would be appropriate for a working group of key stakeholders to develop specific recommendations on whether community prescribing of S100 HIV medication should continue in some form and, if so, how the administrative and financial questions left open by the pilot should be resolved.