

Final Report

Consumer Experiences, Needs and Expectations of Community Pharmacy

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1. EXECUTIVE SUMMARY

1.1 Research Aim

The broad research brief set by the Pharmacy Guild of Australia (PGoA) was to undertake research into consumer needs, experiences and expectations of community pharmacy. The aim of the research was to contribute to improving relationships between consumers, pharmacy staff and government, and to contribute to the development of consumer focused policy and pharmacy services.

1.2 Research Methodology

UniSA and its partners in the research team selected a mixed method methodology utilising both qualitative and quantitative methods for data collection, complemented by a review of relevant Australian and international literature. Statistical analysis was used for the quantitative data and thematic analysis was used for the qualitative data. Triangulation of the various data and information sources was used for the overall synthesis of results.

The six methods selected for the research project were:

- Telephone interviews with health consumers and the general population (n=2005)
- Exit interviews with community pharmacy customers (n=554)
- Pharmacist interviews (n=506)
- Face to face and telephone interviews with stakeholders (n=16)
- Focus groups with consumers (n=92)
- Literature review of Australian and international literature on consumer needs, experiences and expectations of community pharmacy

This report comprises detailed analysis, triangulation and synthesis of all results.

1.2.1 Definition of health consumer

It was agreed that the definition of health consumer should be someone who answers yes to the first of the following two questions, and at least once a month to the second:

“Do you personally, or does someone for whom you are a carer, have an ongoing condition requiring treatment, medication or monitoring?”

"How often, if ever, do you visit a pharmacy, either to buy something, get advice or browse?"

1.3 Profiles of consumers

1.3.1 General survey

2005 consumers were interviewed. Once the sample had been appropriately weighted to properly reflect the geographic, gender and age population distribution it emerged that 41% were health consumers defined (as agreed with the EAG prior to project commencement) as respondents who said that either they, or someone for whom they were a carer, had an ongoing condition requiring treatment, medication or monitoring and who indicated that they visited a pharmacy, either to buy something, get advice or browse, at least once a month. The highest proportion of health consumers was in Tasmania (54%) and the lowest proportion in Northern Territory (29%). Higher levels of health consumers were seen in rural and regional levels (44% and 43% respectively) compared to just over one third (38%) in the metropolitan area. Compared to non health consumers, health consumers were older, more likely to be female, to be retired or on a pension, to be in a household comprising an older couple with no children living at home and to have a lower household income.

1.3.2 Exit survey

554 consumers were surveyed as they left community pharmacies. In both metropolitan and regional areas, 43% of respondents qualified as health consumers. Similarly to the general public survey, health consumers tended to be older, were more likely to be female, to be retired or on a pension, and less likely to be employed full-time.

1.3.3 Focus groups

A total of 12 focus groups were conducted with participants from consumer organisations representing either general health consumers or consumers with specific health conditions. Specific groups included:

- people living in rural areas;
- older people;
- carers;
- people living with chronic conditions including arthritis, diabetes, mental illness, asthma;
- people from culturally and linguistically diverse communities;
- Indigenous groups

1.3.4 Organisation interviews

A total of 13 interviews were conducted, with 5 professional and/or government organisations and with 8 consumer organisations. Specific consumer groups represented were:

- people living in rural areas;
- older people;
- carers;
- people living with chronic conditions including HIV/AIDS;
- injecting and illicit drug users;
- people from culturally and linguistically diverse communities;
- Indigenous groups

1.4 Consumer Experiences of Community Pharmacy

1.4.1 Use of pharmacy services

In the general public survey:

- 16% of respondents were frequent users of pharmacies (once or more times per week), 65% were regular users (2-3 times a month to every few months), 15% were occasional users (once or twice a year or less often) and 4% never used pharmacies.
- A total of 54% of respondents stated that they used one particular pharmacy and 41% shopped at whichever pharmacy was the most convenient at the time.
- The most common reasons provided for choosing a pharmacy were 'close/convenient to home' (39%), 'friendly staff' (32%) and 'the staff and pharmacist know me' (25%).
- The most frequently purchased products were prescription medications (37% monthly, 21% quarterly) followed by OTC medicines (25% monthly, 25% quarterly), vitamins or herbal remedies (6% monthly, 10% quarterly).
- More than half (54%) of respondents had never visited a pharmacy to ask advice from the pharmacist or pharmacy assistant; 30% had previously used a pharmacy to decide whether to see a doctor; 13% had previously experienced a medicine review at pharmacy; 10% had used home delivery services; 8% had used health screening or monitoring facilities; 8% had used dose administration aids; 8% had used pharmacies for help to stop smoking; 2% had used needle exchange services; 2% had experienced a medicine review at home.

- When waiting for a prescription to be filled, the most common behaviours were to browse around the pharmacy (31%), leave and come back when it is convenient to them (19%), sit and wait (19%) or leave and come back when the prescription is ready (16%).

In the exit survey, 46% of respondents were visiting the pharmacy to have a prescription filled, 18% to buy OTC medicines, 5% to buy toiletries, 4% to buy vitamins or herbal remedies. Three quarters of respondents who were having a prescription filled had received the medication before (88% for health consumers and 61% for non health consumers). Consumers who used whichever pharmacy was convenient to them were more likely to receive their medication for the first time (35%) compared to respondents who only frequented one particular pharmacy (14%). While waiting for a prescription, 38% sat and waited, 24% browsed in the pharmacy while waiting and the remainder left and returned later (37%).

In the focus groups, when asked about their experiences of community pharmacy, access issues were raised in several contexts:

- geographic access: the limited number of pharmacies in some areas restricts consumer choice on the basis of service quality and prices, particularly in rural areas;
- opening hours: after hours access to pharmacies is limited in some areas;
- physical access: entry steps, overcrowded displays, absence of seats are of concern particularly for people with mobility restrictions.

1.4.2 General quality of services

In the general public survey, 68% of respondents claimed to have their prescription either always or usually filled within 10 minutes. When getting vitamins or herbal remedies 94% of respondents declared they always or usually received prompt attention. When asked what about using pharmacies that most needed to be improved, 59% could not think of anything, 12% said lower prices on medicines, and 12% said lower prices on other products.

In the exit survey, 80% of respondents waited less than 10 minutes for their prescription and 13% waited between 10-14 minutes. Generally, pharmacy staff were accurate in the waiting times they indicated to customers although one in ten waited longer than the predicted time. Respondents perceived the waiting time as extremely reasonable (rating 9.3 out of 10). When asked what could have been done differently to improve their visit, 79% of respondents said nothing, all was good; 13% could not think of anything. No suggestions of any note emerged.

In both surveys, consumers generally rated highly the performance of pharmacy staff. On a scale from 0 (0 extremely poor) to 10 (extremely well), the mean scores were:

- 8.1 and 9.6 for 'the pharmacist giving clear information and advice' in the general survey and exit survey respectively,
- 8.6 and 9.8 for 'being polite and courteous',
- 7.8 and 9.8 for 'being available when you need to speak with a pharmacist',
- 8.1 and 9.9 for 'listening to what you have to say',
- 7.0 and 9.7 for 'inviting questions'.

Performance ratings given by health consumers were consistently higher than those given by non-health consumers.

The performance of the pharmacy assistants was also rated highly:

- 8.8 and 9.7 for 'being polite and courteous',
- 8.4 and 9.6 for 'listening to what you have to say',
- 7.8 and 9.4 for 'being able to offer advice on products or services',
- 8.6 and 9.1 for 'making you feel welcome',
- 6.8 and 9.4 for 'calling you by name when you are leaving or collecting a prescription'.

The mean scores were consistently higher in the exit survey, probably reflecting that only people who had contact with the pharmacist or pharmacy assistant were asked to rate the performance of pharmacy staff in the exit survey.

In the focus groups, pharmacies were consistently described as a more relaxed and less pressured environment than doctors' rooms, and providing an opportunity for provision of written and verbal information about health conditions, treatments and services. Pharmacists were also described as using more consumer friendly language than doctors when explaining health treatments. Smaller pharmacies were seen by many participants as being more personalised in their service than larger outlets.

The tension between the retail and professional roles of community pharmacists was a topic frequently raised by focus group participants. While acknowledging commercial imperatives, many felt that the balance had moved too far toward non-pharmaceutical products and OTC and complementary medicines. The emphasis seemed to be on the sale of the product, rather than the quality aspects of the transaction, such as checking the persons understanding of the medicines and their need for information. Participants were concerned that pharmacy location in supermarkets may lead to the loss of

personalised relationships and consequent reduction in the provision of information and advice.

Packaging of dose administration aids was described as a valuable service with the added benefit of an accompanying record of the medicines. Home delivery was also frequently cited as a valued service, especially for those experiencing debilitating illness, disability and/or mobility problems.

There were a number of instances where consumers had been concerned by the quality of services, e.g. dosing error, absence of knowledge of the product being dispensed, stigmatization of people with mental illness or on opiate replacement therapy, lack of respect and recognition of patients' knowledge.

Consumer organisations reported that service experiences in community pharmacy varied and that older people tended to maintain a relationship with one pharmacist building rapport over time. This was also true of consumers from non-English speaking backgrounds, who would often seek out a language speaking pharmacy where one is available. However in both these instances, there was a need to ensure that this close relationship did not result in a monopoly over pricing or products to the disadvantage of the consumer.

In both focus groups and organisation interviews, direct access to the pharmacist was seen as restricted because of placement of pharmacists on a raised section at the rear of the pharmacy, and the necessity to deal with pharmacy assistants in the first instance.

Barriers could be magnified where there is limited choice of community pharmacies and where the consumer is known to the pharmacist. A number of peak organisations pointed to the difficulties experienced by consumers in small towns where the pharmacist may be a prominent person in the local community and where concerns or complaints about service standards in the pharmacy can be both negatively received by the pharmacist and divisive among community members.

1.4.3 Availability of medicines

In the general public survey, 73% of respondents stated that the 'pharmacy always had medicine in stock or could get it quickly' and 23% usually.

In the exit survey, 87% of respondents who were there for a prescription said that the pharmacy had their prescription medicine in stock or could get it quickly including 86% of the respondents in the metropolitan areas and 87% in the regional areas. There were important differences between States with the lowest rates of availability in NSW (51%) and the highest rates in Western Australia (98%). Of the consumers who purchased OTC medicines during their visit, 64% stated that the pharmacy had the medication in stock or could get it quickly.

In the focus groups, strong concerns about disruption of supply of medicines were raised. Disruption of supply could have severe health consequences for people who

needed daily medications to maintain their well being e.g. people with asthma, arthritis, mental illness, or on opiate replacement therapy.

Specific concerns were raised about:

- availability of medicines in remote areas where supply is dependent on alternative services (e.g. Flying Doctor services or school buses) which may be interrupted for long periods (school holidays or wet season) and as Health Insurance Commission supply amount restrictions prevent consumers from stocking-up;
- availability of antiretroviral medications for people in HIV/AIDS in NSW where supply is principally through hospital pharmacies as this limits ready access and maintains the experience of HIV/AIDS as a condition requiring hospital treatment;
- availability of opiate replacement therapy that is limited to some pharmacies and prevents “normalization” of people’s life;
- withdrawal of some medicines (e.g. a monoamine oxidase inhibitor).

1.4.4 Communication with the pharmacist and provision of information

In the general public survey, 56% of respondents declared they ‘never or rarely receive written information on how to use the medicine’ when they get prescriptions or OTC medicines, 18% always, 10% usually and 15% sometimes; 30% said they never or rarely speak with the pharmacist about to use the medicine, 30% always, 17% usually and 22% sometimes. Health consumers were less likely to speak with the pharmacist than non health consumers (34% versus 16%). When asked to rate the performance of service-related attributes on a scale from 0 (0 extremely poor) to 10 (extremely well), the mean scores were:

- 8.1 for the pharmacist ‘giving clear information and advice’,
- 8.1 for ‘the pharmacist listening to what you have to say’,
- 7 for ‘inviting questions’,
- 7.8 for the ‘pharmacist being available when you need to speak to him’.

When getting vitamins or herbal remedies, 23% of respondents said they always or usually receive printed information about the health issue relating to the product; 67% said they always or usually receive advice that the product is right for them.

In the exit survey, 77% of the consumers spoke to the pharmacy assistant only during their visit to the pharmacy, whilst 10% spoke to the pharmacist only and 6% spoke to no one. Of the consumers who lodged or collected a prescription, 7% received written instructions on how to use the medicine apart from what is on the bottle or packaging; 19% spoke with the pharmacist about the medicine or related health issue (5% initiated

by the pharmacist and 12% initiated by the consumer), 15% spoke with the pharmacy assistant (7% initiated by the assistant and 8% initiated by the consumer). Respondents who were receiving the medication for the first time were more likely to speak to the pharmacist about using the medication (47%) and to receive written instructions (15%) in comparison to respondents who had received the medication on a prior occasion (15% and 4% respectively). Health consumers were more likely to seek advice from both the pharmacy and pharmacy assistant (54%) during their visit compared to non-health consumers (46%). When purchasing OTC medicines, 44% spoke with the pharmacy assistant about the medicine or related health issue (9% initiated by the assistant and 36% initiated by the consumer) and 9% spoke with pharmacist (3% initiated by the pharmacist, 6% initiated by the consumer).

In the focus groups, participants consistently reported that information about medicines tends to be provided in limited ways and on limited occasions. Consumer Medicines Information (CMI) was rarely offered and broader information about health conditions and their treatments is rarely drawn to consumers' attention. When available, information sheets and cards were described as most commonly associated with product marketing such as vitamins and complementary medicines, rather than being from independent information sources. The focus of the transaction around payment is seen as limiting the consumer's opportunity to ask questions.

Consumer and carer peak organisations describe the provision of both written and verbal information as variable. Carers may be denied information on the basis of privacy concerns; while one peak consumer organisation which has been promoting the uptake of CMI through peer education activities has received reports of consumers being denied this. The reasons pharmacists have given for not providing a CMI were that the consumer didn't need it, that it was too technical and that the consumers wouldn't understand it. In some instances, pharmacists have sought to charge consumers for providing a CMI. All of these reasons were seen as unacceptable.

1.4.5 Privacy

In the general survey, the mean scores given for maintenance of privacy by the pharmacist and the pharmacy assistant were 7.8 and 8 respectively on a scale from 0 to 10. In the exit survey, the maintenance of privacy by the pharmacist and the pharmacy assistant were rated 9.7 for both.

In the exit survey, of consumers who spoke to either the pharmacist or pharmacy assistant, 94% responded that their privacy was quite well or very well maintained. Health consumers were more likely to indicate that their privacy was very well maintained (94%) compared to non health consumers (58%).

In the focus groups, many participants noted the lack of privacy and consequent concerns about confidentiality. There were many examples provided of overhearing other people's medicines history. It was of particular concern to people with mental illness and on opiate replacement therapy. Privacy was also viewed as a major issue by

organisations, especially with the trend to development of additional professional services.

Consumer organisations reported that younger people and those in small towns might not be satisfied, especially for example where the young consumer was seeking products such as condoms or emergency contraception.

1.4.6 Costs

In the general survey, when asked what about using pharmacies most needed to be improved, 12% of respondents indicated 'lower prices on medicines', and 12% 'lower prices on other products'.

Concerns on costs were raised in focus groups and by peak organisations on a number of issues:

- default mark-up previously contained in pharmacy software;
- variations in costs of medicines between pharmacies;
- records of subsidised medicines through "safety net stickers" reported to be inconsistent;
- additional charges being levied over the safety net price;
- costs of buying whole packets of products such as dressings instead of single products;
- substantial dispensing costs for opiate replacement therapy;
- supply charges for medicines only available through hospitals such as some kind of eye drops;
- higher costs of complementary medicines, devices and consumables compared to alternative suppliers.
- costs of additional services such as packaging of dose administration aids.

There was a general view that the additional charges applied to medicines needed to be more open and transparent to consumers.

1.4.7 Generic medicines

In the focus groups, participants expressed concerns that the emphasis on generics focused on costs with a number believing that generics were either not as effective or had different side effects. Some participants were unwilling to take a risk with generics when ongoing therapy is required. Concerns were also raised on frequent changes in appearance and brand name within short time periods of supply. Organizations reported that consumers were frequently confused by the various terms applied to generics such as "home brand" or "chain brand".

1.4.8 Pharmacy assistants

In the general public survey, when purchasing vitamins or herbal remedies, 80% of respondents declared that pharmacy assistants were 'always or usually knowledgeable about health products', 75% that 'assistants refers them always or usually to the pharmacist when preferred'. Mean scores for performance of pharmacy assistants were generally high: 8.8 for 'being polite and courteous', 8.6 for 'making you feel welcome', 8.4 for 'listening to what to have to say', 7.8 for 'being able to offer advice on products or services', 6.8 for 'calling you by name when you are leaving or collecting a scrip'. Scores given by health consumers were always higher than those by non health consumers.

In both focus groups and organisation interviews, pharmacy assistants were consistently described as variable in their interactions with consumers. While many were reported to be knowledgeable and effective in checking and referring to the pharmacist where appropriate, a number of instances were cited where the assistant was seen as a barrier to accessing the pharmacist and on occasions provided incorrect advice or had inappropriate attitudes with consumers with mental illness or on opiate replacement therapy.

1.5 Consumer needs and expectations

1.5.1 General quality of services

The general public survey indicated that almost all of the respondents had a need for the medicine to be in stock or be accessed quickly by the pharmacy (87% of the total sample) and most wanted short waiting times for the prescription to be dispensed (<10 minutes). Couples or singles with children living at home strongly expressed this need, perhaps reflecting the concerns of parents when a child is sick or time pressures.

All participants in the focus groups identified community pharmacy as a key source for meeting their prescription medicines needs and expected that supplies would be readily available. They expected that medicines remained the major focus of pharmacies and were critical of the development of the non-pharmaceutical section in many pharmacies. Pharmacists were seen by most participants as experts in medicines, more so than doctors. A number of participants described the pharmacist as a first stop for primary health care enquiries and some older participants noted that this role seemed to have declined over the years. The role of pharmacists in preventative health care was also seen by a number of participants as important.

All peak professional and government stakeholders identified the need for high standards of service in community pharmacy, provided by well trained staff that are familiar with the products they are supplying. There was a general enquiry across focus groups about the training standards and requirements for pharmacy assistants and concern that they may be principally trained by product suppliers to promote those products.

All participants reported that personalised service from their community pharmacist was highly valued and a key need and expectation. Those participants who had developed such a relationship with their pharmacists found that they tended to get additional benefits such as written and verbal information, assistance with maintenance of their prescription records, and home delivery where required; and that other professional services were offered such as dose administration aids and Home Medicines Review.

1.5.2 Information provision

In the general public survey, the needs the most frequently identified were:

- ‘to receive advice that the non prescription health products were right for them’ (74%),
- ‘to speak with the pharmacist about how to use the medicine’ (65%),
- ‘to receive printed information about the health issue relating to the product’ (56%),
- ‘to receive written instructions on how to use the medicine’ (46%).

Both consumer and carer peak organisations highlighted the need for consistent provision of written information, both about medicines and about the services that community pharmacy offers.

In the focus groups, information was identified as a major need and expectation of community pharmacy. The type of information sought was about prescription, OTC and complementary medicine, how to take it, side effects, interactions and costs. A major theme in most of the group discussions was that information should be provided in a context of dialogue with the consumer. There was also an expectation of impartial and professional advice free from commercial considerations. Provision of information to people from non-English speaking background was also reported as essential.

Consumers also want prominent signage encouraging consumers to ask for both written information about their medicines and independent information brochures on health treatments (eg for the 10 most common conditions) were available.

1.5.3 Other services

From the general survey, when asked about more specific health care needs, the only service needs that were strongly expressed were ‘health screening and monitoring’ (with 29% claiming that they would use this service either biannually or quarterly), followed by ‘medication reviews at the pharmacy’ (23% using biannually or quarterly) were. The small proportion that identified these needs is not surprising as only a small percentage of the population would have any real need for these services; for example medication reviews are probably only considered relevant by those with complex medication regimen.

In the focus groups, a number of pharmacy services were seen as very valuable:

- packaging of dose administration aids;
- home delivery;
- return of unwanted medicines;
- medication list printouts.

Consumers expressed a need for more information about services such as Home Medicines Review, medicines delivery or medicines records assistance.

Consumers would like regional arrangements in place to ensure extended hours availability on a more consistent geographic basis and information about pharmacy locations and opening hours easier to find.

Several peak consumer organisations identified specific needs in relation to generic medicines:

- increased access to generic medicines in particular for people with asthma and those with mental illness;
- more information on generics beyond issues of cost;
- better identification and consistency of supply to avoid confusion.

1.5.4 Continuity of care

In the focus groups a number of participants suggested much closer working relations and interactions need to be developed between local pharmacists and GPs. Where they are closely located, these arrangements are seen by consumers often to work well. Additional options identified by some participants included more systematic engagement possibly facilitated through Divisions of General Practice. Some groups noted the ageing population and growth of services such as Hospital in the Home, and wanted to see community pharmacists much more engaged as a part of the “total health care team”.

Most peak organisations identified the importance of effective working relationships between doctors and pharmacists.

1.6 Recommendations

1.6.1 Medicines information

Recommendation One

It is recommended that:

The PGoA works with the Pharmaceutical Society of Australia (PSA), other pharmacy professional bodies and the Pharmacy Boards as part of an integrated strategy to improve the provision of information on medicines to consumers to:

- a) Emphasise, promote and monitor the routine proactive provision of both verbal and written medicines information to all community pharmacy customers.
- b) Review of the Professional Practice Standards on patient counselling to ensure the inclusion of the recommendations regarding the provision of Consumer Medicines Information (CMI) contained in the PSA guidelines on 'Consumer Medicine Information and the Pharmacist'.
- c) Ensure that pharmacists and their staff are fully aware of the professional standards relating to patient counselling and provision of information to consumers.
- d) Ensure compliance of pharmacists and their staff with the PSA Professional Practice Standards and standards for the provision of pharmacist only and pharmacy medicines through proactive monitoring of these standards
- e) Ensure that compliance with these standards is a mandatory requirement of the QCPP.
- f) Develop in collaboration with the Consumers' Health Forum of Australia (CHF) a campaign through consumer organisations to encourage health consumers to request the provision of information and CMI when they are provided with medicines through pharmacies.
- g) Require all pharmacists to clearly advertise the availability of medicines information within their pharmacies.

1.6.2 Raising expectations of community pharmacy professional services

Recommendation Two

It is recommended that the PGoA:

- Encourages all pharmacies to clearly advertise the availability of specific professional services such as home delivery, dose administration aids, return of unwanted medicines, home medicines review, medication list printouts.
- Works with the PSA, other pharmacy organisations, the Pharmacy Boards and CHF to develop a consumer version of the PSA Professional Practice Standards and Standards for the provision of pharmacist only and pharmacy medicines which could be distributed to consumers.
- Consults with CHF about the development of consumer materials about training of pharmacists and pharmacy assistants. The dissemination of those materials could be co-ordinated through CHF to a wide range of consumer organisations. The materials should also be displayed in community pharmacies.
- Develops resources for all community pharmacies that promote and foster consumer feedback on the services in the pharmacy,
- Develops resources for all community pharmacies to clearly explain the pharmacy's complaints process and the role of the State Pharmacy Boards.

1.6.3 Privacy

Recommendation Three

It is recommended that the PGoA:

- Undertakes further research with consumers and consumer organisations regarding privacy issues in community pharmacy. The research should explore consumers' views, especially those from disadvantaged or marginalised groups, on how privacy is dealt with in the community pharmacy context and propose recommendations to ensure patient privacy in specific situations.
- Pharmacy professional organisations and Pharmacy Boards ensure that adequate guidance is provided to pharmacies participating in methadone programs to protect patient privacy during the dispensing process.

1.6.4 Medicines supply

Recommendation Four

It is recommended that the PGoA further investigates matters affecting the timely availability of medicines to consumers through community pharmacies, particularly in NSW.

Recommendation Five

It is recommended that the exit survey method using an expanded sample of pharmacies across Australia should be routinely used as part of the re-accreditation processes of the Quality Care Pharmacy Program (QCPP). The results of the exit surveys should be presented in the annual reports of the QCPP.

1.6.5 A way forward

Recommendation Six

It is recommended that:

- the Sustainable Model of Consumer Engagement in Community Pharmacy Policies and Practices as outlined in section 7 be accepted by the PGoA and that a Community Pharmacy Consumer Advisory Council be established as a matter of urgency to oversee the implementation of the full model by December 2006. It would be an advisory group to the profession, hosted by the PGoA and supported by the CHF.
- the recommendations of this report be priority items on the agenda of the Advisory Council. Terms of Reference would include:
 - Oversight of a national campaign to raise awareness of professional community pharmacy services amongst consumers and pharmacy staff
 - Oversight of the framework and model of consumer participation in community pharmacy
 - Developing a mechanism for consumer input to:
 - the Pharmacy/Government Agreement negotiations
 - the PSA Professional Practice Standards and the QCPP accreditation development and review processes
 - the training of pharmacists and pharmacy staff
 - Monitoring and advice on key consumer issues:
 - CMI
 - Counselling
 - Consumers with special needs

- The PGoA negotiates through the Guild/Government Agreement appropriate resources for the implementation of the Sustainable Model of Consumer Engagement in Community Pharmacy Policies and Practices.
- The CHF be funded for the equivalent of a FTE Project Officer and travel budget to support the National and State Advisory Structures that are part of the Model.
- The PGoA should draft a strong statement of support for consumer involvement in community pharmacy at all levels and seek the support of the PSA, the Australian College of Pharmacy Practice and Management (ACPPM), the Department of Health and Ageing, the Association of Professional Engineers, Scientists and Managers (APESMA) and the CHF. The statement would be posted on all relevant pharmacy profession related websites and published in all relevant pharmacy publications
- The PGoA actively supports regular monitoring of consumer involvement and feedback at the local pharmacy level during the QCPP accreditation process.

Recommendation Seven

It is recommended that all States and Territories have their own community pharmacy consumer advisory structure.

The Terms of Reference would include:

- Consumer input to continuing professional development activities for pharmacists in relation to consumer engagement strategies, medicines information provision, and other key consumer issues
- Act as a resource for local pharmacies to test ideas and discuss issues with consumers
- Encourage and support local pharmacies to undertake consumer engagement activities by assisting in the implementation of the recommended strategy from this research.

Membership would be comprised of nominees of relevant State and local consumer organisations (the diversity of community pharmacy consumers would be reflected in the membership).

State coordinators should be appointed to support the State consumer advisory structure and resource the implementation of the consumer engagement strategy in the State.

1.6.6 Monitoring research on consumer experiences of community pharmacy

Recommendation Eight

It is recommended that research on consumer experiences, needs and expectations of community pharmacy be undertaken to monitor changes in consumer experiences improvements in consumer engagement in community pharmacy in line with the Guild/Government Agreement cycle, commencing the next research in July 2007 to ensure it is complete in early 2008 in time for negotiations on the next Agreement.

1.7 Conclusions

The research into consumer experiences, needs and expectations has provided the pharmacy profession with a rich source of information about the consumer perspective of community pharmacy.

Consumers' experiences of community pharmacy have generally been positive, however some groups of consumer, notably those with significant health needs have less satisfactory experiences than general consumers.

Information was identified as both a major need and an expectation of community pharmacy.

Consumer needs most frequently identified through the research were:

- Ready access to needed medicines including shorter waiting times for prescriptions to be dispensed
- the need for consistent provision of written information, both about medicines (prescription and non-prescription) and about the services that community pharmacy offers
- to speak with the pharmacist about how to use the medicine and to receive written instructions on how to use the medicine

Pharmacists were seen by most participants as experts in medicines, more so than doctors. All participants reported that personalised service from their community pharmacist was highly valued and a key need and expectation.

All peak professional and government stakeholders identified the need for high standards of service in community pharmacy, provided by well trained staff who are familiar with the products they are supplying.

2. INTRODUCTION

The PGoA commissioned a consortium led by the University of South Australia and comprising Harrison Health Research, Tony Lawson Consulting and Australia's Health Pty Ltd to undertake research into consumer experiences, needs and expectations of community pharmacy. The aim of the research was to contribute to improving relationships between consumers, pharmacy staff and government, and to contribute to the development of consumer focused policy and pharmacy services.

2.1 Context

The development of novel pharmacy services, the national implementation of standards of pharmacy practice, the QCPP and the move from a dispensing-counselling approach toward an integrated patient-centred approach, have been shaping community pharmacy practices in the last 10 years. However, the public may be unaware of these changes as many are subtle, and introduced gradually over time.

Although there have been some initiatives such as the CHF Pharmaceuticals Project (1992-1995) the Implementation Steering Group for Home Medicines Review and the design, implementation and evaluation of the pharmacist only and pharmacy medicines standards projects, there is currently no systematised framework to involve consumers in the enhancement of the quality of pharmacy services, either at the "grassroots" level in community pharmacies or at the federal and state level with peak professional bodies. The reaction to the publication of the survey of consumers about community pharmacy in the Choice magazine illustrated the insufficiency of on-going communication and fruitful collaboration between pharmacy and consumer organisations (Choice magazine survey, 2004).

The development potential of community pharmacy in the health care system is considerable. This potential may include strengthening of the core function of pharmacists in dispensing and counselling to support the quality use of medicines, primary health care services as the first point of call for patients engaged in self-management of chronic illnesses, provision of advice on healthy lifestyle and disease prevention and referral to other health care providers eg general practitioners (GPs).

Pharmacy services designed and delivered with an understanding of the views and needs of those who use it are more likely to effectively meet those needs. Collaboration with consumers as stakeholders will lead to sustainable improvements and maintain public confidence in community pharmacy.

2.2 Aim of the Research

In view of the above, the ultimate aim of this research is the improvement of service delivery to health consumers in community pharmacy to best meet the needs and expectations of the community. In meeting this aim, the following research questions have been addressed:

- What are consumer experiences in relation to community pharmacy?
- What are consumer expectations and needs in relation to community pharmacy? Are these expectations and needs met? What gaps and deficiencies may exist in the services provided by community pharmacy? How can any shortfalls be addressed? How are consumers currently involved in the improvement and development of pharmacy services?
- How can consumer participation be encouraged at the different levels (community pharmacy, professional organisations, and national policy)?

2.3 Intended Outcomes

The intended outcome of this project has been for consumers, pharmacy and government to gain a better understanding of consumers' experience, needs and expectations of pharmacist, pharmacy assistants and community pharmacy in order to improve the relationship between these stakeholders and assist in the development of better policy and services.

3. LITERATURE REVIEW

3.1 Literature Review Methodology

There are two streams of literature relevant to this project. The first stream is that addressing consumer experiences, needs and expectations of community pharmacists and community pharmacy. The second stream is the literature which discusses consumer participation in health. A detailed search of the literature has been conducted in these two streams and has taken into account Australian and international peer reviewed literature as well as Australian non-peer reviewed literature and grey literature published from 1990 to May 2005.

Full searches of the peer reviewed literature were conducted using the following computerized bibliographic databases.

- Medline
- International Pharmaceutical Abstracts (IPA)
- Cochrane library
- Consumer Sciences Index (CSI)
- Current Affairs
- Health Source Consumer Edition
- Sociological Abstracts
- Social Sciences Citation Index
- Australasian Medical Index
- EbscoHost databases

The key words used for the literature searches (alone and in combination) were: consumers, users, needs, expectations, experiences, pharmacy, pharmacy services, pharmacy, community pharmacy, pharmacist, community pharmacist, satisfaction, pharmacy assistants, pharmacy technicians, medicines, drugs, consumer participation, consumer participation and health, participation model, participation and health policy. Search for literature on consumer participation was limited to community pharmacy. Studies and reports on consumer participation in the health care system and in specific settings other than community pharmacy were excluded from the literature analysis.

Peer reviewed articles for both streams of literature were also identified through hand searching and bibliographies of retrieved articles. All studies which were relevant to the aims of the project and which could be easily located were included. Thus studies looking at consumer needs, expectations, experiences and satisfaction with pharmacy

services (general as well as specific) and consumer participation in health were included.

Australian non-peer reviewed literature and articles from the grey literature were located from data sources such as:

- CHF of Australia;
- Department of Health and Aged Care;
- Health Issues Centre;
- National Resource Centre for Consumer Participation in Health;
- Pharmacy Guild of Australia;
- Quality Use of Medicines Map website;
- Councils on the Ageing (COTA) and National Seniors Association.

In order to provide a comprehensive overview of the research, both qualitative and quantitative research was included. Quality assessment frameworks for research focus mainly on experimental studies (e.g. randomised controlled trials). As the vast majority of research on consumer experiences, needs and expectations is descriptive, it was thought to be not appropriate for this review. Hence, it was decided that studies would not be excluded on the basis of the designs or the quality of methods used.

One reviewer examined the lists of titles and abstracts from the searches and obtained hard copies from papers to be considered for inclusion. Unfortunately, it was not possible to obtain hard copies for all articles due to time constraints.

Data from the published papers and reports were abstracted by two reviewers and entered into tables using the following categories: reference, country, objectives, methods, participants and main results. Studies were classified into three broad categories: studies which have examined consumers' experiences in relation to community pharmacy services in Australia (tables 1 and 2) and in other countries (tables 3 and 4), studies which have examined consumers' needs and expectations in Australia (table 5) and in other countries (table 6) and studies which have looked at consumers participation in Australia (table 7). We were not able to identify any study on consumer participation in other countries.

Given the differences in the methods used and the types of questions asked, it was not possible to provide overall quantitative summaries on consumer related issues e.g. frequency of counselling when buying over-the-counter medicines. We have provided a detailed overall summary for the Australian studies and a short summary for the international studies.

3.1.1 Study designs

Studies on consumer experiences, needs and expectations used a range of qualitative and quantitative methods to collect data. They included: surveys with questionnaires (distributed through pharmacies or by mail); interviews (face-to-face or by phone); focus groups; and observations of pharmacist-consumer interactions with or without tape recording. Some studies assessed patients' experiences by using mystery shoppers or pseudo patients. Survey participants were recruited through pharmacies or consumer groups, or sampled from the general population. Some studies focused on specific services (e.g. cardiovascular disease prevention and management, dispensing of OTC medicines, home medication reviews), and some focused on specific populations (e.g. rural, elderly, patients with diabetes or asthma).

3.2 Literature Review Results

3.2.1 Consumer experiences with community pharmacy in Australia

Seventeen studies were located in Australia (table 1 – please see **Attachment 14** for tables of literature review results).

Seven studies looked at experiences with specialised community pharmacy services including three on medication management services [1], [2], [3], one on cardiovascular disease management [4], one on management of skin conditions [5], and one on smoking cessation [6]. Most studies showed a high level of satisfaction with the services provided.

In 1995, the CHF of Australia organised a national consultation with over 150 consumers to investigate the impact on consumers of recent changes in pharmaceuticals policy [7]. Participants were concerned that they were not receiving the information on pharmaceuticals which they wanted. Only some participants reported that there were opportunities to talk to the chemist when getting a new prescription filled. Often, they only dealt with a shop assistant and this was not satisfactory in terms of getting information about medications. It was thought that speaking to the chemist was more likely if it was a first-time prescription, if the consumer had a disability, if the layout of the shop allowed it and if the dispensing area was separate from the rest of the shop.

One study assessed consumer satisfaction in relation to level of drug information provided in 10 high (sit down consultation style) and low (traditional) information provision pharmacies [8]. No difference was found between the two pharmacy types in terms of consumer satisfaction. However, the study showed that up to 41% of consumers currently patronizing low information provider pharmacies indicated a preference for a high information provider pharmacy given equivalent convenience and no preformed loyalties to a particular pharmacist.

In 2002, one study assessed consumers' knowledge of CMI (Consumer Medicines Information) through 6 focus groups [9]. It showed that only a minority of consumers had experienced a pharmacist providing or discussing CMIs.

In 2002, a study assessed the implementation of national standards of practice for the provision of *pharmacist only* and *pharmacy* medicines in approximately 50% of community pharmacies in Australia [10]. Forty-five pseudo patients were recruited and participated in 2370 pharmacy visits in all states and territories. Six scenarios were used to simulate patient requests, either a direct product request or symptom based request. The level of pharmacy interaction was measured by allocating a score for each interaction element (e.g. “who is it for?”, “symptoms how long?”). Some clinical interaction occurred in 80% of pharmacies for direct product requests; 65% of pseudo patient visits resulted in patients receiving verbal information. In contrast, pharmacies assessed whether another treatment had been tried in only 23% of visits and the duration of the symptoms was ascertained in only 24% of cases. For symptom-based requests 99% of pharmacies exchanged information with the pseudo patient; 93% of pseudo patient visits resulted in patients receiving verbal information. In contrast, pharmacies assessed other medications in only 29% of visits and other symptoms in only 31% of cases.

In 2003-2004 a research project assessed the impact of the Quality Care Pharmacy Project (QCPP) [11]. The QCPP aims to maintain the standards and quality of care of community pharmacies through re-accreditation processes. The evaluation included a survey of pharmacy consumers, a survey of consumers with specific diseases (asthma or diabetes) and an assessment of the standards of practice using mystery shoppers.

A questionnaire survey of 1902 pharmacy consumers as they exited 84 sampled pharmacies was conducted using a 22-item survey tool. The survey tool addressed both functional quality (what the consumer experiences eg timely service provision, feeling that the pharmacist understands their specific needs, how the pharmacy looks or interactions with staff) and technical quality (eg the right drug dispensed to the right person, providing a non-prescription item that is appropriate, etc.). Sixty per cent of the respondents rated the service received at the pharmacy as excellent. This included waiting time, level of service and quality of service. Ninety-three per cent of consumers presenting a new prescription reported receiving at least some counselling. Approximately 50% of consumers with prescription for continuing medicines and 75% of consumers seeking non-prescription medicines reported receiving counselling. 22% of consumers reported being given written information (34% if a new medicine was dispensed).

Generally, basic professional services such as advising on how to take a medicine or choosing a non-prescription medicine were performed relatively frequently but that more advanced or high-level services were performed much less frequently. The median score for pharmaceutical care oriented directive guidance was 40% compared with basic counselling (median score 75%). Less than half of the consumers who had experienced an adverse drug reaction reported that the pharmacy knew of this experience. The technical and functional quality of services provided by accredited pharmacies was superior to non-accredited pharmacies in terms of counselling given, consumer perceptions of quality and satisfaction and intention to return. Providing written medication information (Consumer Medicines Information) and maintaining patient profiles include adverse drug reaction history are the subject of two of the QCPP

standards yet there was no difference between accredited and non-accredited pharmacies in these areas of technical quality.

The evaluation of QCPP also included a survey of 246 consumers with diabetes or asthma with questionnaires being distributed through pharmacies [11]. Consumers expressed high levels of satisfaction with their diabetes and asthma related services. This high level of satisfaction was expressed in the face of low technical quality: despite the majority of respondents being regular consumers, a low level of disease management services was reported: 32% and 35% of respondents reported receiving none of the more traditional pharmacy services for diabetes and asthma respectively (e.g. written information on medicines, advice on use of a spacer); 38% and 34% of respondents reported receiving none of the more advanced disease management services (eg checking asthma plan and explaining how to use inhaler and checking technique). There was no difference between accredited and non-accredited pharmacies.

The evaluation of QCPP also included an assessment of standards of pharmacy practice [11]. Mystery shoppers visited pharmacies using a symptom-based or direct-based request scenario. Scores were categorised as unsatisfactory (scores 0-3), satisfactory (4-6) and excellent (scores 7-10). In total 362 visits were made to 293 pharmacies (repeat visits for 69 sites) including 61 visits with symptom-based scenarios. Overall, the median score was 4 with an interquartile range (IQR) of 2-6, 5 for symptom-based scenarios (IQR 4-7) and 4 (IQR 2-6) for direct product request scenarios. Accredited pharmacies performed significantly better than non-accredited pharmacies for direct product requests with a median score of 4 (satisfactory) versus 3 (unsatisfactory) respectively.

In 2004, the Change Management and Community Pharmacy Project analysed the current and potential provision of services within community services [12]. The project explored the attitudes of health consumers in forums involving 68 consumers and consumer representatives and 51 stakeholder interviews. Pharmacies were judged to be more accessible than GPs and their 'shopfront' nature provided a 'place to talk'. A lack of privacy and, at times, a lack of sensitivity shown to consumers by pharmacy staff, were seen as the main drawbacks. Pharmacists were not seen as using their clinical knowledge to assist in a range of areas, particularly in the area of complementary therapies. Patient support organisations generally see pharmacies as an efficient and relative cost-effective delivery point. There is some scepticism over various tests used by pharmacists for screening because of limited or no accreditation standards.

In 2003-4 a study assessed the Medicines Information for Consumers (MIC) Program [13]. The MIC program was designed to encourage and remunerate pharmacists to provide CMI to their customers. Two telephone consumer surveys were conducted in July 2003 and April 2004. Of consumers who had had a prescription filled in the past six months 41 to 47% were aware of the availability of CMI in 2003 and 2004 respectively, and 24 to 29% had at some point in the past received a CMI. Of the consumers being prescribed a medication for the first time, 16 to 21% received a CMI. The provision of a CMI increased consumer satisfaction with pharmacy services.

In 2004, the Australian Consumers' Association conducted a survey in 87 pharmacies. Mystery shoppers used three scenarios to assess the quality of advice given on OTC medicines. An expert panel concluded that advice given in 58 out of the 87 pharmacies visited was "poor" and only one fifth of visits was rated "good" [14].

In summary, consumers expressed generally a high level of satisfaction with the quality of pharmacy services provided. Consumers receiving specialised services such as domiciliary visits also expressed good satisfaction levels with the services. Rural consumers reported valuing the services provided by pharmacists in rural areas. Several studies mentioned the lack of privacy as a barrier to using community pharmacies. When the quality of services were measured against agreed standards of practice, it appeared that the quality was at most satisfactory, and low in some important areas such as dispensation of CMLs, advice on OTC medicines or disease management services. The difference between the high levels of satisfaction expressed by consumers and the average or low quality of services measured in community pharmacies may be explained by the fact that consumer satisfaction is more related to the functional quality of the service (e.g. timely service provision, feeling that the pharmacist understands their specific needs, how the pharmacy looks or interactions with staff) rather than the technical quality. Consumers appear unaware of the variety of the services potentially provided by the community pharmacists and as such, have less reason to be dissatisfied with the services they are provided with.

3.2.1.1 Aboriginal and Torres Strait Islander people

Studies on Aboriginal and Torres Strait Islander (ATSI) people's experiences with community pharmacy are summarised in table 2.

In 1997, a key study investigated ATSI people's access to Medicare and the PBS across Australia through semi-structured interviews with key stakeholders and postal surveys of health professionals [15]. It showed that there were numerous barriers which prevented Aboriginal and Torres Strait Islander people to access Pharmaceutical Benefits Scheme (PBS) medications. They included administrative barriers (e.g. lack of Medicare card/number); inability to afford co-payment; lack of physical access to pharmaceuticals in remote areas; and low compliance. While a number of dedicated pharmacists demonstrated a high level of understanding, there was also a significant number who had showed racist attitudes and behaviours. Immediate access to medications by many Aboriginal and Torres Strait Islander people when they present at a clinic was generally felt to be necessary by health services personnel. In 1998-99, the rate of PBS expenditure on Aboriginal and Torres Strait Islander people was a third of that for other Australians despite their much poorer health [16].

To address identified barriers in accessing the PBS, special arrangements were introduced in February 1999 for the supply of PBS medicines to clients of eligible remote area Aboriginal and Torres Strait Islander Health Services (ATSIHSs). Under the provisions of Section 100 (S100) of the *National Health Act 1953*, clients of approved remote area ATSIHSs are able to receive medicines directly from the ATSIHS at the time of medical consultation, without the need for a normal prescription form, and without

charge. Approved ATSIHSs order PBS medicines in bulk through local pharmacies. Clients of over 170 remote area ATSIHSs, including community controlled and remote services operated by the States and Territories, now benefit from improved PBS access through these arrangements. This represents 36% of the Aboriginal and Torres Strait Islander population. In addition to these supply arrangements, a separate support allowance has been funded under the Third Community Pharmacy Agreement for community pharmacies to provide assistance to the ATSIHSs in the implementation of the S100 program.

An evaluation of these arrangements was completed in July 2004 [16]. It showed an increase in PBS expenditure on Aboriginal and Torres Strait Islander people. Town-based ATSIHSs reported that many of their Aboriginal clients did not access the pharmacies in the local town prior to S100 because they were not confident enough to go and get prescriptions supplied. There were still a number of barriers to access including operational barriers (e.g. when travelling), staffing levels, access to non-PBS medicines. A number of concerns were raised about compliance with statutory requirements including labelling of medicines, record keeping, storage of medicines.

A number of studies have looked at the role of community pharmacy in providing services to ATSIHSs. The pharmacist assistance provided was rated by ATSIHSs as a key success factor in the implementation of Section 100 [17]. Non-remote ATSIHSs have indicated a desire to have access to the S100 scheme, based on the success of the scheme in remote settings and the need to overcome the barriers of access to the PBS that Aboriginal people face in non-remote areas [18]. A study assessed the practicality and the acceptability of the draft *‘Professional Practice Standards for Pharmacy Services to Remote Aboriginal Health Centres’* at the Ltyentye Apurte Health Service near Alice Springs [19]. A recent report by the National Aboriginal Community Controlled Health Organisation (NACCHO) highlights the need to use the existing draft standard to develop a nationally endorsed guideline and standard that defines pharmacy services to Aboriginal Health Services.

In summary, numerous barriers prevent Aboriginal and Torres Strait Islander people to access usual pharmacy services. Since 1999, the implementation of the Section 100 program has improved access to medicines in remote areas. Non-remote Aboriginal Health Services have indicated a desire to have access to the S100 scheme to overcome the barriers of access to the PBS that Aboriginal people face in non-remote areas. There are no recent studies which have looked specifically at Aboriginal and Torres Strait Islander people’s experiences with community pharmacy in areas that do not have access to the S100 scheme.

3.2.2 Consumer experiences in other countries

Eighteen studies were located internationally including 7 in the United Kingdom, 2 in the USA and 1 in each of the following countries: Canada, Finland, Iceland, Japan, Netherlands, New Zealand, Northern Ireland, Portugal, Saudi Arabia (tables 3 and 4). In addition, a literature review was done on communication between patients and health care professionals including pharmacists.

Consumers generally expressed a high level of satisfaction with the pharmacy services provided. Pharmacists were described as friendly, knowledgeable, cooperative, trustworthy, competent, caring, and helpful individuals. However, a number of concerns were raised about the lack of privacy, the waiting times and the lack of time for pharmacist-customer interactions.

Lack of privacy was the concern the most often mentioned. Respondents thought it was difficult to discuss intimate matters concerning medications due to the open nature of pharmacies. A literature review in the UK found this issue was particularly important in research on consumer attitudes to pharmacy advice on contraception and sexual health [20]. It appears that in most surveys, around half of consumers or less were given some type of counselling when visiting pharmacies.

A literature review summarised research on communication between patients and health care professionals about medicines [21]. It reviewed 134 articles published between 1991 and 2000. Pharmacists and patients made verbal contact in over two-thirds of prescription issues, although there was ambiguity concerning how long these discussions lasted. Patients and pharmacists were more likely to discuss a prescription if the pharmacist had a positive attitude towards communicating with patients and was less busy. In most cases pharmacists did not offer counselling about prescription or OTC medicines. Although the majority of patients accepted counselling about prescription medicines when it was offered, most patients said they would prefer to ask for advice about OTC medicines.

According to observations of interactions and pharmacists' reports, a small minority of patients appeared to resent counselling about prescription and OTC medicines. The main reason patients gave for refusing counselling by pharmacists was because they thought that their doctor had already given them sufficient information. Pharmacists only asked questions about prescriptions to a minority of patients. Most patients did not expect to be questioned when buying an OTC medicine. A minority of patients asked pharmacists questions about their medicines. The reasons patients gave for not asking pharmacists questions included fear or embarrassment about asking, lack of awareness of which questions they should/could ask, the pharmacist being too busy, trust in or loyalty to their doctor, the patient being too busy and not wanting to bother the pharmacist.

3.2.3 Consumer needs and expectations in Australia

Nine Australian studies explored consumer needs and expectations in relation to community pharmacy services (table 5).

In 1995, the CHF of Australia organised a national consultation with over 150 consumers to investigate the impact on consumers of recent changes in pharmaceuticals policy [7]. Participants wanted information on pharmaceuticals presented verbally and in written form. They wanted clear instructions firstly from their doctors and then confirmed by their pharmacists on exactly how the medication was to be taken. Information about risks, side-effects and interactions with other drugs was also a high priority.

In 1993-1995, a study explored older persons' opinions about their receipt of prescription drug information from general practitioners (GPs) and pharmacists through 204 home interviews [22]. The vast majority of respondents liked to receive verbal counselling about their prescription medications. Only a small minority had no real perception of a need for information. Respondents wanted to know when and how to use the medication (89%), the condition for which the medication was prescribed (76%) and side effects (72%). For 90% of respondents, GPs were the expected source for drug information; 57% indicated pharmacists as a secondary source. Almost all respondents (92%) thought that the information pharmacists printed on prescription medication labels was adequate although numerous suggestions were advanced for label improvement (e.g. larger print, "don't like "as directed", "don't like label covering manufacturer information").

In a 1996 survey of consumers in rural and remote areas consumers expressed the need of a better interaction between pharmacists and other health professionals to provide a more complete health service, especially upon discharge from hospital [23].

In 2004, a study explored the beliefs and expectations of general practitioners, consumers and pharmacists in relation to concordance, concordance being defined as an agreement between the patient and the health professional about the best use of treatment [24]. There were 2 focus groups of consumers. Consumers expressed the need for more information, both verbal and written, on their treatments and conditions, more CMI, self care cards. The sharing of information between pharmacists and doctors was also seen as essential.

In 2004-2005, a national telephone survey was performed to assist in developing the Pharmacy Cardiovascular Health Care Model [4]. The intention was to assess the public's perceptions of pharmacists' involvement and role in CVD prevention and management. Preliminary results showed that there was a lack of awareness amongst consumers as to the skills and abilities of pharmacists and of professional services available through pharmacies. More than one third of respondents do not know whether their pharmacies had screening services. The majority of respondents see pharmacists as capable of providing a range of services related to cardiovascular health and pharmacists appear to be the second choice for the provision of this kind of services, behind general practitioners.

In 2004, the Change Management and Community Pharmacy Project analysed the current and potential provision of services within community services [12]. The project explored the attitudes of health consumers in consumer forums involving 68 consumers and consumer representatives and 51 stakeholder interviews. Interviewees saw the core functions of pharmacy as relating to medication dispensing and advice. Pharmacists were seen as the first port of call for people who could not afford doctors. They placed greater emphasis on the development and expansion of medication safety function than on the implementation of novel services. There was a low awareness of services currently offered by pharmacies. Consumers and consumer groups want to see pharmacists consistently offer core functions, such as CMI leaflets supplied every time medication is issued, Safety Net information. Pharmacists are not seen as using their

clinical knowledge to assist in a range of areas, particularly in the area of complementary therapies.

In summary, consumers wanted to have more information on the medicines they are taking but saw the pharmacist as their second source of information after their general practitioner. There are unaware of the other potential services offered by community pharmacies and still see the function of pharmacist as mainly associated with the process involved in dispensing prescription medicines and providing advice on non-prescription and complementary medicines.

3.2.4 Consumer needs and expectations in other countries

Fifteen studies were located internationally including 9 in the United Kingdom (2 in Northern Ireland), 3 in the USA and 1 in each of the following countries: Iceland, Malta and Saudi Arabia (table 6). In addition, the findings of 2 literature reviews are presented.

Several studies focused on the expectations of consumers for the management of minor health conditions. In all studies, general practitioners were the preferred source of advice for most minor conditions: 11 to 30% of consumers indicated that they would never ask a pharmacist for advice [25], [26], [27]. However, in one study, 83% of respondents thought pharmacists knew a lot about minor health problems [28].

When asked whether they would support the provision of specific services, consumers were generally in favour: health education (90%-93%) [25], [29], screening services such as cholesterol and blood pressure screenings (70%-90%) [25], [26], [30], [29]. However, they were less supportive of pharmacists monitoring drug therapy and long term illness [31], or providing prescriptions for antibiotics or contraceptive pills [32].

A study in the USA reported that 90% of the respondents wanted written or printed information materials; 85% wanted pharmacists to be available to answer questions, explain possible side-effects and how medication worked [33].

A literature review analysed the manner in which the public used and viewed community pharmacies as a primary health care source in the UK [34]. It found that the public used pharmacies for advice about medicines and minor ailments. However, evidence also showed that the public infrequently sought out pharmacy care as an alternative to general practitioners. The authors concluded that patient need – not just that which is expressed as demanded by patients themselves but professionally identified need – would have to be considered.

A literature review looked at the research that addressed consumer feedback on community pharmacy activities relating to health promotion (e.g. nutrition), illness prevention illness (e.g. smoking cessation, immunisation), screening, and health advice on chronic conditions (e.g. nutrition and physical activity in diabetes) in the UK. [20]. The reviewers found that consumer feedback appears, at times, to be contradictory. When asked on their perception of role of the pharmacist in providing general health advice, the public's response tends to be cautious. However when such advice and services are offered the uptake is generally good and the feedback positive, suggesting that currently,

the public may have low expectations of the community pharmacist. Although users tended to cite the general practitioner as the key source of health information and advice, nevertheless they perceived the pharmacist as a highly appropriate source of advice (e.g. use of aspirin in cardiovascular prevention, emergency hormonal contraception). These findings suggest that users are more likely to accept the community pharmacist's role as health adviser when related to medicines supply.

3.2.5 Consumer participation

Studies which have investigated consumer participation in pharmacy in Australia are listed in table 7. We were not able to identify any study on consumer participation in other countries.

In 1998, a project on the development of standards for the provision of *pharmacist only* and *pharmacy* medicines in Community Pharmacy examined the advantages and disadvantages of several methods to obtain consumer feedback, such as interviews or questionnaires in the pharmacy, free mail-back questionnaires and telephone interviews following purchase [35]. The project provided examples of consumer feedback instruments. These indicators are not formally assessed in the accreditation process of pharmacies.

The Professional Practice Standards developed by the PSA encourage pharmacists to seek feedback from consumers in most professional areas such as health promotion, dispensing, counselling, compounding, etc. [36]

In 2002, a project examined different models for consumer reporting of experiences of pharmacy services in relation to the provision of *Pharmacist Only* and *Pharmacy* medicines [37]. The project examined three models: mystery shopper, external audit and direct consumer feedback. Consumers were most supportive of using a direct consumer feedback model for consumer reporting of pharmacy experiences. The feedback from pharmacists was also supportive of this model. A combination of all three models was also highly favoured.

In 2004, the Change Management and Community Pharmacy Project analysed the current and potential provision of services within community services [12]. Consumer representative groups who were interviewed did not appear to have particularly strong on-going relationships with the pharmacy profession. There had been some contact around specific projects in the past but little feedback. Unlike their relationship with GP organisations, there was limited involvement at the national level so that consumer groups were not influencing ways in which the profession worked and how it impacted on consumers.

In 2005, the National Aboriginal Community Controlled Health Organisation (NACCHO) report on the project "Supporting community pharmacists and Aboriginal Community Controlled Health Services participating in the section 100 initiative" identified the valuable role played by the pharmacist based at the NACCHO national office. This strengthened the partnership between NACCHO and the Pharmacy Guild of Australia

towards improving Aboriginal people's access to medicines and quality use of medicines [38].

In summary, consumer feedback instruments have been developed for the provision of *pharmacist only* and *pharmacy* medicines by community pharmacists but are not currently assessed in the accreditation process of pharmacies. Professional Practice Standards encourage pharmacists to seek consumer feedback in most professional areas. However, there are no data on how these standards are applied in current practice. There is limited involvement of consumer groups at the national level. One example of a successful collaboration is the partnership between NACCHO and the Pharmacy Guild of Australia. It represents a substantial development for improving ATSI people's access to medicines and quality use of medicines.

4. METHODOLOGY

4.1 Overview of Methodology

UniSA and its partners in the research team selected a mixed method methodology utilizing both qualitative and quantitative methods for data collection. Significance testing, using mainly z-scores and t-tests, was used for analysis of the quantitative data, and thematic analysis was used for the qualitative data. Triangulation of the various data sources was used for the overall synthesis of results.

4.1.1 Methods

The six methods selected for the research project were:

- Telephone interviews with health consumers and the general population (n=2005)
- Exit interviews with community pharmacy customers (n=554)
- Pharmacist interviews (n=506)
- Face to face and telephone interviews with stakeholders (n=13)
- Focus groups with consumers (n=12)
- Literature review

4.1.2 PGoA Expert Advisory Group (EAG)

The project team met with the Pharmacy Guild of Australia's nominated EAG on two occasions. The role of the EAG was to provide early input to the research design and comment on and approve the instruments for data collection, then to review both drafts and final reports. Their advice was sought in drafting recommendations.

4.1.3 Definition of health consumer

It was agreed between the researchers, the PGoA and the EAG that the definition of health consumer should be someone who answers yes to the first of the following two questions, and at least once a month to the second:

"Do you personally, or does someone for whom you are a carer, have an ongoing condition requiring treatment, medication or monitoring?"

"How often, if ever, do you visit a pharmacy, either to buy something, get advice or browse?"

4.1.4 Meetings of Project Team

Regular weekly meetings of the Project Team were held by teleconference. Three face to face meetings of the research team were held. The first meeting was held to “kick off” the research project, the second to review results, key themes and decide on the final analysis framework for the Final Report, and the third to discuss changes for the Final Report.

4.1.5 Project Information Sheet

A general information sheet was developed for the project (see **Attachment 1**).

4.1.6 Communication Plan

A Communication Plan was prepared to provide a guide on all the processes that were applied to the management of all internal and external communications for the contract period of the Consumer Experiences, Needs and Expectations of Community Pharmacy Project. See **Attachment 2** for a copy of the Communication Plan

4.1.7 Document Management System

A document management system was developed by the University of South Australia to ensure the integrity of the evaluation project by ensuring the appropriate tracking and recording of all documents created and/or received. See **Attachment 3** for details of the document tracking system.

4.2 Detailed Methodology

4.2.1 National telephone survey of the general public (n=2005)

The telephone survey of the general population aged 15 and over was designed to be completed in 18 minutes. The sample was stratified by region, but was otherwise random. Respondents were selected within each household by speaking with the person aged 15 or over who was last to have their birthday. Regions were defined within each State/Territory at the levels of capital city, regional urban (not applicable in ACT) and rural.

The sample for the telephone survey was drawn from the most recent version of DtMS, an electronic White Pages directory. Mobile phone numbers were included where listed. The survey was being conducted using CATI technology (Computer Aided Telephone Interviewing).

The final sample was guaranteed to include at least 500 health consumers (see above for health consumer definition). The survey commenced on Saturday 28 May 2005 and was completed on 20 June 2005. Questions generally covered the uses people make of community pharmacy, their activities and experiences while there, their interactions with

staff, their needs and expectations, and their anticipated use of various products and services. The survey instrument is provided as **Attachment 5**.

4.2.2 Face-to-face exit survey of community pharmacy customers (n=554)

Face-to-face-surveys were conducted with customers as they left community pharmacies. The focus for the interviews was on capturing customers' immediate experiences and perceptions of the service and facilities provided.

The pharmacies at which the interviews took place were selected at random and contacted in advance for permission to conduct the survey with their customers. The PGoA provided a letter to the pharmacy staff encouraging participation. A total of 42 pharmacies around the country took part. A small number of other pharmacies (fewer than 10) were unable to participate, either due to particularly low customer traffic at the time they were approached, or because owner permission could not be obtained within the required timeframe.

An average of 40 interviews per State/Territory region was anticipated (520 in total). Interviewers were stationed at the pharmacy exits and every n^{th} customer was approached to participate in the survey, thereby ensuring as random a sample as possible. The actual n used varied from site to site depending on how busy the pharmacy was at the time.

The survey instrument is provided as **Attachment 6**.

4.2.3 Telephone survey of pharmacists (n=506)

Telephone interviews, using CATI technology, were conducted with pharmacists, who were selected by contacting a random selection of pharmacies from the Guild's membership list and speaking with the pharmacist on duty at the time. If they were not able to make time for the interview when contacted, call-backs were arranged for a more convenient time.

The survey was designed to take around 5 minutes to complete and was focused on how pharmacies currently or could involve consumers in evaluating and shaping service delivery and facilities.

The survey instrument is provided as **Attachment 7**.

4.2.4 Stakeholder interviews (13 interviews conducted, 16 participants) and consumer focus groups (12 focus groups conducted, 92 participants)

Interviews with peak representative organisations, and focus groups with members of consumer organisations, were held during June and July 2005.

The purpose of the focus groups was to determine (i) if consumer needs and expectations are met; (ii) gaps and deficiencies in service; (iii) how consumers are

involved in quality improvement and development; and (iv) how consumer participation can be encouraged.

A total of 13 interviews were conducted, comprising 5 with professional and/or government organisations and 8 with consumer organisations. The participant/s were either the CEO or Executive Officer or the Senior Policy Officer responsible for medicines programs.

A total of 12 focus groups were conducted with participants from consumer organisations representing either general health consumers or consumers with specific health conditions. A group was scheduled with consumers from non-English speaking backgrounds in Victoria, but due to administrative problems within the host organisation no participants were available when the consultant attended for the group. The lack of focus group data from this sector is offset by an additional organisational interview completed by the QUM project officer for the national peak body for ethnic communities. An Indigenous Focus Group was conducted in Adelaide with community members and staff of the Muna Paiendi Community Health Centre. Because of the particular needs, experiences and expectations of this community, the overview of this focus group is provided separately from the general overview of other focus groups and may be found at section 6.6.3.

Participants were recruited by direct contact from the consultants. Organisations were provided with a copy of the full project outline as posted on the Guild website, and either an outline of the interview schedule (**Attachment 8**) or a focus group invitation (**Attachment 9**) which could be adapted with relevant contact details by the host organisation for distribution to its members. A payment of \$500 plus GST (\$750 in two instances) was offered for the organisation to cover recruitment, venue, refreshments and participant costs, on receipt by the consultants of a tax invoice.

The consultants took both interview and focus group notes, which were transcribed into summary transcripts for subsequent analysis.

A form outlining demographic and health service use information was offered to participants in 6 groups to provide a sub-sample of the participants age ranges, health needs and service use (**Attachment 10**). This was not collected from remaining groups where it was seen to be inappropriate or not feasible (eg on teleconference or where physical limitations of participants precluded collection). Not all participants in the groups where this information was sought elected to provide this information.

All focus groups were offered the choice of providing consent by participation or completing a written consent form (**Attachment 11**). The majority elected for consent by participation.

The focus group sessions began with the consultants providing an overview of the project goals, intended outcomes and definitions, assisted by a written description provided to each participant (**Attachment 12**). Assurance was provided that the data was being collected for the primary purpose of the project report to the Pharmacy Guild of Australia and that no personal identifying information would be contained in that

reporting. Participants were invited to raise any questions, clarification or concerns prior to commencement of the group discussion.

It is worth noting that the project timeframe for participant recruitment for focus groups and interviews was very limited, especially for community organisations with limited resources, substantial workloads and membership-based recruitment processes. These constraints led to one peak organisation declining participation due to other commitments. Subsequent research of this kind should allow for more recognition of the barriers faced by the community sector in effective engagement.

Attachment 13 provides a list of the organisations consulted and the numbers of participants.

5. SYNTHESIS OF OVERALL RESULTS

5.1 Profiles of consumers

5.1.1 General survey

2005 consumers were interviewed. Once the sample had been appropriately weighted to properly reflect the geographic, gender and age population distribution it emerged that 41% were health consumers defined (as agreed with the EAG prior to project commencement) as respondents who said that either they, or someone for whom they were a carer, had an ongoing condition requiring treatment, medication or monitoring and who indicated that they visited a pharmacy, either to buy something, get advice or browse, at least once a month. The highest proportion of health consumers was in Tasmania (54%) and the lowest proportion in Northern Territory (29%). Higher levels of health consumers were seen in rural and regional levels (44% and 43% respectively) compared to just over one third (38%) in the metropolitan area. Compared to non health consumers, health consumers were older, more likely to be female, to be retired or on a pension, to be in a household comprising an older couple with no children living at home and to have a lower household income.

5.1.2 Exit survey

554 consumers were surveyed as they left community pharmacies. In both metropolitan and regional areas, 43% of respondents qualified as health consumers. Similarly to the general public survey, health consumers tended to be older, were more likely to be female, to be retired or on a pension, and less likely to be employed full-time.

5.1.3 Focus groups

A total of 12 focus groups were conducted with participants from consumer organisations representing either general health consumers or consumers with specific health conditions. Specific groups included:

- people living in rural areas;
- older people;
- carers;
- people living with chronic conditions including arthritis, diabetes, mental illness, asthma;
- people from culturally and linguistically diverse communities;
- Indigenous groups

5.1.4 Organisation interviews

A total of 13 interviews were conducted, with 5 professional and/or government organisations and with 8 consumer organisations. Specific consumer groups represented were:

- people living in rural areas;
- older people;
- carers;
- people living with chronic conditions including HIV/AIDS;
- injecting and illicit drug users;
- people from culturally and linguistically diverse communities;
- Indigenous groups

5.2 Consumer Experiences of Community Pharmacy

5.2.1 Use of pharmacy services

In the general public survey:

- 16% of respondents were frequent users of pharmacies (once or more times per week), 65% were regular users (2-3 times a month to every few months), 15% were occasional users (once or twice a year or less often) and 4% never used pharmacies.
- A total of 54% of respondents stated that they used one particular pharmacy and 41% shopped at whichever pharmacy was the most convenient at the time.
- The most common reasons provided for choosing a pharmacy were 'close/convenient to home' (39%), 'friendly staff' (32%) and 'the staff and pharmacist know me' (25%).
- The most frequently purchased products were prescription medications (37% monthly, 21% quarterly) followed by OTC medicines (25% monthly, 25% quarterly), vitamins or herbal remedies (6% monthly, 10% quarterly).
- More than half (54%) of respondents had never visited a pharmacy to ask advice from the pharmacist or pharmacy assistant; 30% had previously used a pharmacy to decide whether to see a doctor; 13% had previously experienced a medicine review at pharmacy; 10% had used home delivery services; 8% had used health screening or monitoring facilities; 8% had used dose administration aids; 8% had used pharmacies for help to stop smoking; 2% had used needle exchange services; 2% had experienced a medicine review at home.

- When waiting for a prescription to be filled, the most common behaviours were to browse around the pharmacy (31%), leave and come back when it is convenient to them (19%), sit and wait (19%) or leave and come back when the prescription is ready (16%).

In the exit survey, 46% of respondents were visiting the pharmacy to have a prescription filled, 18% to buy OTC medicines, 5% to buy toiletries, 4% to buy vitamins or herbal remedies. Three quarters of respondents who were having a prescription filled had received the medication before (88% for health consumers and 61% for non health consumers). Consumers who used whichever pharmacy was convenient to them were more likely to receive their medication for the first time (35%) compared to respondents who only frequented one particular pharmacy (14%). While waiting for a prescription, 38% sat and waited, 24% browsed in the pharmacy while waiting and the remainder left and returned later (37%).

In the focus groups, when asked about their experiences of community pharmacy, access issues were raised in several contexts:

- geographic access: the limited number of pharmacies in some areas restricts consumer choice on the basis of service quality and prices, particularly in rural areas;
- opening hours: after hours access to pharmacies is limited in some areas;
- physical access: entry steps, overcrowded displays, absence of seats are of concern particularly for people with mobility restrictions.

5.2.2 General quality of services

In the general public survey, 68% of respondents claimed to have their prescription either always or usually filled within 10 minutes. When getting vitamins or herbal remedies 94% of respondents declared they always or usually received prompt attention. When asked what about using pharmacies that most needed to be improved, 59% could not think of anything, 12% said lower prices on medicines, and 12% said lower prices on other products.

In the exit survey, 80% of respondents waited less than 10 minutes for their prescription and 13% waited between 10-14 minutes. Generally, pharmacy staff were accurate in the waiting times they indicated to customers although one in ten waited longer than the predicted time. Respondents perceived the waiting time as extremely reasonable (rating 9.3 out of 10). When asked what could have been done differently to improve their visit, 79% of respondents said nothing, all was good; 13% could not think of anything. No suggestions of any note emerged.

In both surveys, consumers generally rated highly the performance of pharmacy staff. On a scale from 0 (0 extremely poor) to 10 (extremely well), the mean scores were:

- 8.1 and 9.6 for 'the pharmacist giving clear information and advice' in the general survey and exit survey respectively,
- 8.6 and 9.8 for 'being polite and courteous',
- 7.8 and 9.8 for 'being available when you need to speak with a pharmacist',
- 8.1 and 9.9 for 'listening to what you have to say',
- 7.0 and 9.7 for 'inviting questions'.

Performance ratings given by health consumers were consistently higher than those given by non-health consumers.

The performance of the pharmacy assistants was also rated highly:

- 8.8 and 9.7 for 'being polite and courteous',
- 8.4 and 9.6 for 'listening to what you have to say',
- 7.8 and 9.4 for 'being able to offer advice on products or services',
- 8.6 and 9.1 for 'making you feel welcome',
- 6.8 and 9.4 for 'calling you by name when you are leaving or collecting a prescription'.

The mean scores were consistently higher in the exit survey, probably reflecting that only people who had contact with the pharmacist or pharmacy assistant were asked to rate the performance of pharmacy staff in the exit survey.

In the focus groups, pharmacies were consistently described as a more relaxed and less pressured environment than doctors' rooms, and providing an opportunity for provision of written and verbal information about health conditions, treatments and services. Pharmacists were also described as using more consumer friendly language than doctors when explaining health treatments. Smaller pharmacies were seen by many participants as being more personalised in their service than larger outlets.

The tension between the retail and professional roles of community pharmacists was a topic frequently raised by focus group participants. While acknowledging commercial imperatives, many felt that the balance had moved too far toward non-pharmaceutical products and OTC and complementary medicines. The emphasis seemed to be on the sale of the product, rather than the quality aspects of the transaction, such as checking the persons understanding of the medicines and their need for information. Participants were concerned that pharmacy location in supermarkets may lead to the loss of

personalised relationships and consequent reduction in the provision of information and advice.

Packaging of dose administration aids was described as a valuable service with the added benefit of an accompanying record of the medicines. Home delivery was also frequently cited as a valued service, especially for those experiencing debilitating illness, disability and/or mobility problems.

There were a number of instances where consumers had been concerned by the quality of services, e.g. dosing error, absence of knowledge of the product being dispensed, stigmatization of people with mental illness or on opiate replacement therapy, lack of respect and recognition of patients' knowledge.

Consumer organisations reported that service experiences in community pharmacy varied and that older people tended to maintain a relationship with one pharmacist building rapport over time. This was also true of consumers from non-English speaking backgrounds, who would often seek out a language speaking pharmacy where one is available. However in both these instances, there was a need to ensure that this close relationship did not result in a monopoly over pricing or products to the disadvantage of the consumer.

In both focus groups and organisation interviews, direct access to the pharmacist was seen as restricted because of placement of pharmacists on a raised section at the rear of the pharmacy, and the necessity to deal with pharmacy assistants in the first instance.

Barriers could be magnified where there is limited choice of community pharmacies and where the consumer is known to the pharmacist. A number of peak organisations pointed to the difficulties experienced by consumers in small towns where the pharmacist may be a prominent person in the local community and where concerns or complaints about service standards in the pharmacy can be both negatively received by the pharmacist and divisive among community members.

5.2.3 Availability of medicines

In the general public survey, 73% of respondents stated that the 'pharmacy always had medicine in stock or could get it quickly' and 23% usually.

In the exit survey, 87% of respondents who were there for a prescription said that the pharmacy had their prescription medicine in stock or could get it quickly including 86% of the respondents in the metropolitan areas and 87% in the regional areas. There were important differences between States with the lowest rates of availability in NSW (51%) and the highest rates in Western Australia (98%). Of the consumers who purchased OTC medicines during their visit, 64% stated that the pharmacy had the medication in stock or could get it quickly.

In the focus groups, strong concerns about disruption of supply of medicines were raised. Disruption of supply could have severe health consequences for people who

needed daily medications to maintain their well being e.g. people with asthma, arthritis, mental illness, or on opiate replacement therapy.

Specific concerns were raised about:

- availability of medicines in remote areas where supply is dependent on alternative services (e.g. Flying Doctor services or school buses) which may be interrupted for long periods (school holidays or wet season) and as Health Insurance Commission supply amount restrictions prevent consumers from stocking-up;
- availability of antiretroviral medications for people in HIV/AIDS in NSW where supply is principally through hospital pharmacies as this limits ready access and maintains the experience of HIV/AIDS as a condition requiring hospital treatment;
- availability of opiate replacement therapy that is limited to some pharmacies and prevents “normalization” of people’s life;
- withdrawal of some medicines (e.g. a monoamine oxidase inhibitor).

5.2.4 Communication with the pharmacist and provision of information

In the general public survey, 56% of respondents declared they ‘never or rarely receive written information on how to use the medicine’ when they get prescriptions or OTC medicines, 18% always, 10% usually and 15% sometimes; 30% said they never or rarely speak with the pharmacist about to use the medicine, 30% always, 17% usually and 22% sometimes. Health consumers were less likely to speak with the pharmacist than non health consumers (34% versus 16%). When asked to rate the performance of service-related attributes on a scale from 0 (0 extremely poor) to 10 (extremely well), the mean scores were:

- 8.1 for the pharmacist ‘giving clear information and advice’,
- 8.1 for ‘the pharmacist listening to what you have to say’,
- 7 for ‘inviting questions’,
- 7.8 for the ‘pharmacist being available when you need to speak to him’.

When getting vitamins or herbal remedies, 23% of respondents said they always or usually receive printed information about the health issue relating to the product; 67% said they always or usually receive advice that the product is right for them.

In the exit survey, 77% of the consumers spoke to the pharmacy assistant only during their visit to the pharmacy, whilst 10% spoke to the pharmacist only and 6% spoke to no one. Of the consumers who lodged or collected a prescription, 7% received written instructions on how to use the medicine apart from what is on the bottle or packaging; 19% spoke with the pharmacist about the medicine or related health issue (5% initiated

by the pharmacist and 12% initiated by the consumer), 15% spoke with the pharmacy assistant (7% initiated by the assistant and 8% initiated by the consumer). Respondents who were receiving the medication for the first time were more likely to speak to the pharmacist about using the medication (47%) and to receive written instructions (15%) in comparison to respondents who had received the medication on a prior occasion (15% and 4% respectively). Health consumers were more likely to seek advice from both the pharmacy and pharmacy assistant (54%) during their visit compared to non-health consumers (46%). When purchasing OTC medicines, 44% spoke with the pharmacy assistant about the medicine or related health issue (9% initiated by the assistant and 36% initiated by the consumer) and 9% spoke with pharmacist (3% initiated by the pharmacist, 6% initiated by the consumer).

In the focus groups, participants consistently reported that information about medicines tends to be provided in limited ways and on limited occasions. Consumer Medicines Information (CMI) was rarely offered and broader information about health conditions and their treatments is rarely drawn to consumers' attention. When available, information sheets and cards were described as most commonly associated with product marketing such as vitamins and complementary medicines, rather than being from independent information sources. The focus of the transaction around payment is seen as limiting the consumer's opportunity to ask questions.

Consumer and carer peak organisations describe the provision of both written and verbal information as variable. Carers may be denied information on the basis of privacy concerns; while one peak consumer organisation which has been promoting the uptake of CMI through peer education activities has received reports of consumers being denied this. The reasons pharmacists have given for not providing a CMI were that the consumer didn't need it, that it was too technical and that the consumers wouldn't understand it. In some instances, pharmacists have sought to charge consumers for providing a CMI. All of these reasons were seen as unacceptable.

5.2.5 Privacy

In the general survey, the mean scores given for maintenance of privacy by the pharmacist and the pharmacy assistant were 7.8 and 8 respectively on a scale from 0 to 10. In the exit survey, the maintenance of privacy by the pharmacist and the pharmacy assistant were rated 9.7 for both.

In the exit survey, of consumers who spoke to either the pharmacist or pharmacy assistant, 94% responded that their privacy was quite well or very well maintained. Health consumers were more likely to indicate that their privacy was very well maintained (94%) compared to non health consumers (58%).

In the focus groups, many participants noted the lack of privacy and consequent concerns about confidentiality. There were many examples provided of overhearing other people's medicines history. It was of particular concern to people with mental illness and on opiate replacement therapy. Privacy was also viewed as a major issue by

organisations, especially with the trend to development of additional professional services.

Consumer organisations reported that younger people and those in small towns might not be satisfied, especially for example where the young consumer was seeking products such as condoms or emergency contraception.

5.2.6 Costs

In the general survey, when asked what about using pharmacies most needed to be improved, 12% of respondents indicated 'lower prices on medicines', and 12% 'lower prices on other products'.

Concerns on costs were raised in focus groups and by peak organisations on a number of issues:

- default mark-up previously contained in pharmacy software;
- variations in costs of medicines between pharmacies;
- records of subsidised medicines through "safety net stickers" reported to be inconsistent;
- additional charges being levied over the safety net price;
- costs of buying whole packets of products such as dressings instead of single products;
- substantial dispensing costs for opiate replacement therapy;
- supply charges for medicines only available through hospitals such as some kind of eye drops;
- higher costs of complementary medicines, devices and consumables compared to alternative suppliers.
- costs of additional services such as packaging of dose administration aids.

There was a general view that the additional charges applied to medicines needed to be more open and transparent to consumers.

5.2.7 Generic medicines

In the focus groups, participants expressed concerns that the emphasis on generics focused on costs with a number believing that generics were either not as effective or had different side effects. Some participants were unwilling to take a risk with generics when ongoing therapy is required. Concerns were also raised on frequent changes in appearance and brand name within short time periods of supply. Organizations reported that consumers were frequently confused by the various terms applied to generics such as "home brand" or "chain brand".

5.2.8 Pharmacy assistants

In the general public survey, when purchasing vitamins or herbal remedies, 80% of respondents declared that pharmacy assistants were 'always or usually knowledgeable about health products', 75% that 'assistants refers them always or usually to the pharmacist when preferred'. Mean scores for performance of pharmacy assistants were generally high: 8.8 for 'being polite and courteous', 8.6 for 'making you feel welcome', 8.4 for 'listening to what to have to say', 7.8 for 'being able to offer advice on products or services', 6.8 for 'calling you by name when you are leaving or collecting a scrip'. Scores given by health consumers were always higher than those by non health consumers.

In both focus groups and organisation interviews, pharmacy assistants were consistently described as variable in their interactions with consumers. While many were reported to be knowledgeable and effective in checking and referring to the pharmacist where appropriate, a number of instances were cited where the assistant was seen as a barrier to accessing the pharmacist and on occasions provided incorrect advice or had inappropriate attitudes with consumers with mental illness or on opiate replacement therapy.

5.3 Consumer needs and expectations

5.3.1 General quality of services

The general public survey indicated that almost all of the respondents had a need for the medicine to be in stock or be accessed quickly by the pharmacy (87% of the total sample) and most wanted short waiting times for the prescription to be dispensed (<10 minutes). Couples or singles with children living at home strongly expressed this need, perhaps reflecting the concerns of parents when a child is sick or time pressures.

All participants in the focus groups identified community pharmacy as a key source for meeting their prescription medicines needs and expected that supplies would be readily available. They expected that medicines remained the major focus of pharmacies and were critical of the development of the non-pharmaceutical section in many pharmacies. Pharmacists were seen by most participants as experts in medicines, more so than doctors. A number of participants described the pharmacist as a first stop for primary health care enquiries and some older participants noted that this role seemed to have declined over the years. The role of pharmacists in preventative health care was also seen by a number of participants as important.

All peak professional and government stakeholders identified the need for high standards of service in community pharmacy, provided by well trained staff that are familiar with the products they are supplying. There was a general enquiry across focus groups about the training standards and requirements for pharmacy assistants and concern that they may be principally trained by product suppliers to promote those products.

All participants reported that personalised service from their community pharmacist was highly valued and a key need and expectation. Those participants who had developed such a relationship with their pharmacists found that they tended to get additional benefits such as written and verbal information, assistance with maintenance of their prescription records, and home delivery where required; and that other professional services were offered such as dose administration aids and Home Medicines Review.

5.3.2 Information provision

In the general public survey, the needs the most frequently identified were:

- ‘to receive advice that the non prescription health products were right for them’ (74%),
- ‘to speak with the pharmacist about how to use the medicine’ (65%),
- ‘to receive printed information about the health issue relating to the product’ (56%),
- ‘to receive written instructions on how to use the medicine’ (46%).

Both consumer and carer peak organisations highlighted the need for consistent provision of written information, both about medicines and about the services that community pharmacy offers.

In the focus groups, information was identified as a major need and expectation of community pharmacy. The type of information sought was about prescription, OTC and complementary medicine, how to take it, side effects, interactions and costs. A major theme in most of the group discussions was that information should be provided in a context of dialogue with the consumer. There was also an expectation of impartial and professional advice free from commercial considerations. Provision of information to people from non-English speaking background was also reported as essential.

Consumers also want prominent signage encouraging consumers to ask for both written information about their medicines and independent information brochures on health treatments (eg for the 10 most common conditions) were available.

5.3.3 Other services

From the general survey, when asked about more specific health care needs, the only service needs that were strongly expressed were ‘health screening and monitoring’ (with 29% claiming that they would use this service either biannually or quarterly), followed by ‘medication reviews at the pharmacy’ (23% using biannually or quarterly) were. The small proportion that identified these needs is not surprising as only a small percentage of the population would have any real need for these services; for example medication reviews are probably only considered relevant by those with complex medication regimen.

In the focus groups, a number of pharmacy services were seen as very valuable:

- packaging of dose administration aids;
- home delivery;
- return of unwanted medicines;
- medication list printouts.

Consumers expressed a need for more information about services such as Home Medicines Review, medicines delivery or medicines records assistance.

Consumers would like regional arrangements in place to ensure extended hours availability on a more consistent geographic basis and information about pharmacy locations and opening hours easier to find.

Several peak consumer organisations identified specific needs in relation to generic medicines:

- increased access to generic medicines in particular for people with asthma and those with mental illness;
- more information on generics beyond issues of cost;
- better identification and consistency of supply to avoid confusion.

5.3.4 Continuity of care

In the focus groups a number of participants suggested much closer working relations and interactions need to be developed between local pharmacists and GPs. Where they are closely located, these arrangements are seen by consumers often to work well. Additional options identified by some participants included more systematic engagement possibly facilitated through Divisions of General Practice. Some groups noted the ageing population and growth of services such as Hospital in the Home, and wanted to see community pharmacists much more engaged as a part of the “total health care team”.

Most peak organisations identified the importance of effective working relationships between doctors and pharmacists.

6. PRIMARY RESEARCH RESULTS

6.1 Result Summation of Quantitative Surveys

The quantitative results highlight a positive level of satisfaction with respect to pharmacy at the total sample level. Pharmacy consumers and, to a larger extent, health consumers relayed very positive experiences generally, demonstrated both in the exit surveys immediately following service experiences and the longer term customer sentiment revealed in the general public survey.

Further, there were few needs that were not adequately addressed by the range of services currently provided. There were several areas of service provision that were less frequently offered, including speaking with the pharmacist, receiving written information and having the pharmacist check that the customer had no side effects, however it emerged from the analysis of needs, that the latter two services were not a perceived need amongst the majority of the sample anyway.

The results do display higher perceived performance ratings amongst health consumers, in terms of both the services offered and the staff members that they have contact with. These consumers were typically heavier visitors to pharmacy generally and more loyal to one pharmacist. They were also more likely to suggest that the drivers of their loyalty to one pharmacy were primarily the friendliness of staff and the fact that the staff knew them. Based on these findings, it was possible to infer that the relationships established with these consumers were stronger. It was impossible to statistically establish, however, whether the loyalty to one pharmacist and the relationship established was due to the higher need for, and frequency of visitation.

The same quality of relationship did not appear to be established with one or several pharmacists among non health consumers. These consumers were typically light repertoire users of pharmacy who tended to choose their pharmacist based on convenience. As such, it was likely that these respondents took their switching behaviour into account when evaluating pharmacy and staff members within the context of this research. Clearly, the results indicated that non health consumers were happy with the level of service provided by pharmacists at the aggregate level.

It should be noted that non health consumers tended to have higher expectations from the range of pharmacists that they used.

The results from the pharmacist survey revealed that most already encouraged consumers to provide feedback, either through informal discussions or feedback forms. Two in five pharmacists, however, actually used this feedback in developing the range of services that they provide. Having said this, almost all pharmacists felt that this feedback was extremely important in shaping future service related strategy and providing quality outcomes. Whilst it is impossible to disentangle the effect of consumer input from the many other factors influencing customer satisfaction within this research

to make this inference statistically valid, there is a clear need to encourage a larger proportion of pharmacists to undertake this activity.

The results suggest that pharmacists clearly recognise the broader benefit from gaining input from their customers but appear to require assistance at either a national or state level in guiding them to implement measures to evaluate quality and service related issues and ultimately, achieve better outcomes. For specific recommendations as to how to provide this guidance, refer to the pharmacist survey results.

In relation to influencing pharmacy policy and strategies, almost two in three pharmacists felt that consumers should have some input at an individual pharmacy level. Support for consumer input at state or national level, however, was significantly lower.

It was not possible to provide a clear overlap of the responses to support the discussions above, given the inconsistencies in questions posed across the three sample bases. Where possible, however, section 4.5 attempts to compare the results within the general public and exit surveys to support the conclusions drawn.

6.2 National telephone survey of the general public

(n=2005 unweighted)

6.2.1 Survey length

This module featured an anticipated 18 minute telephone survey of the general population aged 15 and over. The actual survey length for this component averaged 17.3 minutes, a figure on par with the estimate.

6.2.2 Sampling

Sampling was stratified by region, defined within each State/Territory at the levels of capital city, regional urban (not applicable in ACT) and rural, but was otherwise random.

Respondents were selected within each household by speaking with the person aged 15 or over who was last to have their birthday. This survey used a replacement sampling methodology, meaning that households who refused to participate were replaced with another household. However, if the respondent whose birthday was last refused to participate, they were not replaced by another person from that household, the household was replaced.

The sample for this survey was drawn from the most recent version of DtMS, an electronic White Pages directory. Mobile phone numbers were included where listed. The survey was conducted using CATI technology (Computer Aided Telephone Interviewing).

Harrison Research guaranteed that a quota of at least 500 health consumers would be included in the total sample. Health consumers were defined using two questions within the questionnaire. Specifically:

- Respondents who said that either they, or someone for whom they were a carer, had an ongoing condition requiring treatment medication or monitoring
 - AND
- Respondents who indicated that they visited a pharmacy either to buy something, get advice or browse at least once a month.

Respondents who either did not care for someone with, or themselves have, an ongoing condition, or who did not visit a pharmacy at least once a month, were classified as non-health consumers.

People who were pharmacists or worked in pharmacy were excluded.

It was agreed at the project planning phase that sampling would be random initially, to enable the accurate proportioning of health consumers within the general population, then (if necessary) potential respondents would be screened to ensure a minimum of 500 health consumers were interviewed. As fieldwork unfolded, the quota of 500 health consumers was easily achieved, thus no screening for these respondents was required at any time. As a result, the actual size of this health consumer sub-group was notably higher than the agreed minimum frequency, as detailed in Table 1.

Sample Base	Target Sample	Actual No. of Respondents		Actual % of Respondents	
		<i>Unweighted</i>	<i>Weighted</i>	<i>Unweighted</i>	<i>Weighted</i>
health consumers	500	1019	825	51	41
non-health consumers	1500	986	1176	49	59
Total sample	2000	2005	2001	100	100

Table 1: Comparison of Target and Actual Respondents

Using data from the Australian Bureau of Statistics (ABS), quotas were set for each State and Territory, to ensure accurate representation of all areas of Australia. Quotas were also implemented to ensure that minimum numbers of respondents were obtained from each of the following three categories within each State and Territory:

- Metropolitan (capital city)
- Regional urban
- Rural

Given that some areas of the nation constitute such a small percentage of the total population, whilst others are heavily represented, quotas were adjusted for fieldwork to ensure that all regions in the eight States and Territories were included. At the completion of fieldwork, data were weighted to align the results with the geographic distribution recorded in the 2001 Census. Results in the draft report to the Pharmacy Guild featured data weighted by these figures, with the aim to conduct further analysis during preparation of the final report to determine if data needed to be further weighted by age and gender.

Upon further investigation of the data, it became evident that data did in fact need to be weighted by gender and age. Given that the eight States and Territories of Australia have varying proportions of genders and age groups, data were weighted by two additional variables:

Q1. Gender within each State (e.g. the proportion of males and females in South Australia; the proportion of males and females in Western Australia and so on), calculated as a percentage of the total population of Australia aged 15 years or over.

Q2. Age within each State (e.g. the proportion of 15-24, 25-34, 35-44, 45-54, 55-64 and 65+ year olds within South Australia; the proportion of 15-24, 25-34, 35-44, 45-54, 55-64 and 65+ year olds within New South Wales and so on), calculated as a percentage of the total population of Australia 15 years or over.

Table 2 and Table 3 detail the weighted and unweighted samples achieved in the General Public telephone survey. Please bear in mind that these tables are presented to summarise the weighting applied to data, and do not show the actual weights applied to gender and age differences within each State and Territory.

Sample Distribution by State or Territory	# of Respondents		% of Respondents	
	Raw	Weighted	Raw	Weighted
ACT	50	33	2	2
NSW	673	674	34	34
NT	61	21	3	1
QLD	380	380	19	19
SA	140	158	7	8
TAS	71	48	4	2
VIC	470	494	23	25
WA	160	194	8	10
Total sample	2005	2002	100	100

Table 2: General Public Telephone Survey – sample distribution by State or Territory

Sample Distribution by State or Territory	# of Respondents		% of Respondents	
	Raw	Weighted	Raw	Weighted
metropolitan (capital city)	801	800	40	40
regional urban	709	766	35	38
rural	495	435	25	22
Total	2005	2001	100	100

Table 3: General Public Telephone Survey – overview of sample distribution by urban rural categories

Sample Distribution by Gender and Age	# of Respondents		% of Respondents	
	Raw	Weighted	Raw	Weighted
Males	671	978	33	49
Females	1334	1023	66	51
15-24 year olds	162	345	8	17
25-34 year olds	218	367	11	18
35-44 year olds	279	385	14	19
45-54 year olds	358	347	18	17
55-64 year olds	389	237	19	12
65 years or over	599	319	29	16
Total sample	2005	2002	100	100

Table 4: General Public Telephone Survey – sample distribution by gender and age

N.B. Due to the data being weighting and rounded to integers (whole numbers), some figures in this section of the report may not sum precisely, either numerically or as percentages.

The survey commenced on Saturday 28 May 2005 and the final interview was completed on Monday 20 June 2005.

6.2.3 Overview

For the purposes of this report, the data obtained from the general public telephone survey have been collapsed into four sections:

- Profile of Pharmacy Customers - Health and Non-health
- Experiences
- Needs
- Expectations

Across these four sections, the results are analysed by a number of different variables to examine the variation in responses across the population surveyed. Some of these bases, aside from general demographic information, include health and non-health consumers, frequency of pharmacy usage and loyalty to pharmacies. Where significant differences emerge from the data, the statistics are highlighted within the body of this report.

Both ‘Difference in proportions’ tests and ‘Means’ (T tests) are employed to examine the statistical significance of the differences in scores between sub groups. These tests examine the real differences in scores or proportions, accounting for the sampling error present within the results as well as the probability of obtaining a false ‘real’ result due to chance.

6.2.4 Profile of Respondents

Across the whole General Public sample, 49% either have or care for chronic illness (i.e. an ongoing condition requiring treatment, medication or monitoring), including 35% who have a chronic illness themselves and 18% who are carers for someone chronically ill. There is a 4% overlap - i.e. 4% both have a chronic illness and care for someone with such a condition.

Taking into account the frequency of visiting a pharmacy shows that, included in the 49% of the general public aged 15+ with a direct chronic illness connection, 41% qualified as health consumers. The table overleaf summarises the distribution of chronic illness in the general public sample.

Sample distribution by incidence of having, or being a carer for someone who has, an ongoing condition requiring treatment, medication or monitoring	General Public Respondents		
	% of total sample (n=2001)	% of health consumers (n=825)	% of non-health consumers (n=1176)
Personally have chronic illness (not also carer)	31	63	9
Carer (only) for someone with chronic illness	14	58	4
Chronic illness - both personally and as carer	4	9	<1
Neither have, nor are carer for, chronic illness	51	-	87

Table 5: General Public Sample – distribution by health status and carer status

This section of the report is structured to provide a reflection of health as opposed to non-health consumers of pharmacy. For ease of reporting, each consumer type is evaluated independently and then drawn together for a comparative analysis later in the section.

6.2.4.1 Profile of Health consumers

Table 6 highlights the characteristics of health consumers that distinguish them from non-health consumers, or rather, those that are significantly different from non health consumers according to statistical norms (i.e. at the 95% level of confidence, where $p < .05$). As such, where differences across the two consumer types are not statistically significant they are not included in this summary.

Health Consumers	Shared characteristics
Demographics	<p>A statistically significantly higher proportion of health consumers were female (58% compared with 46% females within the non-health sample).</p> <p>Health consumers tended to be older, with a significantly higher proportion of respondents aged 65 years and over (28%) and between 55 and 64 years of age (16%). Accordingly, a significantly lower proportion of health consumers were younger.</p> <p>The results revealed a significantly higher level of retired and full-time employed respondents within the health consumer sample base (30% and 29% respectively).</p> <p>A significantly higher proportion of health consumers were from older couple with no children or lone person households (27% compared to 11% non-health, and 24% compared to 16% of non-health respectively).</p> <p>Health consumers were more likely to have lower household incomes, with the proportion of respondents having an income of less than \$25,000 being 33%, compared to 18% amongst non-health customers. Further, significantly fewer health consumers were from a household where the income fell between \$75,000 and \$150,000 (19% compared to 28% non-health consumers).</p> <p>A higher proportion of pharmacy users in Tasmania were health consumers when compared to the average (54% compared to 41% on average). In contrast, a significantly lower proportion of health consumers were evident in both the Northern Territory and Western Australia (29% and 37% consecutively).</p> <p>Higher levels of health consumers were seen in rural and regional levels when examined at the total sample level (44% and 43% in turn), compared to just over one third (38%) in the metropolitan area.</p>

Health Consumers	Shared characteristics
Pharmacist/ Assistant Advice	<p>A slightly higher proportion of health consumers claimed to regularly ask the Pharmacist for advice (11% on a monthly basis compared to 4% amongst non-health consumers; significant at the 95% confidence interval).</p> <p>Further, a lower proportion of health consumers claimed to never ask the Pharmacist for advice (42% compared to 59% cited for non-health consumers). This finding is not statistically significant at 95% loc.</p> <p>A similar result was revealed for Pharmacy assistants, where 57% of health consumers claimed to never ask this person for advice, relative to 67% for non-health consumers (statistically significant at 95% confidence interval).</p>
Loyalty/ Relationship	<p>Not surprisingly, a significantly higher proportion of loyal customers were health consumers (53%), further constituting 40% of chain users and 25% of those who use multiple pharmacies.</p> <p>Amongst those who were loyal to one provider, the key reasons cited for their behaviour included 'friendly staff' (39%), 'staff and pharmacy know me' (30%) and 'pharmacist gives me good advice' (21%). These scores were significantly lower within the non health consumer sample at the 95% confidence interval.</p>
Pharmacy/ product Usage	<p>The majority of health consumers visited pharmacies regularly, with 76% visiting a pharmacy between 2-3 times a month and every few months (statistically significantly higher than the 47% recorded by non-health consumers).</p> <p>In terms of product range used and frequency of purchase, a significantly higher proportion of health consumers purchased prescriptions and medications at pharmacies monthly (72% compared to 13% amongst non health consumers; significant at the 95% confidence interval). They were also more likely to use over the counter medicines more frequently than non-health consumers (32% monthly versus 19%).</p> <p>A higher proportion of health consumers reported never going to the pharmacy to purchase vitamins, other health care, personal care products or gift cards.</p>
Purchase Behaviour	<p>When asked to reveal their typical behaviour when waiting for a prescription to be filled, a significantly higher proportion of health consumers claimed to leave and come back at their convenience (24% compared to 19% on average). Moreover, a significantly lower proportion browsed while waiting (26% compared to 35% non-health consumers).</p>

Table 6: Distinguishing characteristics of health consumers from non-health consumers

6.2.4.2 Profile of Non-Health Consumers

The results revealed some stark differences between health and non-health consumers in demographic, usage and behavioural terms. These are evident in Table 7.

Non-Health Consumers	Shared characteristics
Demographics	<p>A significantly higher proportion of non-health consumers were male within the weighted sample (54% compared to 42% amongst health consumers).</p> <p>These respondents tended to be younger, with significantly higher proportions of respondents being aged between 15 and 34 years of age (47% compared to 19% amongst health consumers).</p> <p>As opposed to health consumers where the most common employment status was retirement, the most common employment status amongst non-health consumers was working full time (46% compared with 29% among health consumers). A higher proportion of students were also seen within this group (13% compared to 3%).</p> <p>Non-health consumers were not typical of one household description or demographic; rather they spanned the entire range of descriptions, from couples with no children to couples/singles with pre-school children.</p> <p>A significantly lower proportion of non-health consumers had lower household incomes. Having said this, the bulk of non-health consumers were from households with incomes ranging from less than \$25,000 to \$75,000 per annum.</p> <p>A significantly higher proportion of non-health customers were seen in both the Northern Territory and Western Australia (71% and 63% compared to 29% and 37% amongst health consumers).</p>
Pharmacist/ Assistant Advice	<p>Not surprisingly, a significantly higher proportion of non-health consumers claimed to never ask the Pharmacists or Pharmacy assistants for advice (67% and 59% respectively).</p>
Loyalty/ Relationship	<p>The majority of pharmacy customers who visited a repertoire of pharmacies were non-health consumers (75%). Further, of all customers who claimed to use one chain of pharmacists, 60% were non-health consumers.</p> <p>When those using just one pharmacy were asked to justify their behaviour, the most common response was 'it was close/convenient' (43%).</p>

Non-Health Consumers	Shared characteristics
Pharmacy/ product usage	<p>Non-health consumers were typically light to medium level users of pharmacy, with 48% being light visitors and 47% being medium level visitors.</p> <p>Over the counter and prescription/medications were used at a range of frequencies across this group. It should be noted however, that the frequency of usage was significantly lower than the frequencies noted for health consumers on both counts (25% of non health purchased OTC quarterly and 28% biannually compared to 20% and 17% respectively among health consumers, and 27% of non health purchase prescriptions quarterly and 38% biannually, compared to 13% and 3% among health consumers).</p> <p>Similar proportions of non-health consumers claimed to ‘never’ visit the pharmacy to purchase the remaining products (including vitamins, herbal remedies, health care products, personal care products or gift cards).</p>
Purchase Behaviour	<p>When asked to indicate their typical behaviour when waiting for a prescription to be filled, the most common response amongst non-health consumers was ‘to browse while waiting’ (35% compared to 26% amongst health consumers).</p>

Table 7: Demographic, usage and behavioural differences between health consumers and non-health consumers

6.2.4.3 Total Sample and Comparative Profiling

The following charts examine the profile of pharmacy consumers in more detail. The characteristics of the total market are described, relative to those of health consumers and non-health consumers. Differences between each consumer type are clearly identified, as well as any other distinguishing characteristics of each group.

6.2.4.3.1 Demographics

a. Geographic

When the proportion of health to non-health consumers was explored by State, the results reveal significantly higher levels of health consumers in Tasmania (54% compared to 41% at the total sample level). For sample numbers, please refer to the following chart. In contrast, lower levels of health consumers were seen in both the Northern Territory and Western Australia (29% and 37% respectively compared to the 41% average).

PROPORTION OF HEALTH & NON HEALTH CONSUMERS, BY STATE

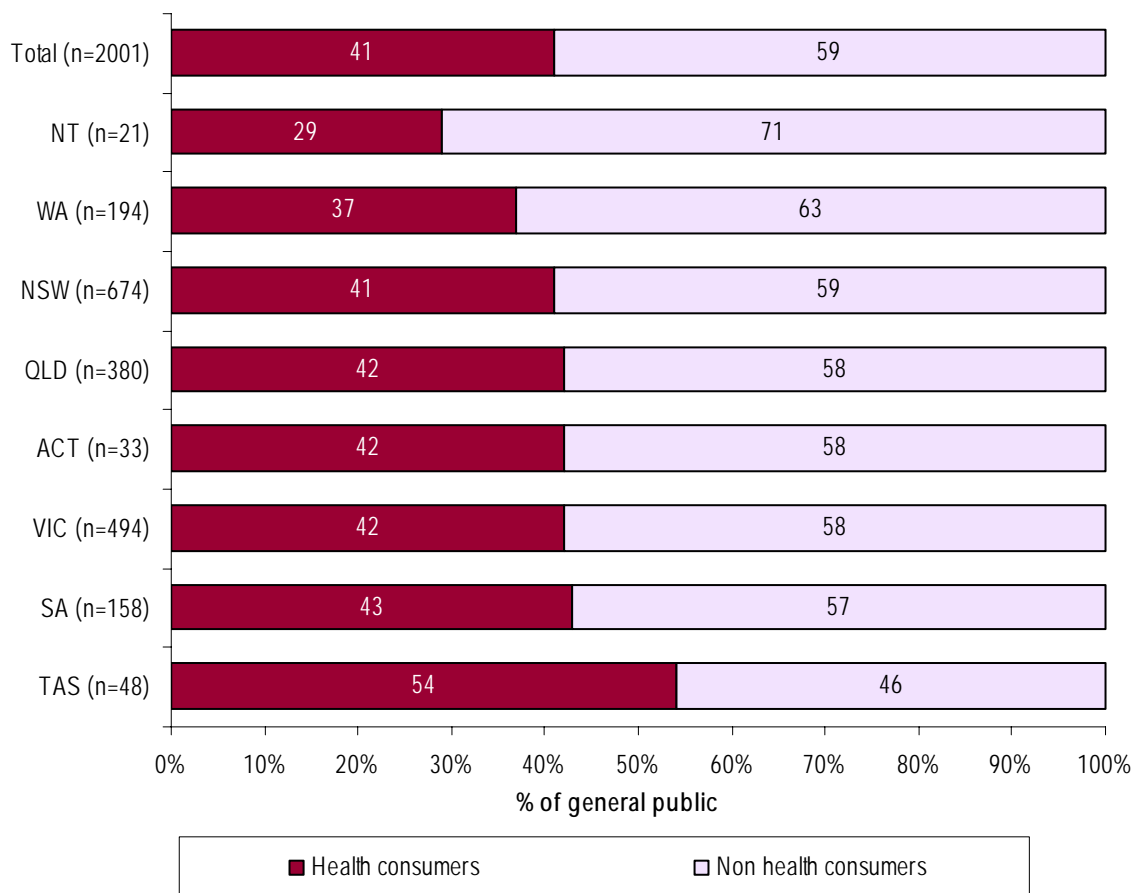


Fig 1. General Public Survey: Health to non health consumers by State: Total Sample n=2001

When the total sample results were explored by geographic region, regardless of State, a significantly higher proportion of health consumers emerged in both rural and regional areas (44% and 43% compared to 38% in metropolitan areas).

PROPORTION OF HEALTH/NON HEALTH CONSUMERS BY GEOGRAPHIC AREA

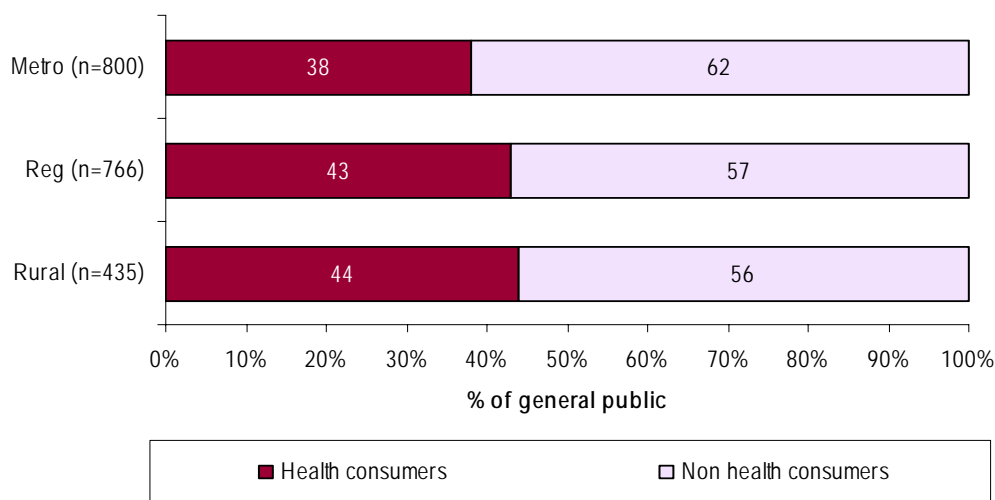


Fig 2. General Public Survey: Health to non health consumers by geographic area, n=2001

b. Gender

With regard to gender, a significantly higher proportion of non-health consumers were male (54% compared to 42% amongst health consumers); while a reverse analysis shows 47% of females were health consumers, compared to 36% of males.

HEALTH VS NON HEALTH CONSUMERS - GENDER

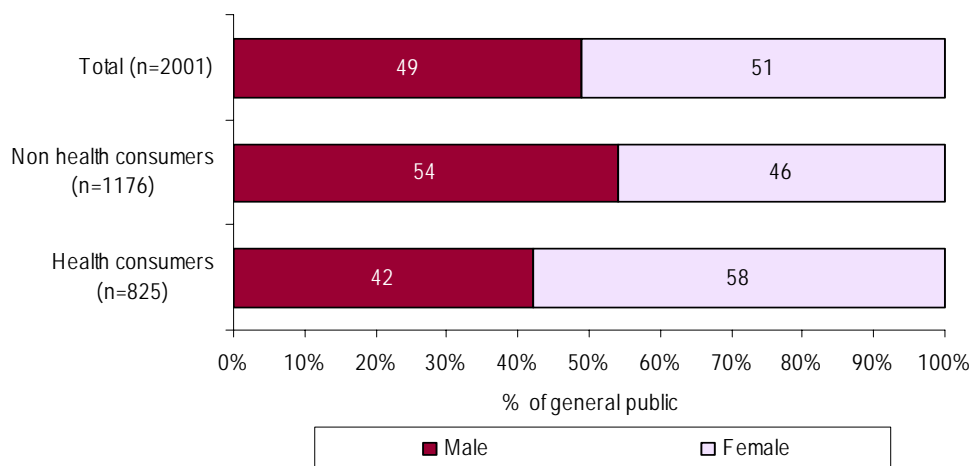


Fig 3. General Public Survey: Health vs non health consumers by gender, n=2001

HEALTH VS NON HEALTH CONSUMERS - GENDER

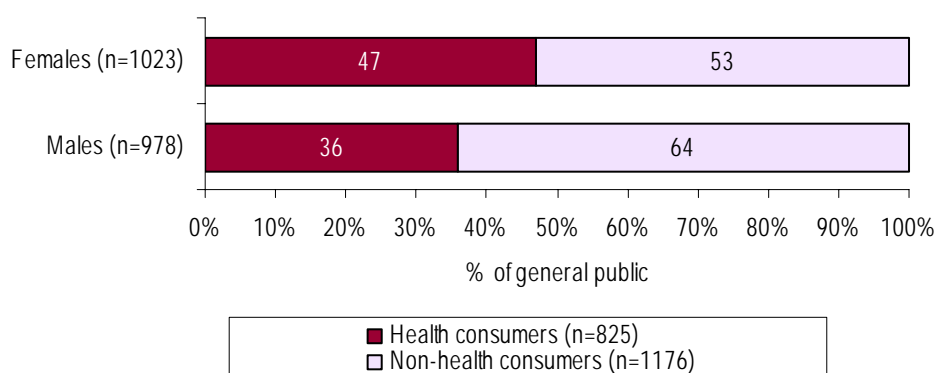


Fig 4. General Public survey: Health vs. non-health consumers by gender, n=2001

c. Age

Health consumers tended to be older than non-health consumers, with a significantly higher proportion of respondents aged 55 years and over (44% compared to 17% amongst non-health customers). Comparatively, reverse analysis indicated that 16% of 15-24 year olds were health consumers compared with 71% of 65+ year olds.

HEALTH VS NON HEALTH CONSUMERS - AGE

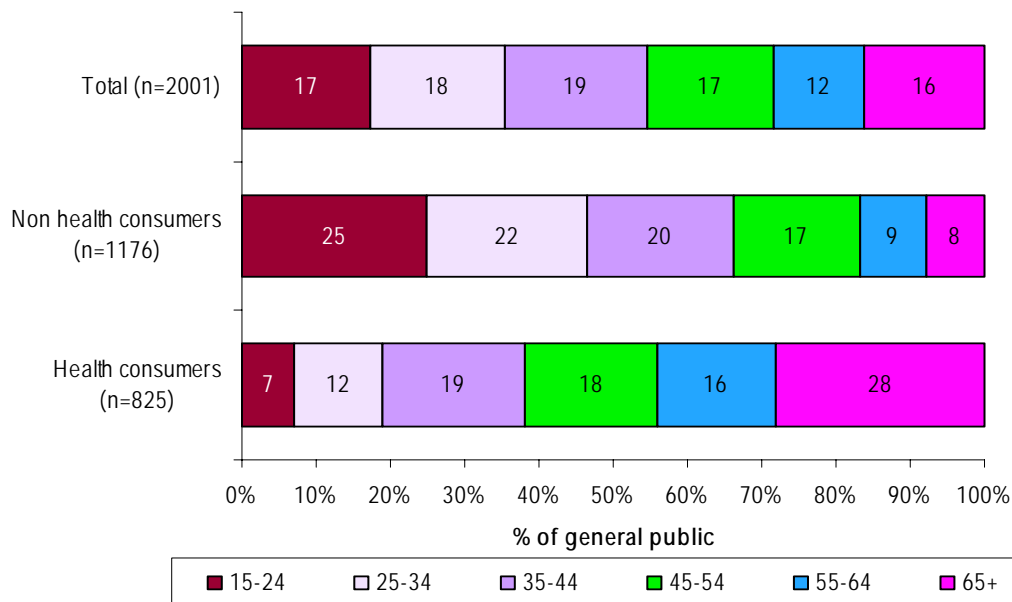


Fig 5. General Public Survey: Health vs non health by age, n=2001

HEALTH VS NON HEALTH CONSUMERS - AGE

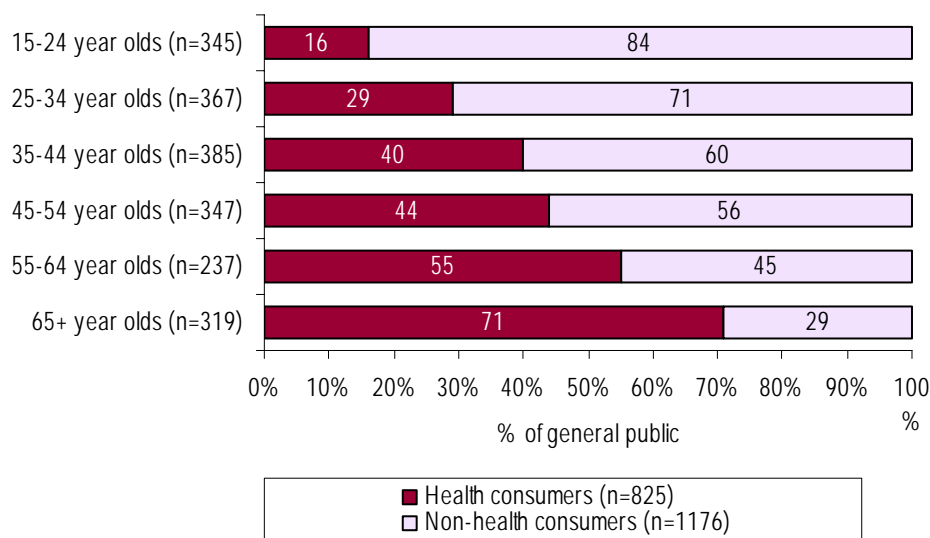


Fig 6. General Public survey: Health vs. non health consumers by age, n=2001

d. Employment Status

At the total sample level, the majority of respondents were either employed full or part time or retired (39%, 19% and 18% respectively). More specifically, health consumers were significantly more likely to be retired (30% compared to 9%), with a slightly smaller proportion also working full time. In contrast, non-health consumers were more commonly working on a full time basis (46%).

In line with the typical age profile of non health consumers, a higher proportion of this base was students (13% compared to 3%). Reverse analysis of this question revealed that 47% of employed respondents and 64% of unemployed respondents qualified as health consumers.

HEALTH VS NON HEALTH CONSUMERS - EMPLOYMENT STATUS

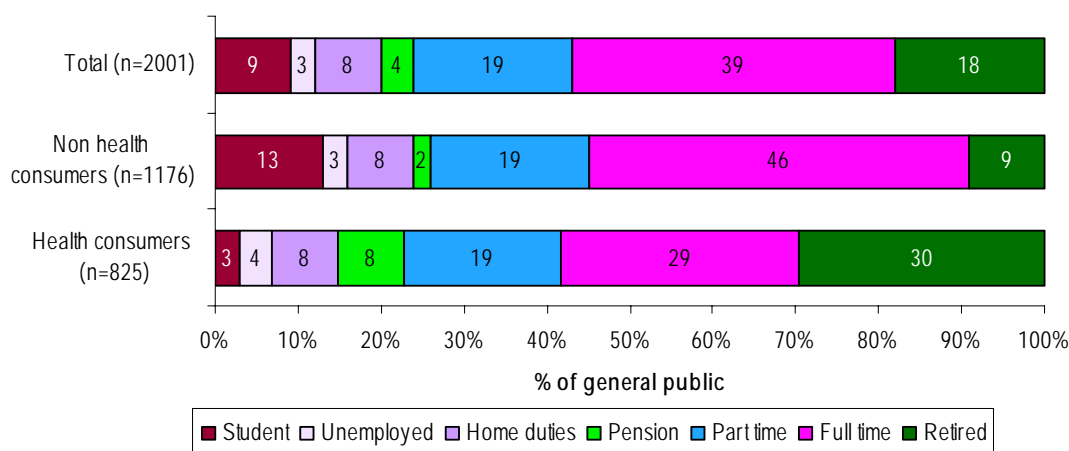


Fig 7. General Public Survey: Health vs non health by employment status

HEALTH VS NON HEALTH CONSUMERS - EMPLOYMENT STATUS

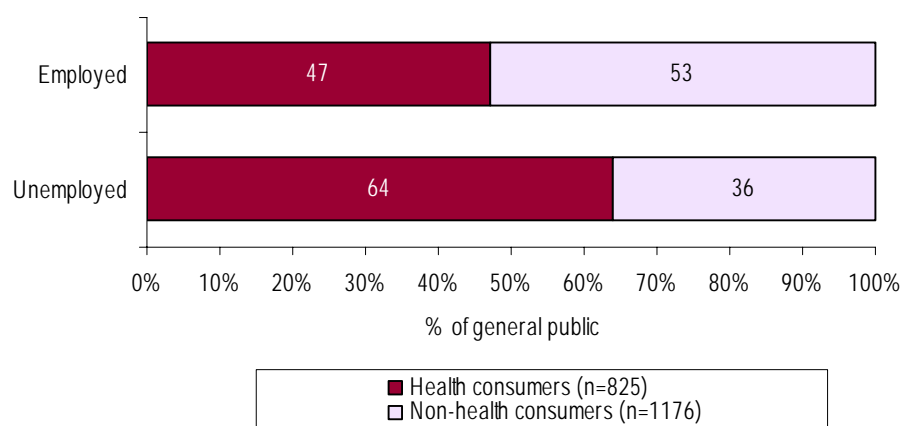


Fig 8. General Public survey: Health vs. non-health consumers, by employment status, n=2001

e. Household Description

The most common descriptors defining the household of health consumers included older couples with no children at home (27%) and lone person households (24%). In comparison, non-health consumers more equally spanned the full range of household descriptions.

HEALTH VS NON HEALTH CONSUMERS - HOUSEHOLD DESCRIPTION

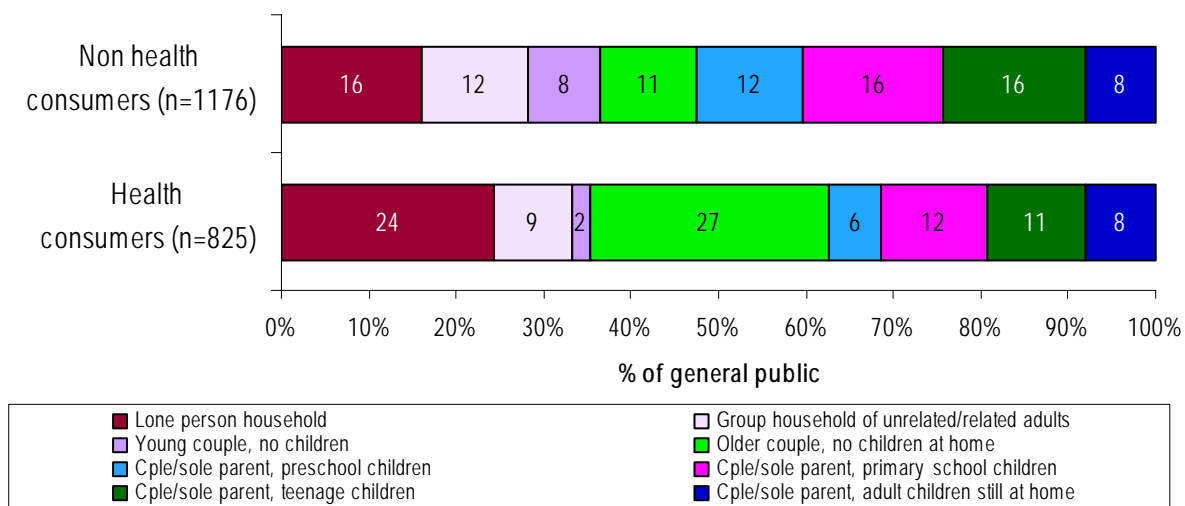


Fig 9. General Public Survey: Health vs non health consumers by household description, n=2001

f. Household Income

Non-health consumers tended to reflect the typical demographics of the total sample population with respect to household income, while within the health consumer segment, the proportion of lower income earners was heightened, with 61% having a household income of less than \$50,000, the current median, compared to 45% at the total sample level. The differentiation was most notable in the relative proportions under \$25,000 (33% compared to 18%).

HEALTH VS NON HEALTH CONSUMERS - HOUSEHOLD INCOME

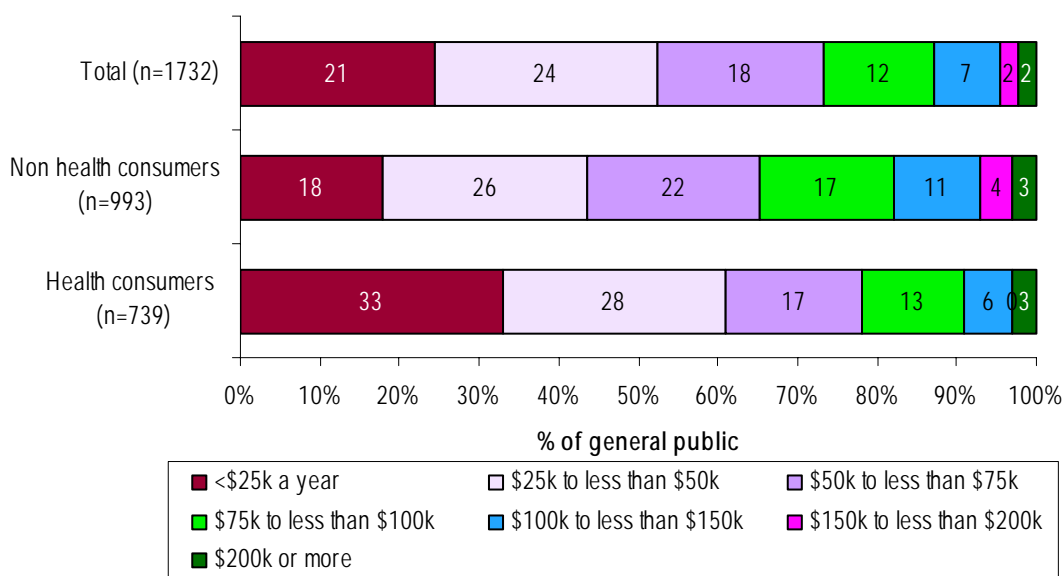


Fig 10. General Public Survey: Health vs non health consumers by household income, n=2001

6.2.5 Experiences

This section of the report examines the experiences of the general public with regard to pharmacy, referring to both objective (i.e. how long did you wait?) and more subjective performance measures (e.g. in your opinion, how friendly was the staff member?).

The findings outlined within this section play a significant role in determining the level of customer satisfaction and confidence with pharmacy from a consumer health care perspective and ultimately, the degree to which current strategies for the ongoing and sustainable improvement in the attitudes and behaviour of pharmacy staff toward consumers are achieving the desired outcomes.

6.2.5.1 Pharmacy/Healthcare professional usage

For ease of reporting, the frequency of visiting the pharmacy codes have been condensed into four categories - frequent, regular, occasional and non users. The definitions are listed overleaf.

Frequent users are those who use pharmacies at least once a week; regular users visit pharmacies less than weekly but at least every few months, and occasional users use pharmacies but no more than twice a year. Non users said they never use pharmacies. The graph below illustrates the frequency of visitation in full for the total, health consumer and non-health consumer samples.

Subsequent analysis for the General Public and Exit surveys generally uses the condensed (frequent/regular/occasional/non) codes and refers to the specific frequency codes (e.g. 2-3 times per week) where significant differences emerge within the data.

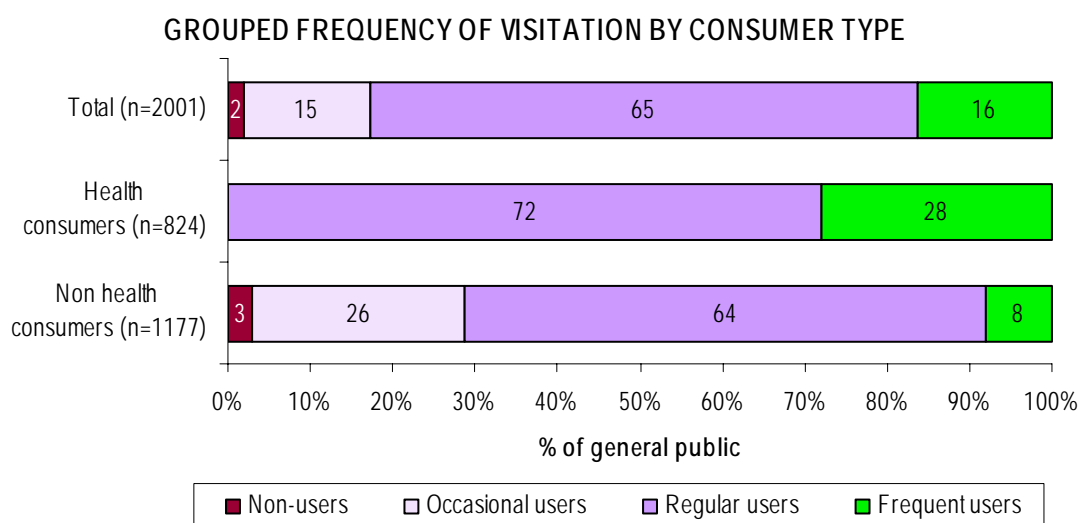


Fig 11. General Public survey: Frequency of visitation by health vs. non-health consumer, n=2001

Across the general public sample, the most common frequency of visiting the pharmacy was regularly (65%). Among health consumers, however, the proportion of regular users increased dramatically (72%). This is attributable to the definition of health consumers being regular to frequent visitors to pharmacy generally. Accordingly, non-health consumers were typically more likely to be occasional users (26% compared to 15% in the total sample).

At the total sample level, the frequency of pharmacy visitation correlates to some extent with the frequency of visiting a health care professional. A significantly higher proportion of frequent pharmacy visitors were also frequent users of health care professionals generally (62%), a higher proportion of regular level visitors were also regular level users of health care professionals. However, the pattern did not continue with light to non-users of health care professionals, who still use community pharmacy with light to medium frequency, as can be seen in Table 8.

		Pharmacy usage			
		Heavy	Medium	Light	Non-users
Health care professional usage	Frequent (n=64)	62	34	4	0
	Regular (n=1177)	20	73	7	1
	Occasional (n=702)	6	62	29	3
	Non-users (n=58)	6	47	56	13

Table 8: General Public Sample: Frequency of pharmacy usage by health care professional usage

The results also suggest that males were lighter visitors to the pharmacy generally, with a significantly higher proportion visiting between once a month to less than once or twice a year (68% compared to 55% females). This is not surprising given the female skew within the health consumer segment and the heavier frequency of visitation emerging amongst health consumers generally.

Further, a significantly higher proportion of customers who claimed to be solely loyal to one pharmacy (n=1261) were weekly visitors to the pharmacy (5% compared to 2% or lower), while in contrast, users of multiple pharmacies (640) were more likely to be regular and occasional users (85% compared to 77% on average).

Respondents defined as health consumers were generally regular users of health professionals (76%), whilst non-health consumers were typically occasional to regular users.

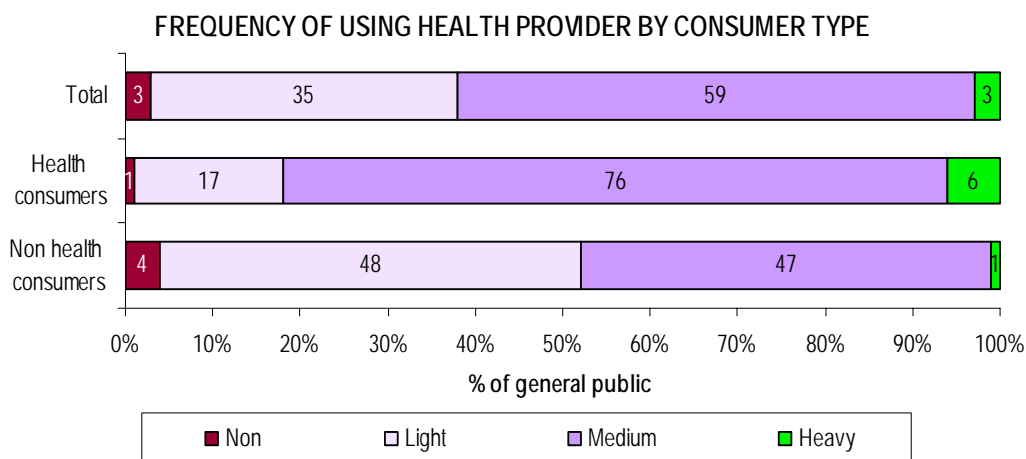


Fig 12. General Public Survey: Health vs non health consumers by frequency of using health professional, n=2001

Given the high correlation between the frequency of visitation and use of health care professionals, the significant differences emerging in the previous section parallel those revealed in this question. In short, a higher proportion of males and repertoire buyers were also less frequent users of health care professionals.

6.2.5.2 Product usage

Respondents were asked how often they visit a pharmacy to purchase particular product groups. The graph overleaf outlines the purchase frequencies at both the total sample level and split by health and non-health consumers. The results reveal that the most frequently purchased products were prescriptions and OTC medications.

As expected, health consumers visit pharmacies for a range of products at higher frequencies than non-health consumers. A significantly larger base of health consumers visited pharmacies at least monthly to purchase prescriptions (72% compared to 13% of non-health consumers, including 10% of health consumers who get prescriptions weekly (1% amongst non-health consumers). In contrast, non-health consumers tended to visit the pharmacy for prescriptions and medications biannually or less (60%).

Results also reveal a higher proportion of health consumers who visited the pharmacy to purchase OTC medicines at least monthly (32% vs 19% of non-health consumers). Other health care products were also more frequently purchased by health consumers, with 26% purchasing quarterly compared to 19% for non-health.

At the total sample level, males were significantly less likely to frequently purchase non-script/non-OTC health care products, as were younger respondents, those working full time and those earning between \$50,000 and \$100,000.

The proportion of respondents claiming to very rarely or never purchase the remaining products differed across the health and non-health consumer samples, with slightly fewer health consumers falling into the 'never' response code in each product category.

With regard to the purchase of vitamins and herbal remedies through pharmacies, a significantly lower frequency of purchase was seen within the ACT, South Australia and Victoria, with 24% in the ACT claiming to use a pharmacy to purchase these products less than biannually, and significantly higher proportions in SA (74%) and Victoria (77%) claiming to never use the pharmacy for these products. Respondents based in regional areas were also more likely to claim never to use the pharmacy to purchase these products (71%).

The purchase of personal care products through pharmacy was significantly less frequent amongst respondents based in Western Australia (66% to 61% on average) and respondents in regional areas (60%). Higher purchase frequency within this product category was seen amongst younger respondents, particularly those aged between 15 and 24 years (with 12% purchasing approximately once a month compared to the 6% total sample average). This was further supported by a higher purchase frequency among students, with 13% purchasing about once a month).

PRODUCT RANGE AND FREQUENCY OF USAGE

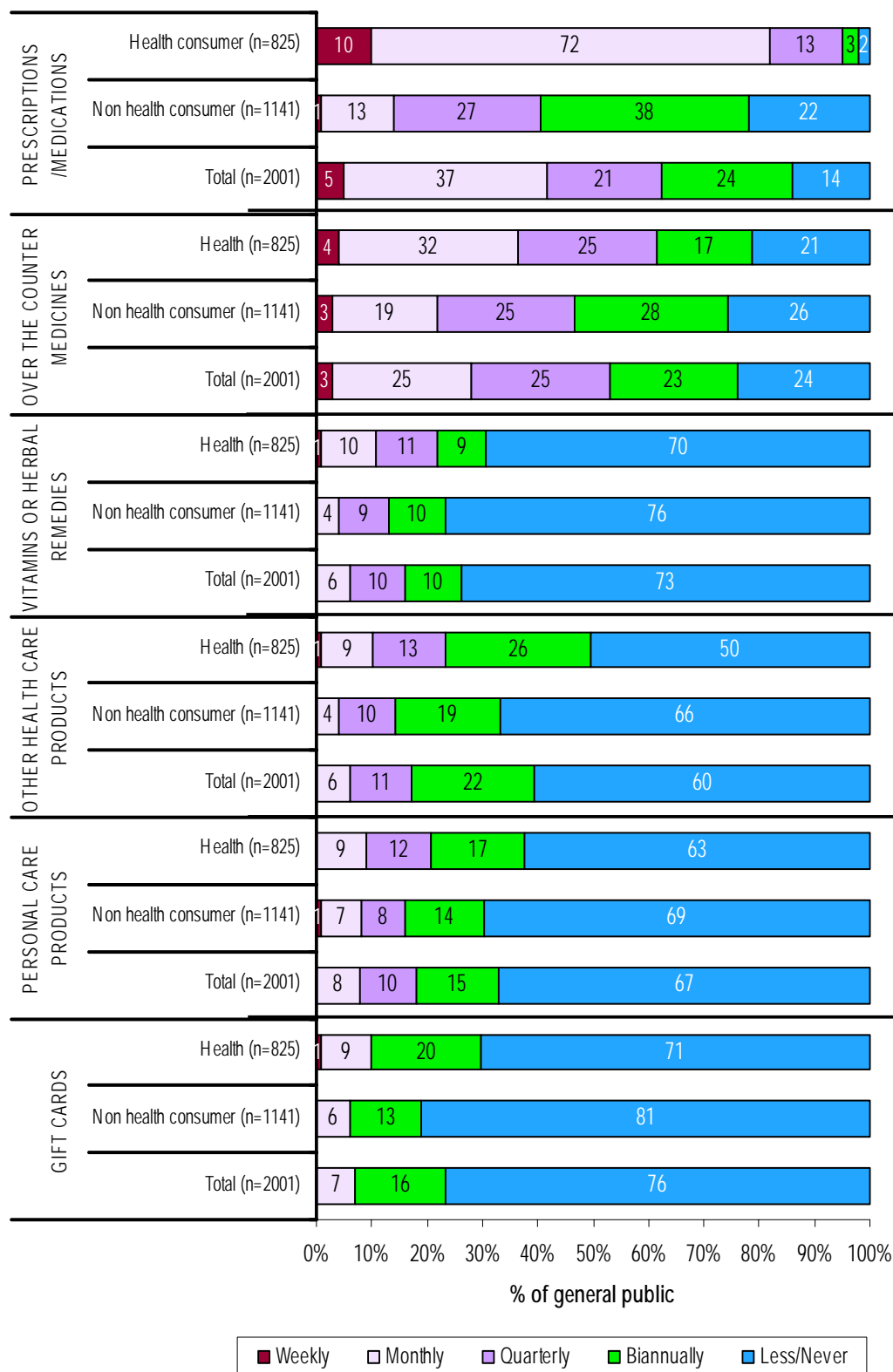


Fig 13. General Public Survey: Product usage and frequency of usage, Base: those who visit pharmacy, n=1966

6.2.5.3 Frequency of asking for Pharmacist/Assistant Advice

A significantly higher proportion of health consumers ask both the pharmacist and pharmacy assistant for advice on a monthly basis (11% and 10%, compared to 4% and 3% of non health consumers respectively). In contrast, significantly higher proportions of non-health consumers claimed to never ask these staff members for advice (59% and 67%).

Those respondents who claimed to ask the Pharmacist for advice more frequently (i.e. between 2 to 3 times a month and once a week, n=56) were more likely to be located in metropolitan areas, be more frequent visitors to pharmacy generally and be frequent users of health care professionals.

Interestingly, a higher proportion of South Australians (n=158) claimed to never ask the Pharmacist for advice. Light users of pharmacy were also less likely to ask for advice, as well as repertoire users of pharmacy, respondents aged 15 to 24 years, students and full time workers.

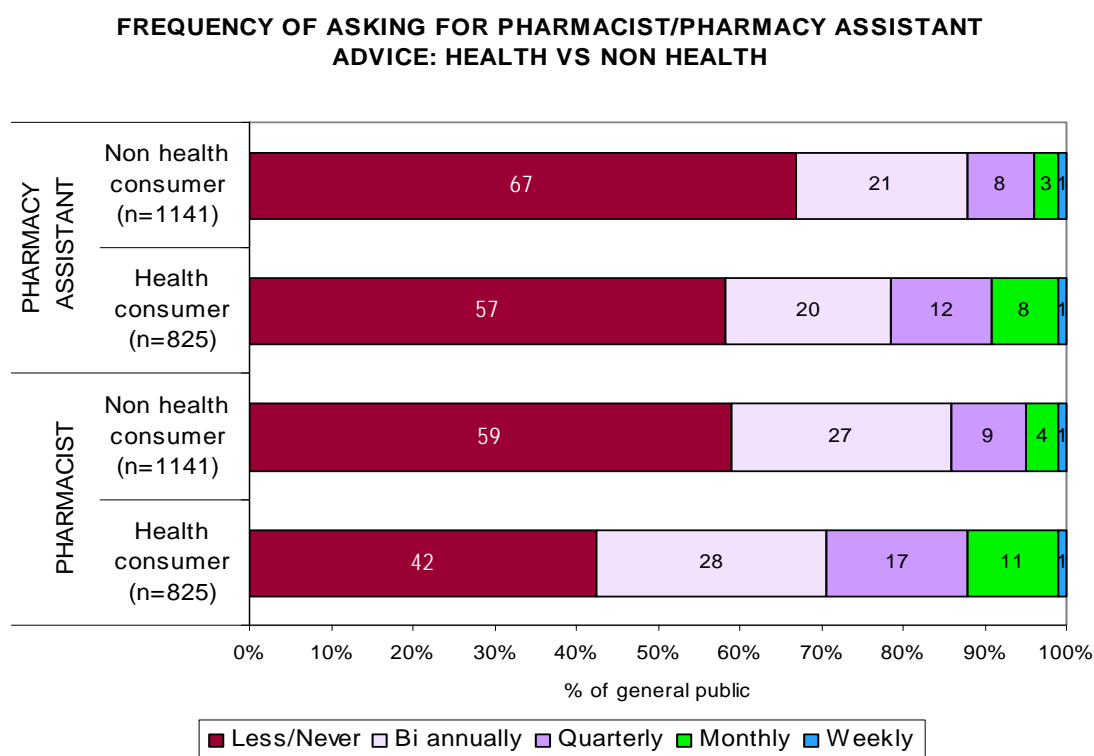


Fig 14. General Public Survey: Frequency of asking for advice, health vs non health consumer, Base: those who use pharmacy n=1966

6.2.5.4 Pharmacy Loyalty

Across the full sample, 54% of the general public suggested that they are loyal to one pharmacy. In 46% of cases, this was attributed to respondent choice, while in the remaining 8% of cases, it was a convenience decision. The remaining 46% of respondents were users of multiple pharmacies.

Of the multiple pharmacy users (n=818), a significantly lower proportion of respondents were health consumers (25% compared to 75% non-health). Thus, a significantly higher proportion of loyal users were health consumers (53% compared to 47% non-health).

A higher proportion of loyal users were based in Victoria (51% compared to the 46% average) and in regional areas across all States (50%). A significantly higher proportion of respondents in rural areas indicated that their choice of pharmacy was limited, resulting in the use of only one provider (16% compared to the 8% average).

Conversely, multiple pharmacy users were more likely to be based in metropolitan areas (48% compared to the 41% average) and in particular, Western Australia (46%). A higher proportion of light users of pharmacy also visited the most convenient pharmacy (60%), as well as younger respondents (aged between 15 and 44 years), students, and respondents with household incomes of between \$50,000 and \$100,000 per annum.

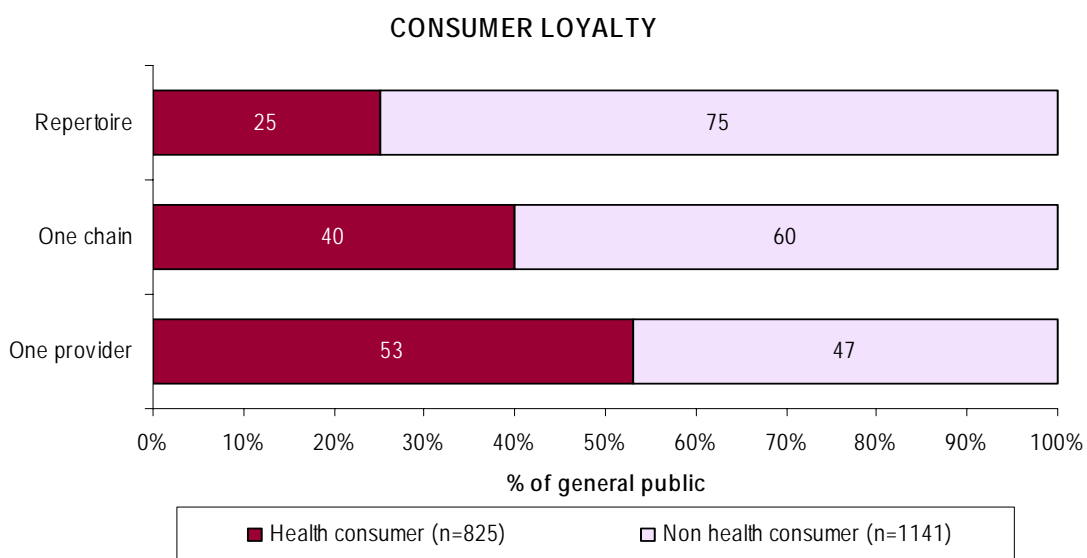


Fig 15. General Public Survey: Consumer loyalty by health vs non health consumers, Base: those who use pharmacy, n=1966

Those respondents who claimed to use only one pharmacy (n=1089) were asked why this was so. Reasons provided by respondents were somewhat consistent across both the health and non-health samples.

The most common reasons provided at the total sample level included 'close/convenient to home' (39%), 'friendly staff' (36%), and 'the staff and pharmacist know me' (25%). In line with the broad theme of results emerging from this report, however, a considerably

larger proportion of health consumers suggested that they chose the one provider due to relationships, demonstrated by responses attributed to the friendliness of staff and the fact that the staff knew them personally (39% and 30% respectively).

Alternatively, a higher proportion of non-health consumers attributed their choice of one provider to convenience (43% compared to the 39% average).

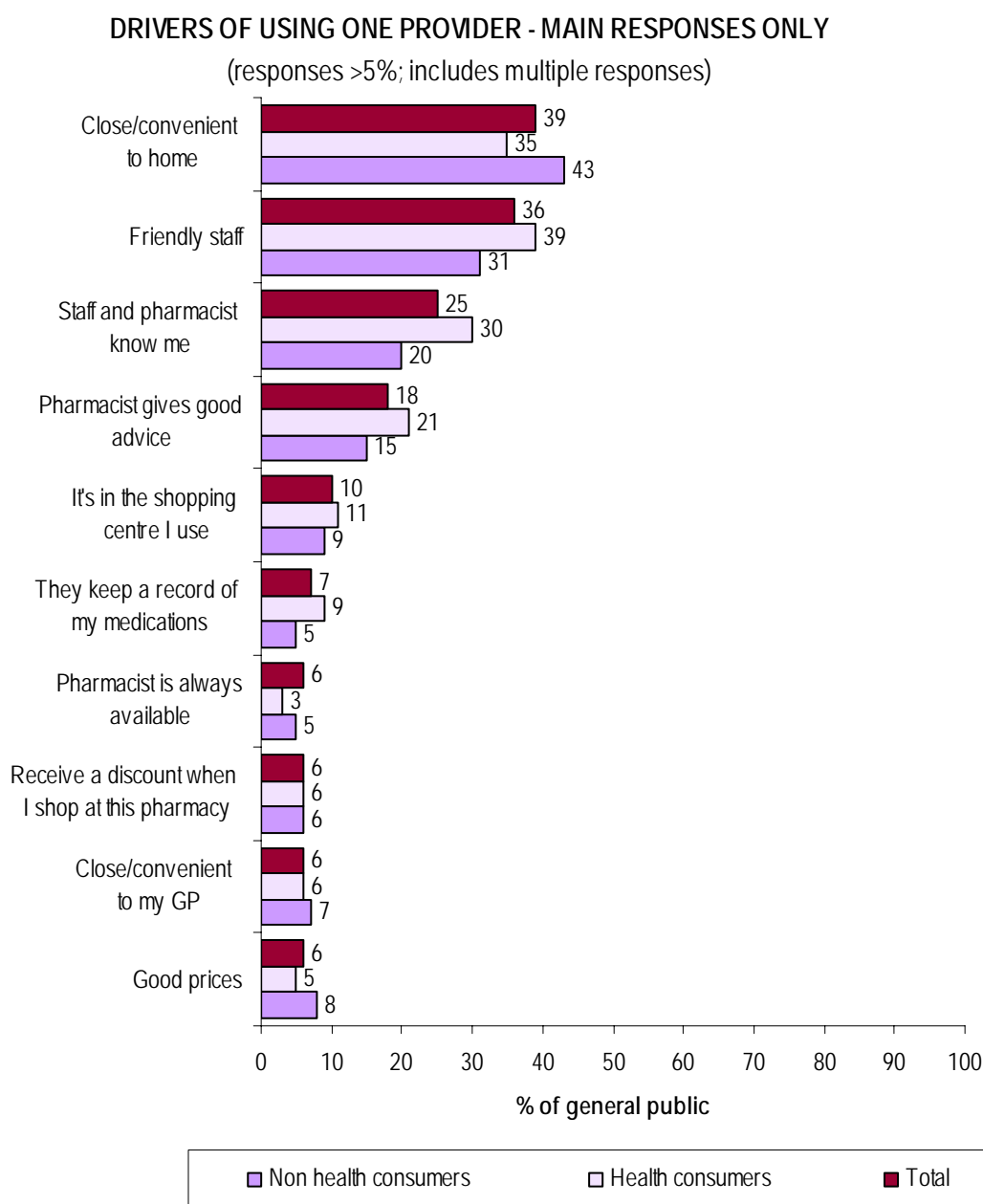


Fig 16. General Public Survey: Drivers of using one provider, Base: those who use one provider, n=1089

6.2.5.5 Impact of NESB on Pharmacy Choice

A total of 6% of the general public sample claimed that English was not their first language. This proportion was steady across both health and non-health consumers.

Of the 6% of the total sample (n=120) who were of NESB (non-English speaking backgrounds), none claimed to choose their pharmacist due to the availability of staff who speak their language (0%).

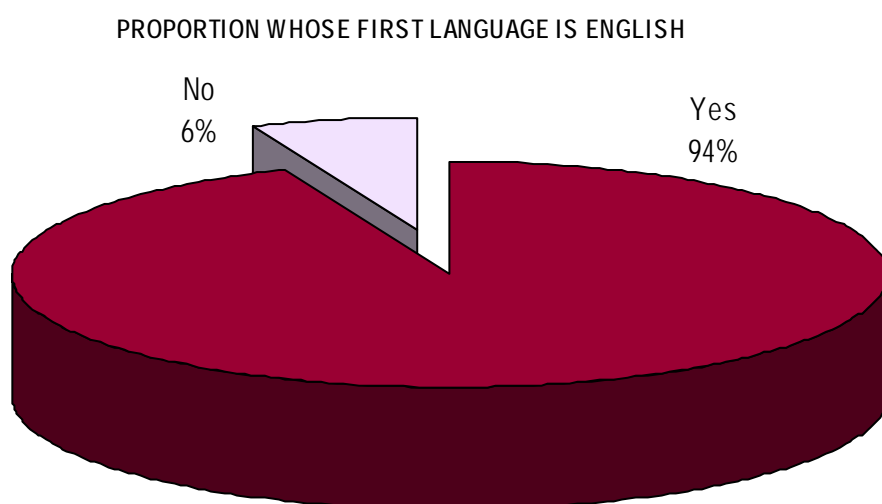


Fig 17. General Public Survey: Proportion have English as their first language, n=2001

6.2.5.6 Purchase Behaviour Profile

When waiting for a prescription to be filled, the most common behaviours at the total sample level (n=2001) were to browse around the shop (31%), leave and come back, or sit and wait (each 19%).

When examined by consumer group, several key differences in behaviour emerged. A significantly lower proportion of health consumers claimed to browse around the shop (26% compared to the 31% average), with a commensurate increase in their incidence of leaving and returning when it was convenient (24% compared to the 19% average).

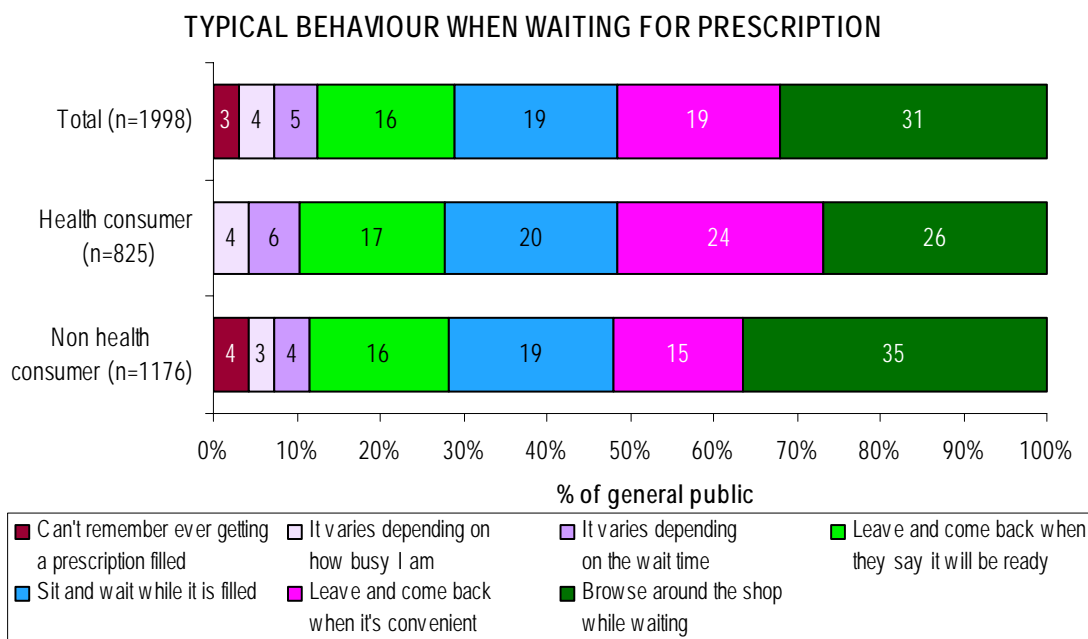


Fig 18. General Public Survey: Behaviour when waiting for prescription, Base: Total Sample, n=2001

6.2.5.7 Time waiting for prescriptions

Those respondents who use the pharmacy to get prescriptions filled (n=1876) were asked how frequently their prescriptions had been filled within less than 10 minutes, then less than 20 minutes and finally, less than 30 minutes. The results are outlined in the following table at the total sample level and split by health and non-health consumers.

Approximately two thirds of the sample **always** have their prescriptions filled within 30 minutes (69%); in other words, one customer in three sometimes waits longer than 30 minutes. 63% claim to **always** have their prescription filled within 20 minutes and just over one third (36%) claim to **always** have their prescription filled within 10 minutes. It should be noted, however, that, in total, 73% of the general public claimed to have their prescription either **always** or **usually** filled within 10 minutes, which is an extremely positive finding.

There were no significant differences in wait times for filling prescriptions by consumer type (i.e. health and non-health consumers).

Having said that, a significantly higher level of service is evident in both Western Australia and New South Wales, with the proportion of respondents claiming to receive their prescription in less than 10 minutes being significantly higher (44% and 42% respectively compared with 34% on average). Wait times were also significantly lower in metropolitan areas (with 40% always receiving their prescription in less than 10 minutes compared to the 34% average).

A significantly higher proportion of younger respondents claimed to have their prescription filled within 10 minutes, with 71% of those aged between 25 and 44 years claiming to always or usually receive their prescription within that time frame, compared with 68% at the total sample level.

FREQUENCY OF WAITING TIME FOR PRESCRIPTIONS

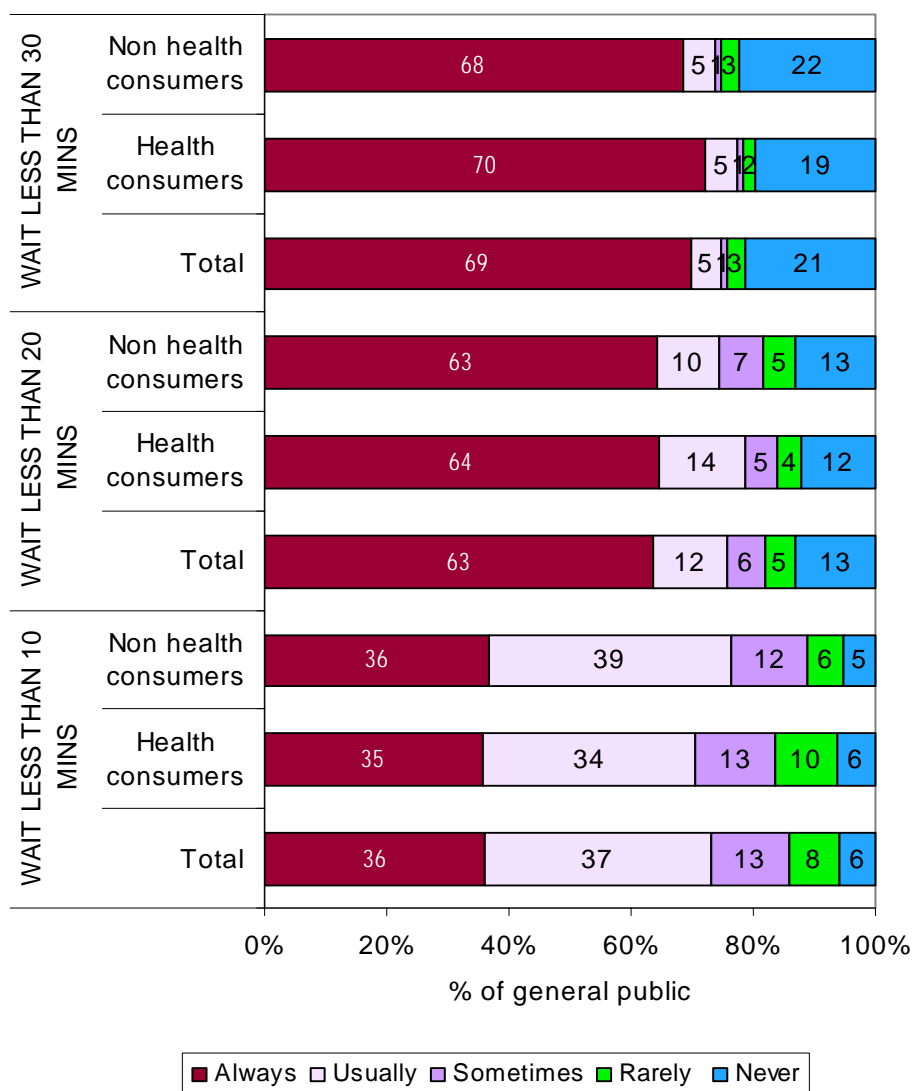


Fig 19. General Public Survey, Wait time for prescriptions (Base: Those who use pharmacy for prescriptions, n=1876; Health consumers, n=820, Non-health consumers, n=1056)

6.2.5.8 Service Performance – Prescriptions & OTC Medications

Respondents who use the pharmacy for OTC and prescription medications (n=1557) were asked to indicate the frequency with which they experienced a number of scenarios relating to prescriptions and over the counter medications.

The most frequently performed service at the total sample level was having the medication in stock or getting it in quickly, with 73% of respondents claiming that this always occurred. However, this means that up to one quarter of people cannot always get their medication promptly.

Approximately 30% of respondents claimed to always speak with the Pharmacist about how to use the medicine, with a further 17% suggesting that they usually spoke with the Pharmacist. The proportion usually receiving this service was significantly higher within the ACT (47% compared to the 17% average). No significant differences emerged across those who always received the service by State.

The proportion of health respondents who always spoke with the Pharmacist about how to use their medication was significantly lower than that seen for non-health consumers (25% compared to 33%).

A total of 18% of the total sample indicated that they always received written information regarding how to use their medication in addition to the pack instructions when they visited the pharmacy for prescription or over the counter medications, with a further 10% claiming to usually receive this service. The frequency of providing this service was significantly higher within Western Australia (with 24% always receiving written information compared to the 18% average).

The proportion of respondents claiming to always receive written information was significantly lower within metropolitan areas across SA, with 47% claiming to never receive this service compared to the 42% average. Respondents located within SA were also less likely to receive written information (50%).

The most infrequently provided service was the Pharmacist checking to ensure that the customer had no side effects from the medication provided, with just 12% claiming to either always or usually receive this service. The majority of the general public claimed to 'never' receive this Pharmacist check. The proportion always receiving this service was significantly higher amongst health consumers (11% compared to 6% non-health) and heavy users of health care professionals (24% always using the service, compared to 8% on average). These respondents were also more likely to perceive that the pharmacist gives good advice.

It should be noted that this higher level of service experienced by health consumers may be attributable to the pharmacist making a professional judgment within a busy environment to provide higher level professional services to those with presumably poorer health.

FREQUENCY OF SERVICES PROVIDED - PRESCRIPTIONS/OVER THE COUNTER MEDICATIONS

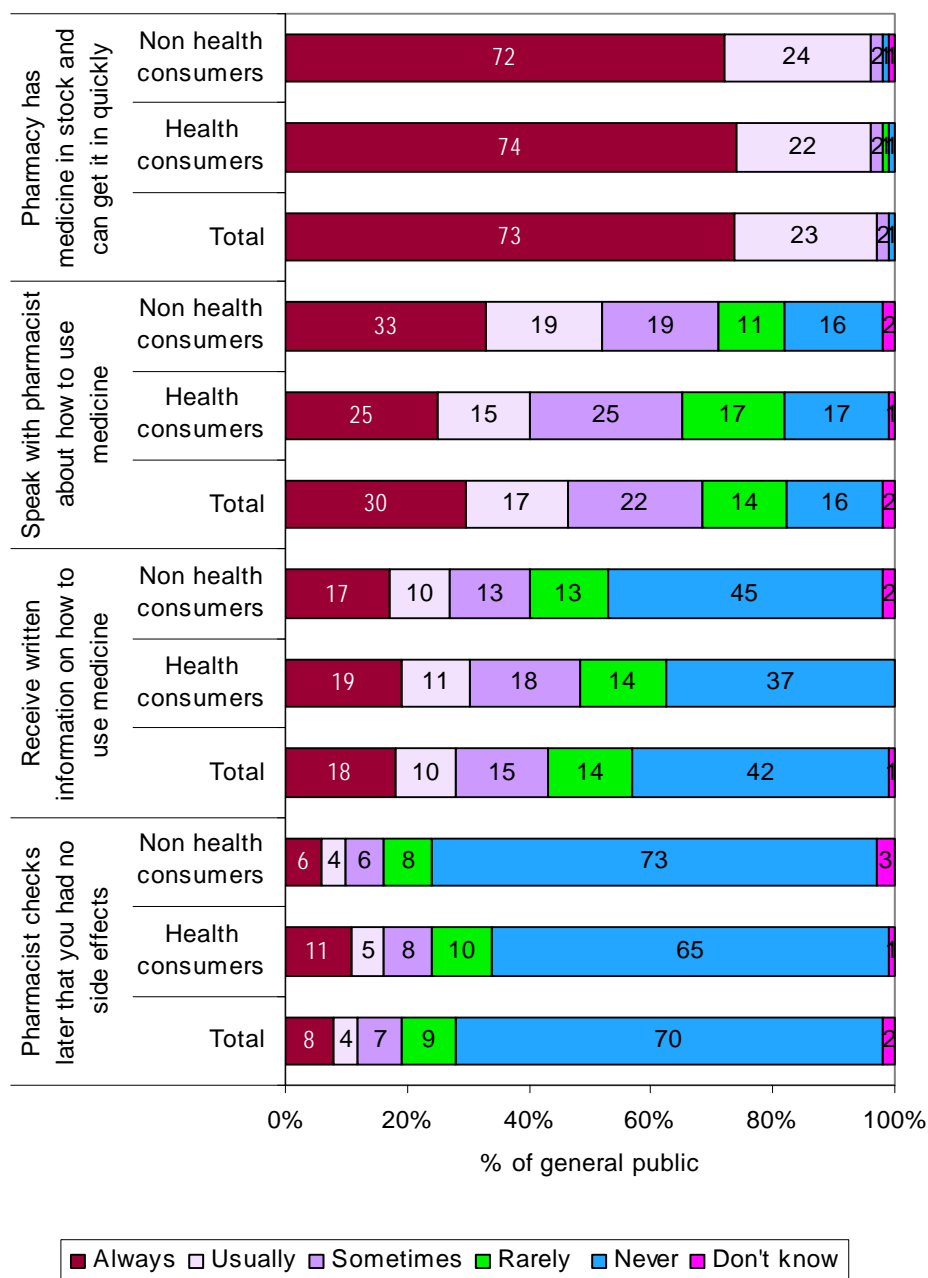


Fig 20. General Public Survey: Frequency of Prescription/OTC Services Provided (Base: those who use pharmacy for prescription, OTC Medication, n=1557, Health Consumers, n=691, Non-health Consumers, n=866)

6.2.5.9 Service Performance – Vitamins and Herbal Remedies

Amongst those who visit the pharmacy to purchase vitamins and herbal remedies (n=399), the most frequently provided services pertaining to the provision of these products were prompt attention (with 94% citing that it was always or usually provided) and referrals to the Pharmacist as often as the customers would like (75% always or usually provided).

Approximately 80% of respondents felt that the assistants were either always or usually knowledgeable about health related vitamins and herbal remedies. Respondents aged between 25 and 44 years of age were more confident with the level of assistant knowledge (80%).

Just over two thirds of the sample claimed to always or usually receive advice as to whether the product was right for them (67%). The incidence of this service was significantly more frequent among respondents aged between 25 and 44 years of age (45% compared to the 40% average), as well as couples or singles with children of mainly primary school age (52%). In contrast, a significantly higher proportion of respondents in metropolitan areas claimed never to receive advice regarding the appropriateness of such products (15% compared to 10% on average).

Just 23% always or usually received printed information about health issues relating to their product. The frequency of this service provision was significantly lower amongst metropolitan residents, where 46% claimed to never receive the service compared to the 37% average.

Health consumers rated the frequency with which each service was provided significantly higher, particularly with respect to receiving prompt attention, assistant referrals and assistant knowledge regarding health products.

FREQUENCY OF SERVICES PROVIDED - VITAMINS AND HERBAL REMEDIES

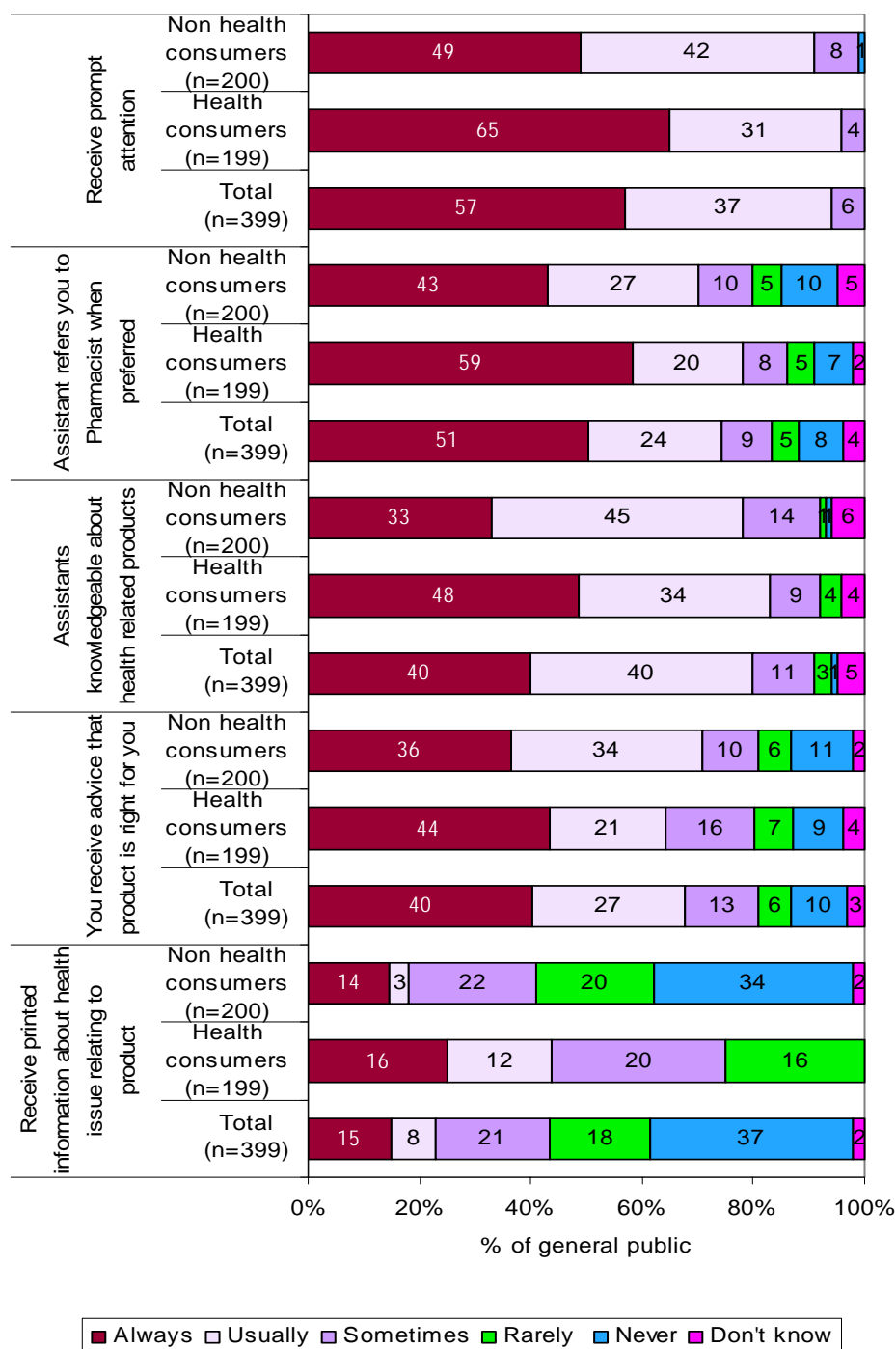


Fig 21. General Public Survey, Service Performance Vitamins and Herbal Remedies (Base: Those who use pharmacy for vitamins and herbal remedies, n=399, Health consumers, n=199, Non-health consumers, n=200)

6.2.5.10 Cultural Diversity

Of those who were from a non English speaking background (n=118), or rather, whose first language was other than English, 81% claimed that there was never someone available at the pharmacist who spoke their language.

It was established in the 'Profiling' section that none of these respondents selected their pharmacy based on the availability of someone who spoke their language. This finding provides a better justification as to why this does not occur.

A slightly higher proportion of health consumers indicated that someone was available who speaks their language (7% compared 2% among non-health consumers). This is not statistically significant at the 95% confidence interval.

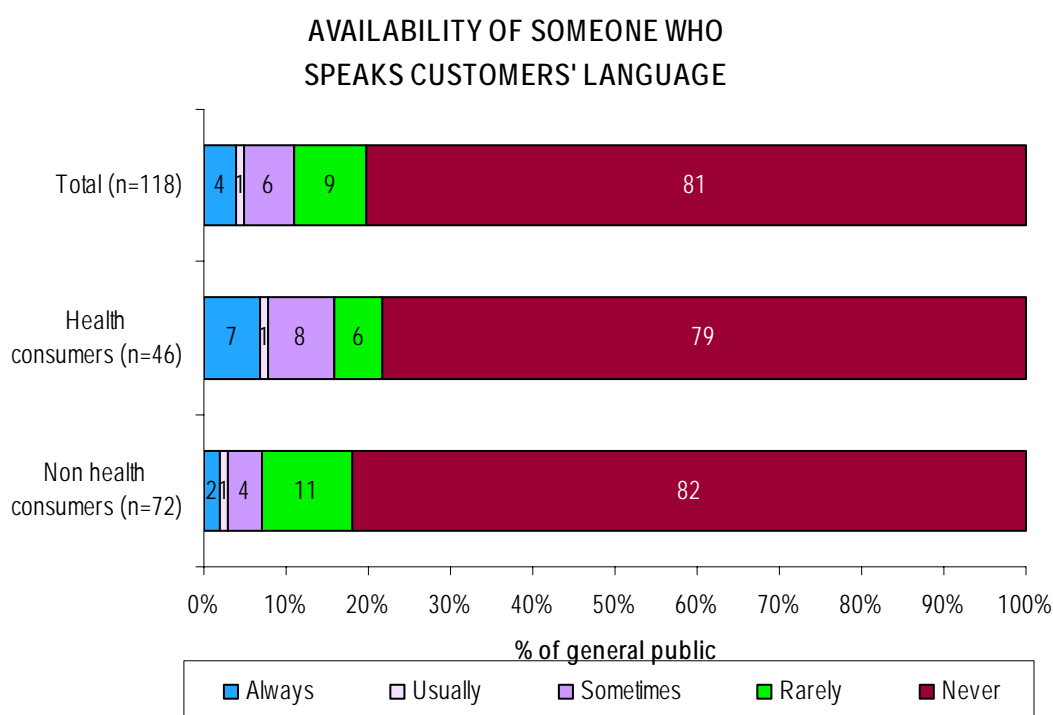


Fig 22. General Public, Someone there who speaks your language (Those whose first language is other than English, n=118, Health Consumers, n=46, Non-health Consumers, n=72).

6.2.5.11 Pharmacist Performance Ratings

Respondents were presented with a range of service-related attributes and asked to rate the performance of each one, on a scale from 0 to 10, where 0 meant extremely poor and 10 meant extremely well. In all cases, the respondent was asked to think about the pharmacy that they use most often when considering their ratings.

The following graph summarises the mean scores provided by the total sample for each of the attributes evaluated.

The results suggest that, at a national level, pharmacists are performing well, with the results ranging from 7.0 to 8.6 out of a possible 10 across the attributes.

The highest performing attributes were the politeness and courtesy of pharmacists (8.6), giving clear information and advice (8.1) and listening to what the customer has to say (8.1).

The lowest rated attribute pertained to the degree to which the pharmacist invited questions from the customer, scoring 7.0 out of 10. While this was the lowest performing attribute in relative terms, this it should not necessarily be inferred that pharmacists are under performing in this area; rather it is the lowest scoring attribute relative to the others evaluated.

Not surprisingly, these ratings were significantly higher amongst those who frequently visited a pharmacy, were heavy users of health care professionals or were loyal customers. Ratings were also significantly higher amongst respondents aged 65 years and above.

Differences in average performance were also seen across States and Territories. Respondents within the ACT awarded higher ratings to pharmacists for giving clear information or advice (8.6 compared to the 8.1 average), maintaining customer privacy (9.0 compared to 7.8 on average), listening to the customer (8.6 compared to 8.1)) and inviting questions (7.8 compared to 7.0). Similarly, pharmacists in Tasmania scored higher on giving clear information and advice (8.6 compared to the 8.1 average) and inviting questions (7.8 compared to 7.0). Scores within the Northern Territory were significantly lower across all of the attributes evaluated, particularly in relation to providing clear information and advice (6.8 compared to 8.1).

Other low ratings within the NT were awarded to being polite and courteous (8.1 compared to the 8.6 average), maintaining privacy (7.3 compared to 7.8), the pharmacist being available (6.8 compared to 7.8), listening to the customer (7.4 to 8.1) and inviting questions (7.1 compared to 7.9).

RATINGS OF PHARMACISTS

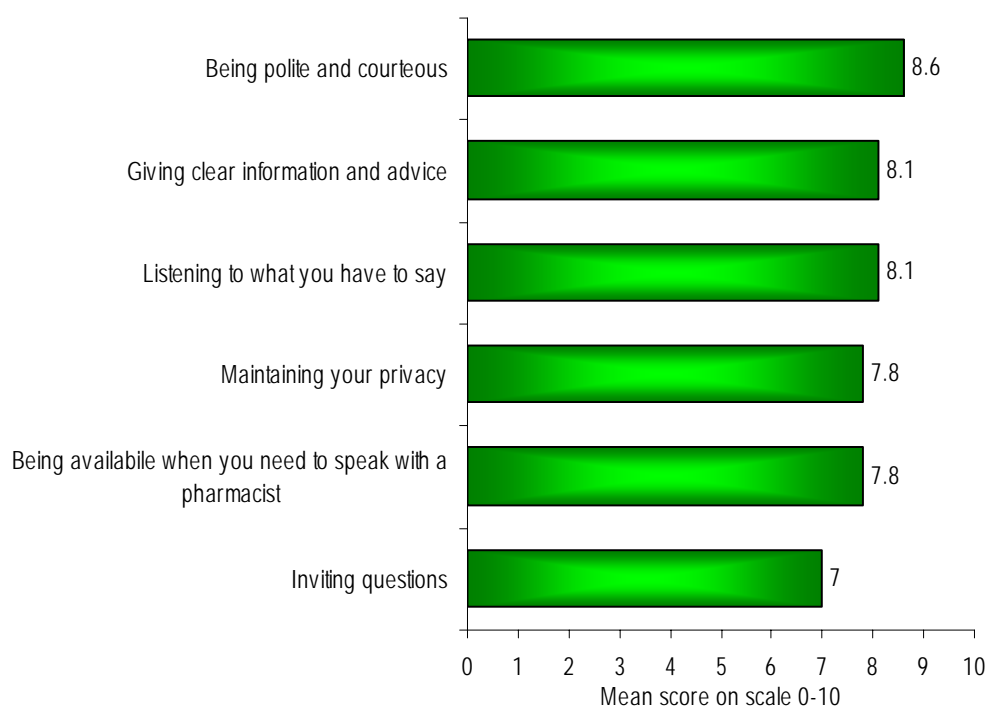


Fig 23. General Public Survey: Ratings of pharmacists, (Total Sample, n=2001)

The following graph reveals the performance ratings awarded by health and non-health consumers to the service attributes. Clearly, the ratings provided by health consumers were significantly higher than those awarded by non-health consumers across all attributes evaluated.

RATINGS OF PHARMACISTS; HEALTH AND NON HEALTH CONSUMERS

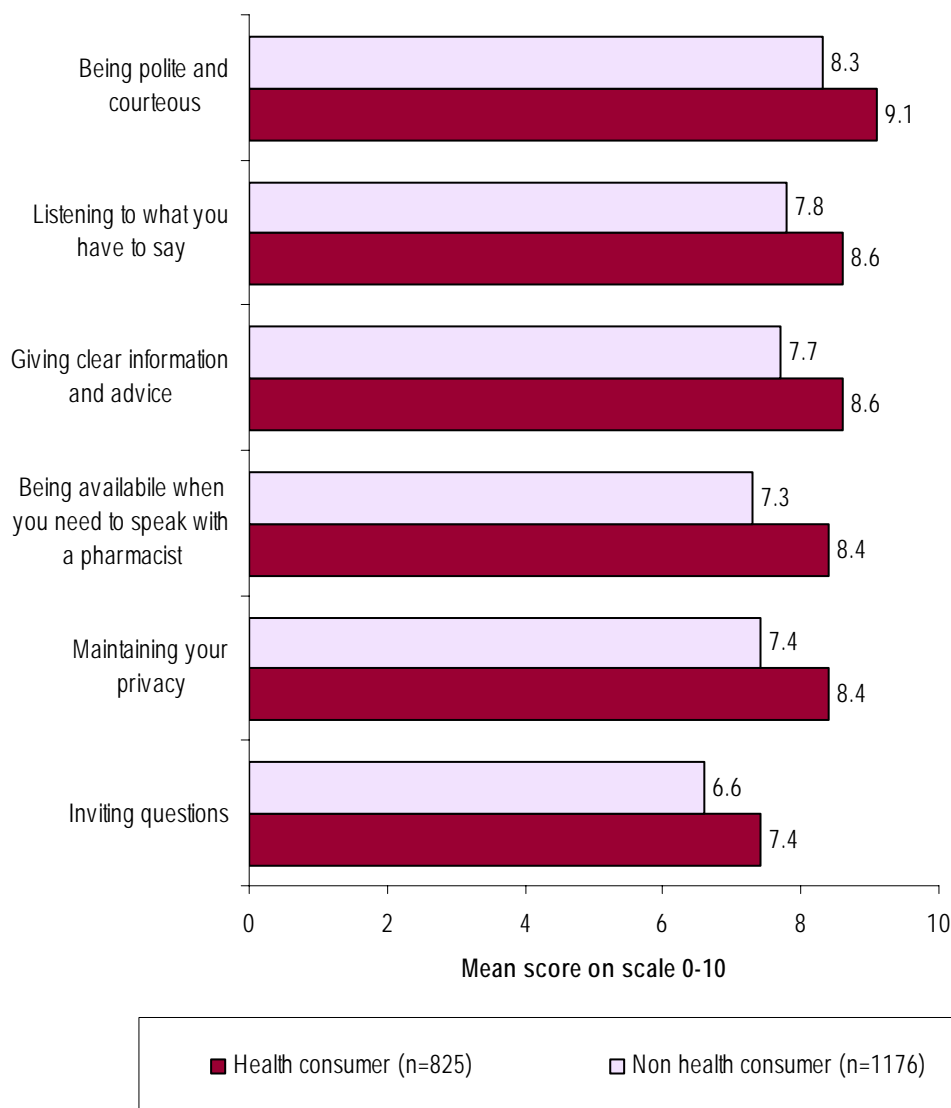


Fig 24. General Public Survey: Ratings of Pharmacists split by health/non-health consumers (Base: Total Sample, n=2001)

6.2.5.12 Pharmacy assistant Performance Ratings

Perceptions toward the performance of pharmacy assistants were also positive, with the attribute scores ranging from 6.8 to 8.8 out of a possible 10.

The highest scores for pharmacy assistants were seen for being polite and courteous (8.8), making the customer feel welcome (8.6) and listening to the customer (8.4).

The lowest relative score was seen for referring to the customer by name upon leaving or collecting a script (6.8). In Tasmania, this practice scores much higher (7.8 compared to the 6.8 average).

Higher perceived performance of pharmacy assistants was seen in the ACT for all attributes, excepting ability to offer advice on products and services (7.1 compared to the 7.8 average). The scores for all other attributes are outlined for the ACT below:

- Making you feel welcome (9.1 compared to 8.6)
- Calling you by name (7.1 compared to 6.8)
- Being polite and courteous (9.1 compared to 8.8)
- Listening to what they have to say (8.9 compared to 8.4)
- Maintaining privacy (9.0 compared to 8.0)

Again, lower scores were seen in the Northern Territory across all facets of performance. The scores within the Northern Territory are compared to the average scores for each attribute below:

- Making you feel welcome (8.1 compared to the 8.6 average)
- Calling you by name (6.0 compared to 6.8)
- Being polite and courteous (8.2 compared to 8.8)
- Offering advice on products and services (7.1 compared to 7.8)
- Listening to what they have to say (7.9 compared to 8.4)
- Maintaining privacy (7.4 compared to 8.0)

All differences highlighted above are statistically significantly different at the 95% confidence interval.

RATINGS OF PHARMACY ASSISTANTS



Fig 25. General Public Survey: Ratings of Pharmacist Assistants (Base: Total Sample, n=2001)

Again, the mean scores for each attribute were evaluated by consumer type (health consumer, n=825 and non health consumer, n=1176). The ratings awarded by health consumers were slightly higher than those awarded by non-health consumers, but to a lesser extent than that seen for Pharmacists. These differences were still statistically significant at the 95% confidence interval, with the exception of one attribute; being able to offer advice on products and services.

The largest discrepancy between health and non-health consumers was seen in the higher scores awarded to Pharmacy assistants for using the health consumer's name upon leaving or collecting a script (8.0 compared to 6.0 for non-health consumers).

RATINGS OF PHARMACY ASSISTANTS; HEALTH AND NON HEALTH CONSUMERS

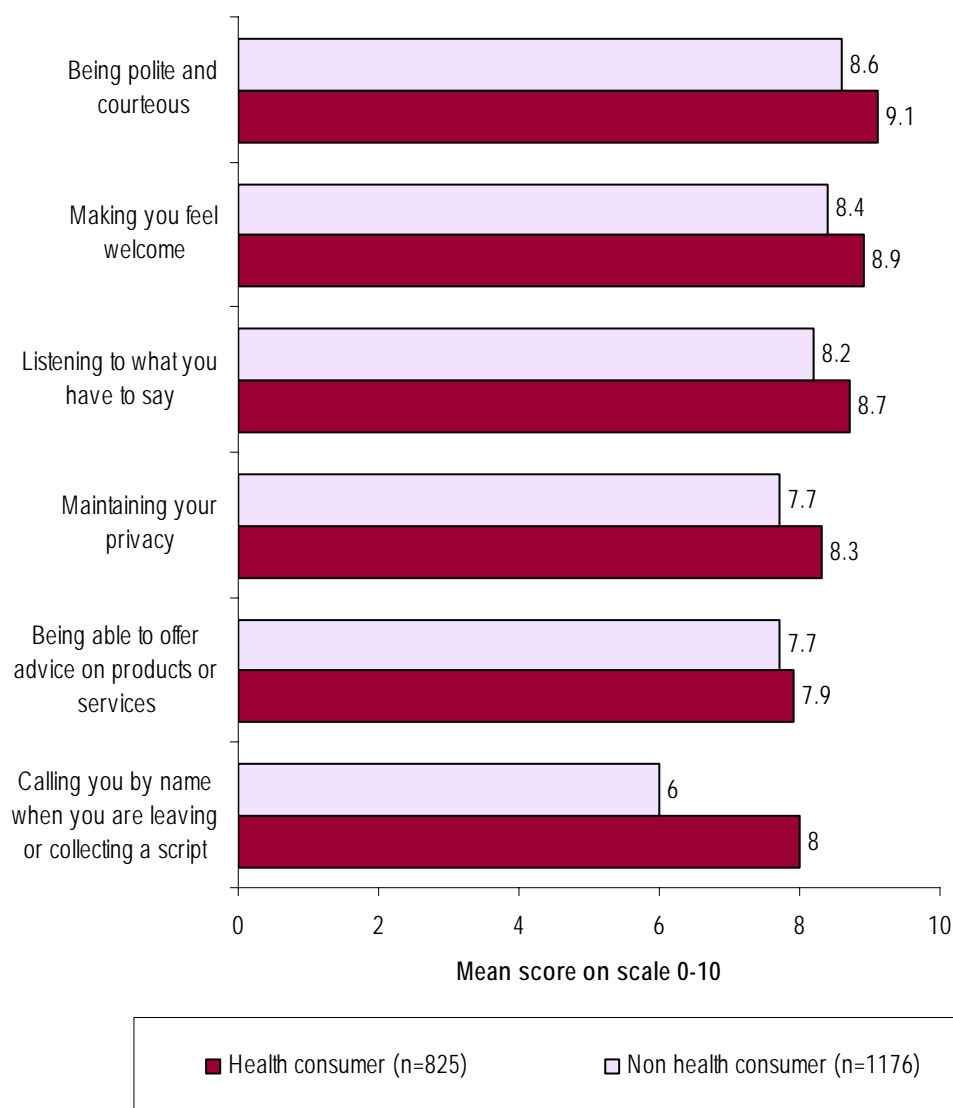


Fig 26. General Public Survey: Mean score ratings of pharmacy assistants by customers, relevant to the pharmacy they use most often (n=2001)

6.2.6 Needs

The questions within this section provided the general public with the opportunity to convey their needs with regard to pharmacy services, the strength of frequency of their requirements and what they would be willing to pay for those needs.

6.2.6.1 Real Needs

- More specifically, in order to gauge the level of need for various services to be available at pharmacies, respondents were read a list of potential services and asked to indicate whether they had a real need for each service to be provided.
- Not surprisingly, almost all of the respondents claimed to have a real need for the medicine to be in stock or be accessed quickly by the pharmacy (87% of the total sample). The need for this service was significantly higher amongst respondents based in Victoria and couples/singles with children living at home. Lower than average need for this service was seen amongst occasional users of health care providers, users of multiple pharmacies and respondents aged between 15 and 24 years.
- Advice was another widely held need, with 74% indicating that they needed advice that the non prescription products that they chose are right for them. This need was significantly higher amongst respondents in regional areas, those aged between 15 and 44 years of age, students and part time workers and couples/singles with children at home.
- Just under two thirds of the sample (65%) claimed to need to speak with the pharmacist about how to use medicines. Again, this need was more prominent among households consisting of couples/singles with children at home.
- 58% of the sample indicated that they needed to wait less than 20 minutes for their prescriptions to be filled and just fewer than 50% needed their scrip filled within 10 minutes. Those wanting their scrip faster were more likely to be aged between 35 and 44 years of age and be in a couple/single situation with children at home.
- Just 3% claimed not to need any of the services evaluated.
- A lower proportion (25%) of respondents were concerned about speaking with a pharmacist as opposed to an assistant about non prescription items or follow ups to ensure that no side effects were suffered from recommended medications (33%).

CUSTOMER NEEDS - TOTAL SAMPLE

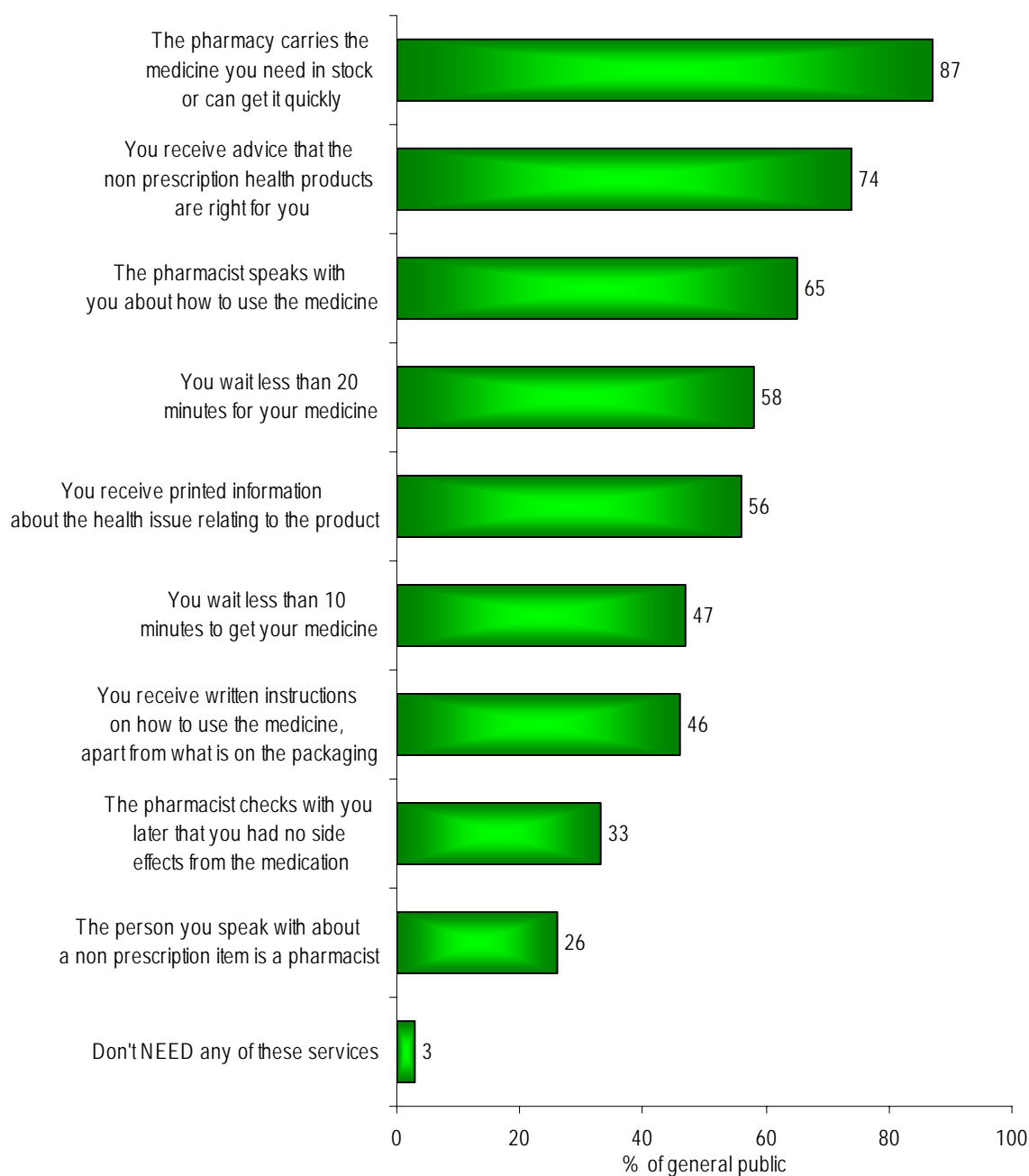


Fig 27. General Public Survey, Real Customer Needs, Base: Total Sample, n=1991

The following graph examined the needs of pharmacy consumers by health and non-health consumers.

The results indicate that the needs of health consumers were more widely held for only one attribute, namely, the ability to have medications in stock or be able to get them in

quickly (90% compared to 84% non-health). For four of the eight remaining variables, a higher proportion of non-health consumers claimed to have a real need for the service. These services included receiving advice regarding appropriateness of products, speaking with the pharmacist about how to use medicines and waiting less than 10 to 20 minutes for prescriptions to be filled.

CUSTOMER NEEDS - HEALTH VS. NON HEALTH CONSUMERS

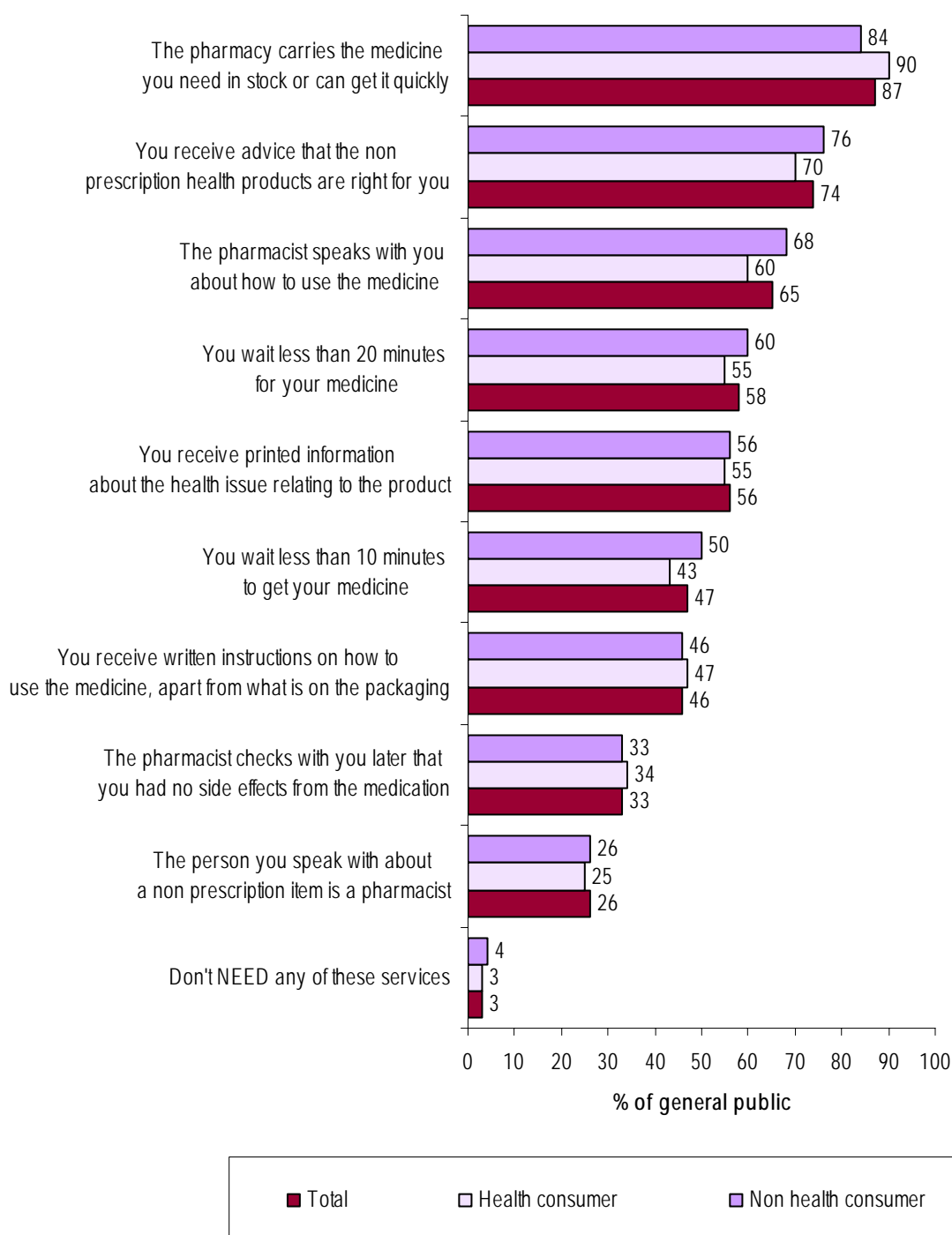


Fig 28. General Public Survey, Real Needs split by health and non-health consumers, Total Sample, n=1991

6.2.6.2 Stated Service Usage

- Respondents were asked if they had used a pharmacy for a variety of services such as deciding whether to see a doctor, home delivery of medications or prescriptions, health monitoring and medicine reviews.
- At the total sample level (n=2001), 49% had never used the pharmacy for the services raised. A further 30% claimed to have used the pharmacy to decide whether or not to see a doctor and 13% claimed to have had a medicine review on site at the pharmacy.
- 10% of the total sample had had medicines or prescriptions delivered to their home.
- Very few respondents (8% or less) reported using each of the other remaining services raised.

PREVIOUS USAGE FOR PHARMACY FOR VARIOUS SERVICES

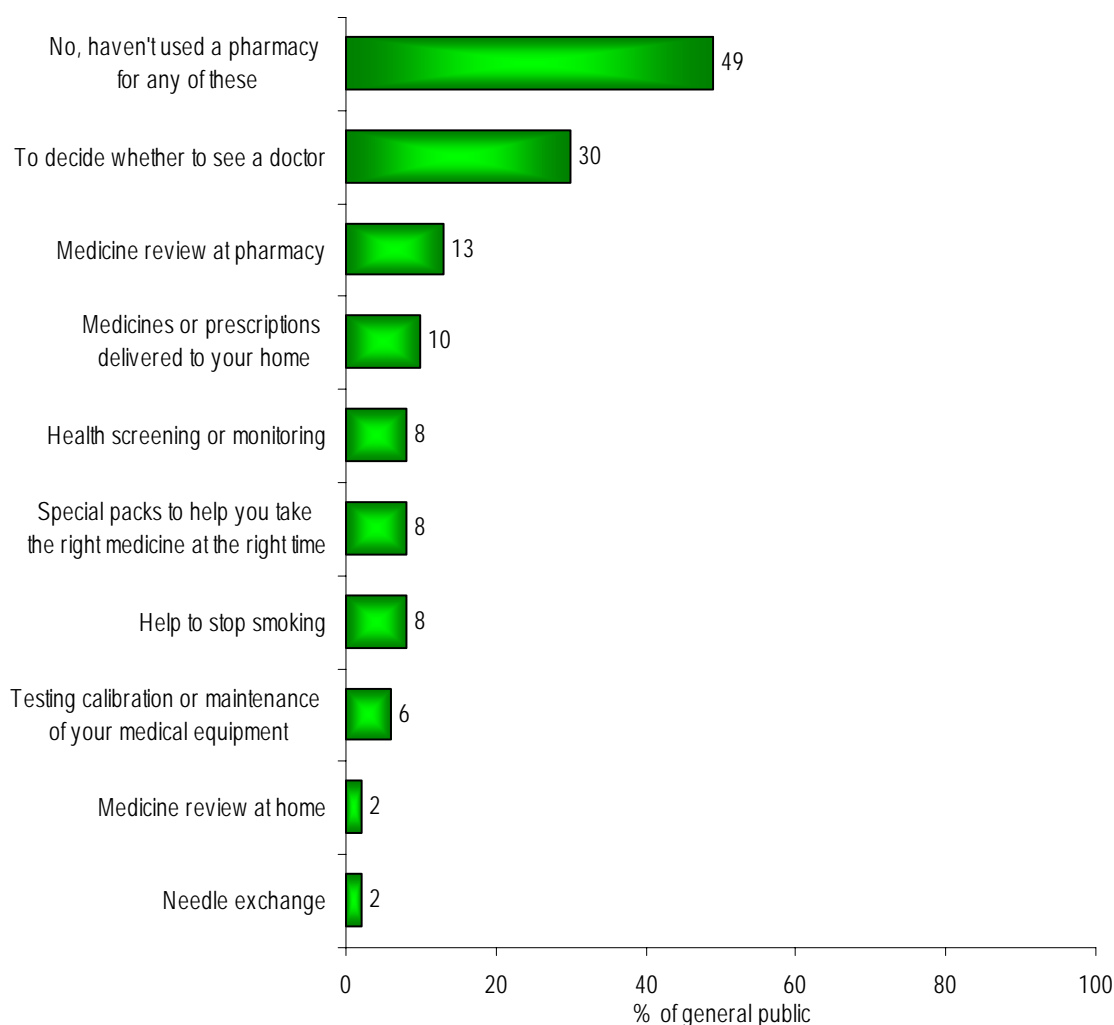


Fig 29. General Public Survey: Stated Service Usage, Total Sample, n=2001

When evaluated by consumer type, a significantly higher proportion of non-health consumers had never used any of the services offered (55% compared to 40% among non-health consumers). In contrast, a significantly higher proportion of health consumers had used all of the health services raised, excepting assistance to stop smoking and needle exchange.

PHARMACY USAGE FOR VARIOUS SERVICES - HEALTH VS NON

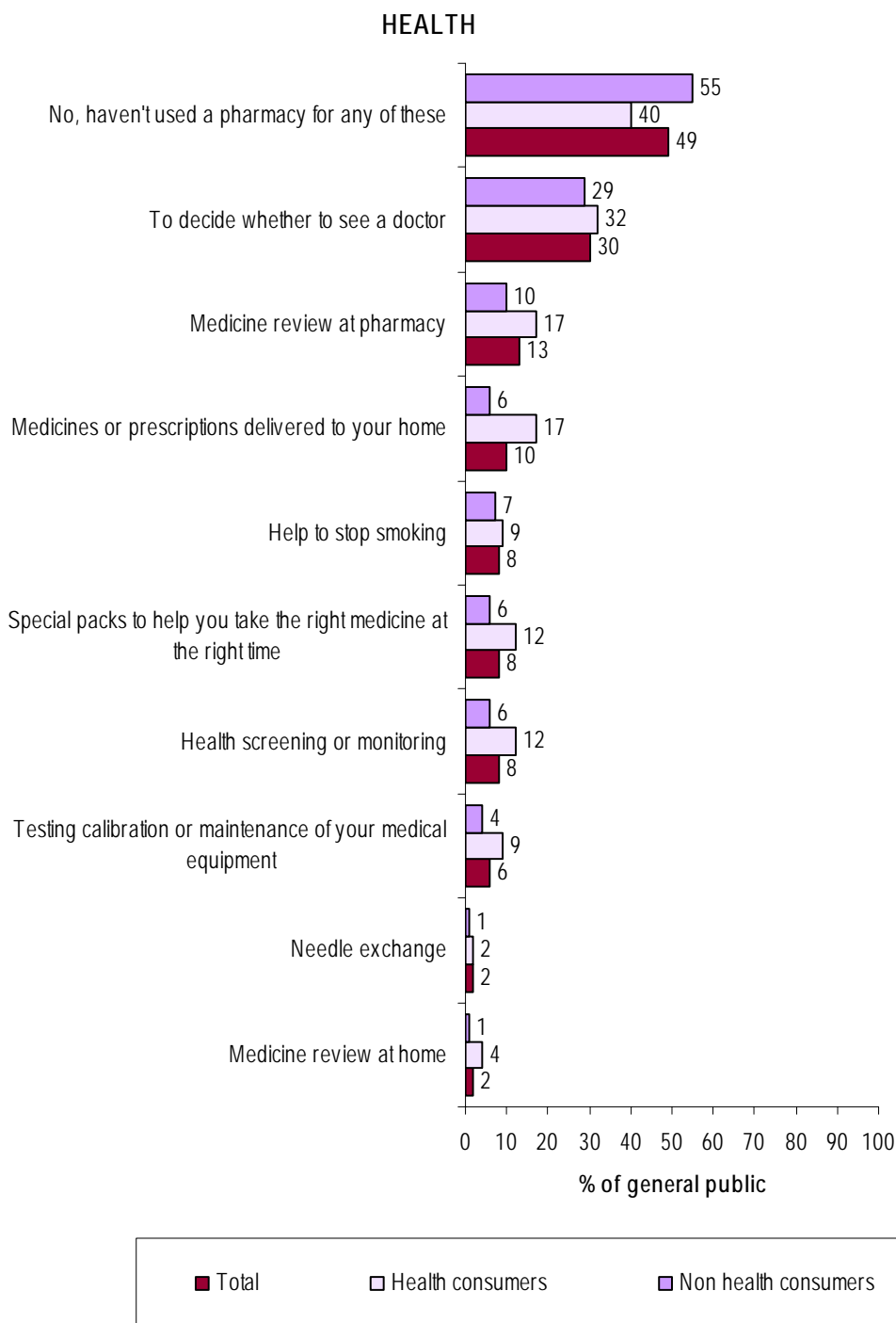


Fig 30. General Public Survey: Pharmacy services used by consumer type, Total Sample, n=2004

6.2.6.3 Stated Future Frequency of Use

Respondents were presented with the same list of services, and asked how often they thought they would use these services if they were free of charge.

The majority of respondents for each of the services said they would never use these services, even if they were free of charge (ranging from 52% to 97% citing never at the total sample level).

According to the responses in the following table, the two services with the most frequent intended use were health screening and monitoring (with 29% claiming that they would use this service either biannually or quarterly), followed by medication reviews at the pharmacy (23% using biannually or quarterly). It should be noted, however, that even these services appeared to display low levels of need at the total sample level. It should be noted, however, that strong levels of need may be evident within smaller sub groups within the population, i.e. those with specific health conditions as revealed within the focus group results to this project.

There were very few significant differences in intended usage of these products by consumer type and other demographic characteristics, particularly in relation to those services outlined above.

PERCEIVED FREQUENCY OF PRODUCT USAGE IF AVAILABLE

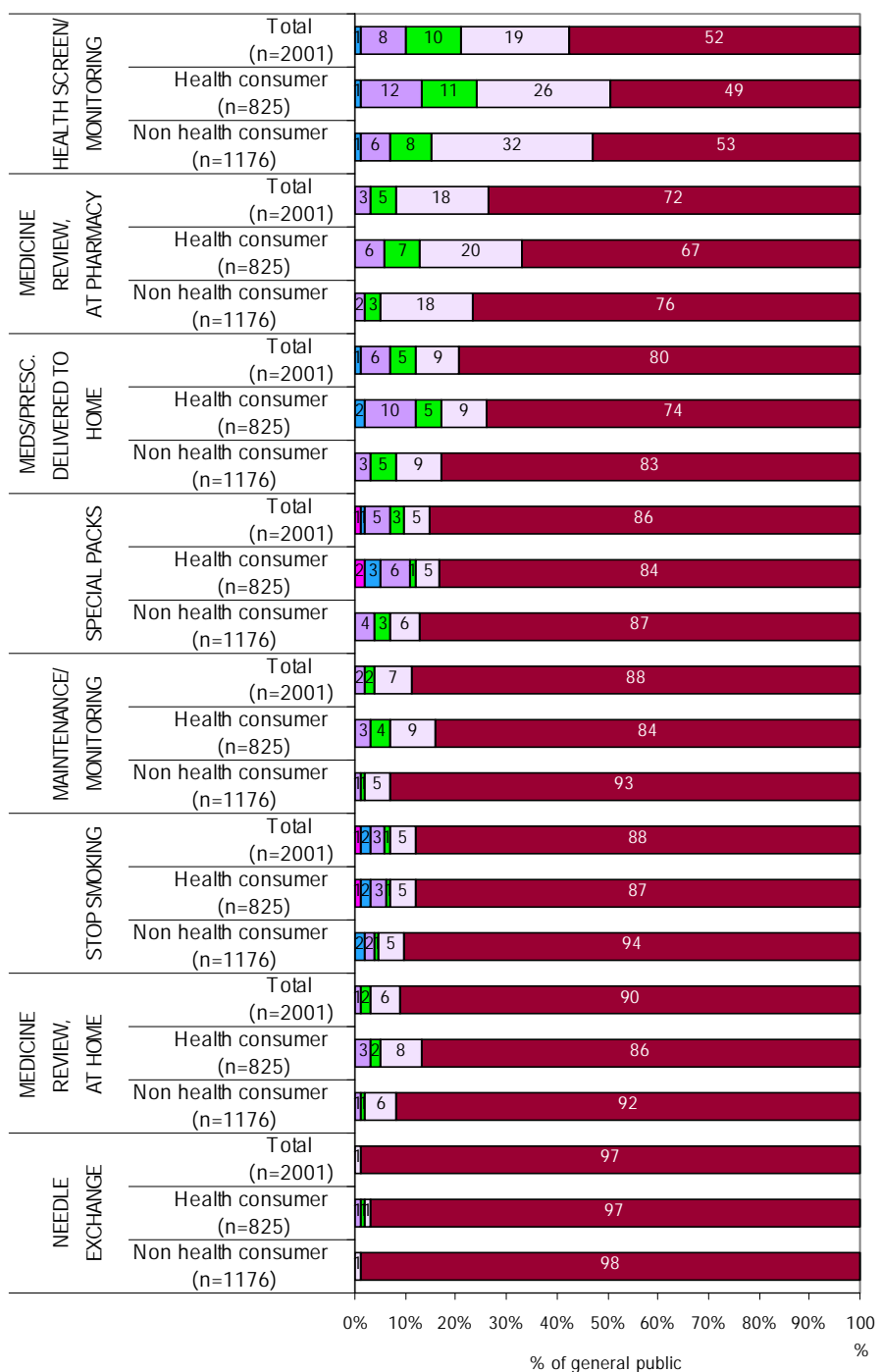


Fig 31. General Public Survey: Stated frequency of use for pharmacy services, Total sample, n=2001

6.2.6.4 Price Points for Pharmacy Services

- Several services were selected from this list and presented to respondents again, this time asking them how much they would be willing to pay to use these services at pharmacies.
- Between 30% and 36% of the general public surveyed claimed to be unwilling to pay anything for any of the services tested, including blood pressure checks, special packs and monitoring.
- The most variation in responses was seen for spending time with the pharmacist. While this service was most commonly the service that respondents would not pay for, it was also the service that respondents would most commonly pay more for, with 29% claiming that they would be willing to pay between \$15 and \$25 for the service. This was significantly higher amongst non-health consumers (34%).
- Just over half of the sample (51%) claimed that they would be willing to pay between \$5 and \$10 for special packs, and 63% of the sample claimed that they would be willing to pay between \$5 and \$15 for special packs.
- Well over half of the sample (56%) indicated that they would pay between \$5 and \$15 for blood pressure checks at their pharmacy.

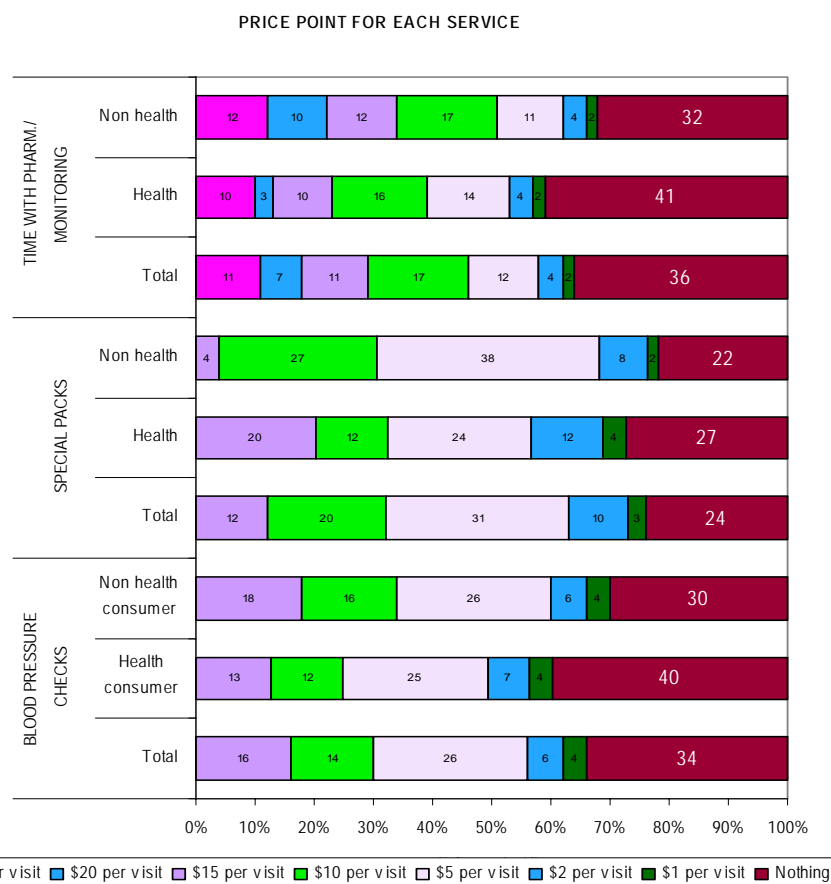


Fig 32. General Public Survey, Price Points per Service, Base: Those who would use the service, n=317

6.2.6.5 Additional Comments

- At the end of the survey, respondents were given the option to make any other comments about pharmacies if they wished, 72% did not do so. 8% however, said they were very happy with the service they provided, whilst 5% spontaneously said they did not want to see pharmacies in supermarkets. A range of other responses was obtained for this question; however none was mentioned by more than 1% of the total sample.

6.2.7 Expectations

- Respondents were presented with a list of services and asked to indicate which they would expect to be provided at a pharmacy.
- Just under a third of the sample suggested that they did not expect any of those presented in the list (31%). A further 46% stated that they expected their prescriptions filled within 10 to 20 minutes, and 19% expected the pharmacist to speak to them about how to use medicines.
- Other than those cited above, expectations were generally very low.

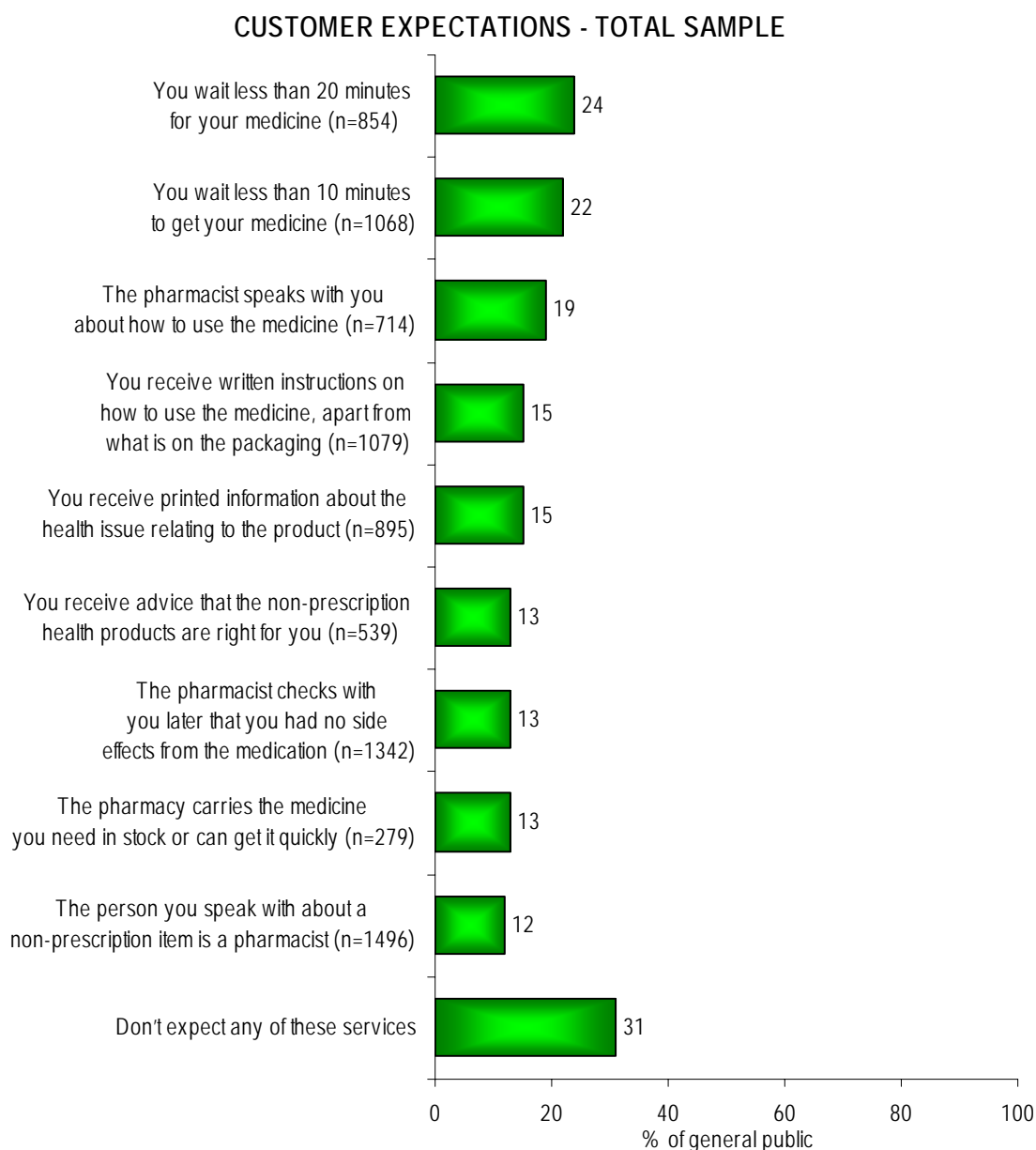


Fig 33. General Public Survey, Customer expectations, Base: Total Sample n=2001

The following graph shows the combined percentages needing versus expecting the various services explored in this question. The percentages expecting each service have been recalculated as percentages of the total sample so that the graph accurately reflects the overall population's needs and expectations.

NEEDED AND EXPECTED SERVICES AT PHARMACIES

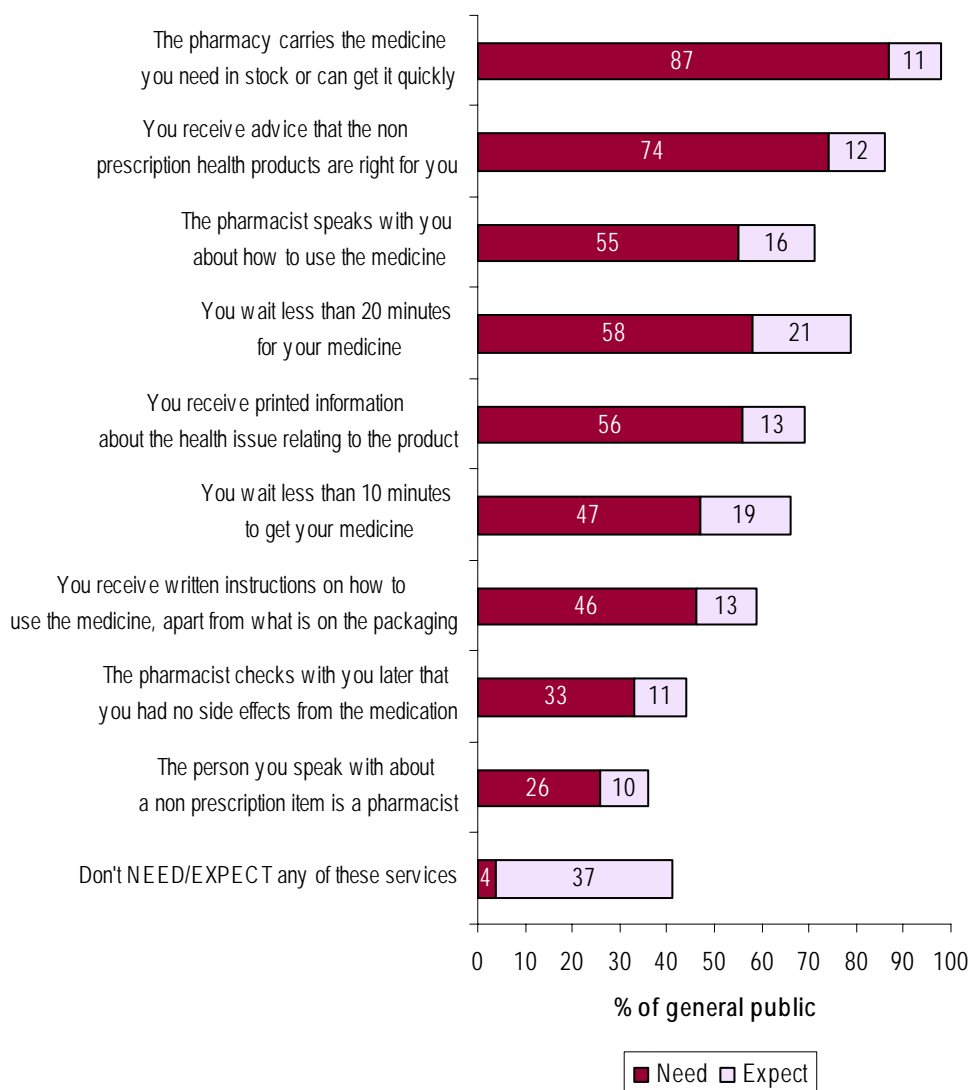


Fig 34. General Public survey: Needed and expected services at pharmacies, Total Sample, n=2001

When evaluated by consumer type, the pattern of responses was remarkably similar for each sub-group.

CUSTOMER EXPECTATIONS - HEALTH VS. NON HEALTH CONSUMERS

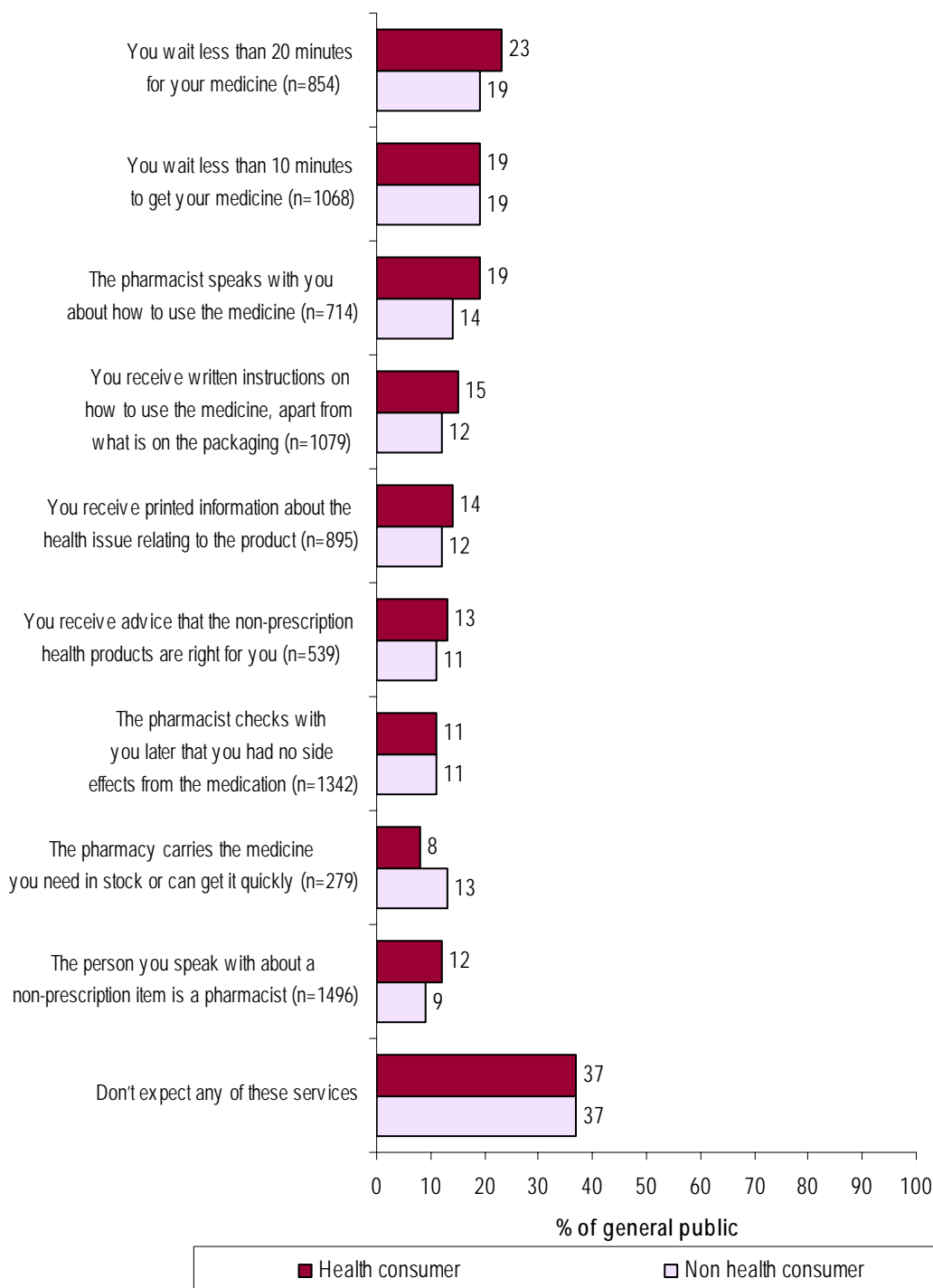


Fig 35. General Public Survey: Expectations by consumer type: health vs non-health. Base: Respondents who did not need all services, n=1924

59% of respondents said that they couldn't think of anything their pharmacy could do to improve. Lowering prices of medications and other products inevitably came up, with 12% spontaneously wanting a reduction on the price of medicines, and 10% on the price of other products sold at pharmacies.

RECOMMENDATIONS FOR PHARMACY IMPROVEMENT

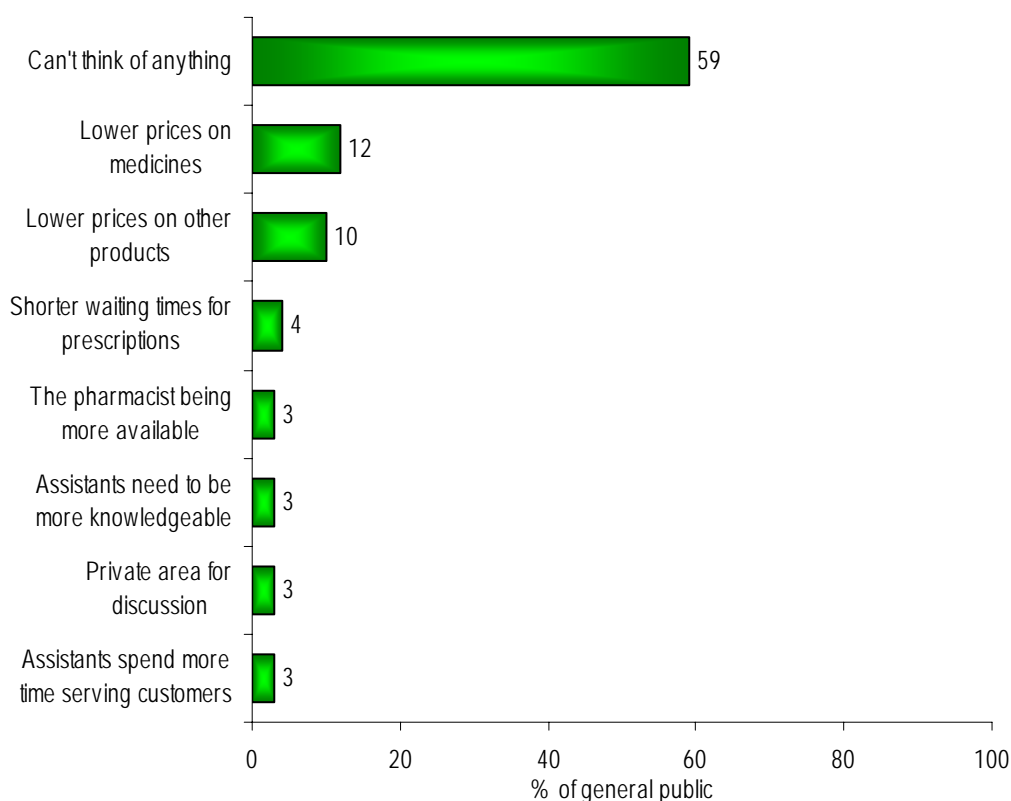


Fig 36. General Public Survey, Recommendations for Pharmacy Improvement, Total Sample, n=2005

6.3 Face-to-face exit survey of pharmacy customers

This module consisted of a total of 554 face-to-face exit surveys with pharmacy customers between Saturday 4 June and Thursday 16 June 2005.

6.3.1 Sampling

Face-to-face exit surveying was conducted in NSW, VIC, SA, QLD, WA and NT. All surveys were conducted with customers as they left community pharmacies. The focus for this module was on capturing customers' immediate experiences and perceptions of the services and facilities provided, in order to gain an accurate picture of consumers' experiences while the activities were fresh in their minds, rather than based on recollection as is inherent in the telephone survey methodology used for the general public survey.

The pharmacies at which the interviews occurred were selected at random from a list of Pharmacy Guild members and contacted in advance for permission to conduct the survey with their customers. The Guild provided a letter encouraging participation, which proved valuable in obtaining pharmacies' support for the process.

It was expected that around 40 interviews per location would be achieved at each of the locations involved in this component of the research. Interviewers were stationed at the pharmacy exits and every n^{th} customer was approached to participate in the survey, thereby ensuring as random a sample as possible. (N.B. The actual n used to randomise the selection of participants varied from site to site, depending on how busy the particular pharmacy was at the time.) The spread of geographic locations addressed within this module is demonstrated below.

One 7 to 8-hour day of interviewing was conducted in each of the locations listed in Table 9.

State	Location	Pharmacies Participating
NSW	Sydney (including CBD and suburbs)	3
	Regional NSW (Goulburn and Wagga Wagga)	4
NT	Darwin	3
	Regional NT (Katherine)	2
QLD	Brisbane	5
	Regional QLD (Townsville and Cairns)	4
SA	Adelaide	3
	Regional SA (Barmera, Berri, Loxton, Renmark)	4
VIC	Melbourne (CBD and suburbs)	3
	Regional Vic (Seymour, Wodonga, Wangaratta)	4
WA	Perth	3
	Regional WA (Albany)	4
Total		42

Table 9: Face to face exit survey of pharmacy customers: number of participating pharmacies by State and location.

While the research methodology for this module was designed to randomise respondent selection, an inherent feature of any intercept methodology is its tendency to over-sample frequent visitors - at any one time there are more frequent visitors passing through a location than infrequent ones. Consequently, the sample has been weighted by frequency of visiting a pharmacy, but is otherwise unweighted.

Table 10 details the visitation rates, in both unweighted and weighted form, and shows that, in this instance, the weighting required is quite limited.

Sample distribution by frequency of visiting a community pharmacy	# of Respondents		% of Respondents	
	Raw	Weighted	Raw	Weighted
Daily/most days	6	6	2	1
2-3 times a week	27	23	5	4
About once a week	94	85	17	15
2-3 times a month	110	132	20	24
About once a month	187	171	34	31
Every few months	84	85	15	15
Once or twice a year	41	49	7	9
Less often	5	9	1	2
Total	554	560	100	100

Table 10: Face to face exit survey of pharmacy customers: sample distribution by frequency of community pharmacy visitation

The sample has not been weighted by geographic location, but both the unweighted and weighted sample distributions are shown in Table 11 for completeness.

Sample distribution by State or Territory	# of Respondents		% of Respondents	
	Raw	Weighted	Raw	Weighted
Metropolitan (capital city)	264	260	48	47
Regional urban	290	294	52	53
Total	554	554	100	100

Table 11: Face to face exit survey of pharmacy customers: overview of sample distribution by urban rural categories

Sample Distribution by State or Territory	# of Respondents		% of Respondents	
	Raw	Weighted	Raw	Weighted
NSW	58	53	10	10
NT	98	95	18	17
QLD	150	148	27	27
SA	88	90	16	16
VIC	56	59	10	11
WA	110	109	20	20
Total	554	554	100	100

Table 12: Face to face exit survey of pharmacy customers: sample distribution by State or Territory

All exit survey data quoted from here on are weighted results only.

N.B. Due to the data being weighting and rounded to integers (whole numbers), some figures in this section of the report may not sum precisely, either numerically or as percentages.

6.3.2 Profile of Respondents

Overall, the exit survey sample shows a predictable bias towards older respondents, females and people unemployed or on non-age pensions. Seven in ten customers were female, and these two occupation categories alone accounted for half the sample. Table 13 shows the gender and age distribution of the sample, with occupations shown in Table 14. General population figures are also shown, for comparison.

Sample Distribution by Gender and Age	# of Respondents	% of Respondents	% of General Population 15+
Males	161	29	49
Females	393	71	51
15-24 year olds	54	10	17
25-34 year olds	93	17	18
35-44 year olds	80	14	19
45-54 year olds	121	22	17
55-64 year olds	88	16	12
65 years or over	117	21	16
Total sample	554	100	100

Table 13: Face to face exit survey of pharmacy customers: sample distribution by gender and age

Sample Distribution by Main Occupation	# of Respondents	% of Respondents	% of General Population 15+
part-time employment	27	5	19
full-time employment	108	19	39
unemployed	197	36	3
student	0	0	9
home duties	12	2	8
retired / aged pensioner	69	13	18
non-age pensioner	119	21	4
Total sample	554	100	100

Table 14: Face to face exit survey of pharmacy customers: sample distribution by main occupation

As in the general public survey, respondents have been classified as health or non-health consumers on the basis of two questions put to all exit survey customers. Health consumers are:

- respondents who said that either they, or someone for whom they were a carer, had an ongoing condition requiring treatment medication or monitoring,
 - AND
- who indicated that they visited a pharmacy either to buy something, get advice or browse at least once a month.

Across the whole sample, 51% of customers either have or care for chronic illness, including 42% who have a chronic illness themselves and 15% who are carers for someone chronically ill. There is a 5% overlap - i.e. 5% both have a chronic illness and care for someone with such a condition.

Taking into account the frequency of visiting a pharmacy reveals that 43% of those interviewed as they left pharmacies qualified as health consumers.

Table 15 summarises the distribution of chronic illness in the exit survey sample.

Sample distribution by incidence of having, or being a carer for someone who has, an ongoing condition requiring treatment, medication or monitoring	% of exit survey respondents		
	% of total sample (n=554)	% of health consumers (n=238)	% of non-health consumers (n=316)
Personally have chronic illness (not also carer)	36	72	9
Carer (only) for someone with chronic illness	10	18	3
Chronic illness - both personally and as carer	5	10	2
Neither have, nor are carer for, chronic illness	49	-	86

Table 15: Face to face exit survey of pharmacy customers: sample distribution by incidence of chronic illness

The next two sub-sections profile the health and non-health segments and highlight the significant differences found in each.

6.3.2.1 Profile of Health customers

Health Consumers	Shared characteristics
Demographics	<p>It is interesting to note that no differences were detected between metropolitan and regional areas of Australia with regard to the presence of health versus non-health consumers. In both regions, 43% of respondents qualified as health consumers.</p> <p>Health consumers from the exit survey sample tended to cluster near older age groups, with 66% of 65+ year old respondents being classified as health consumers, compared to 19% of 15-24 year olds. The percentage of health consumers in all six age groups increased as the age of respondents increased. Conversely, the percentage of respondents classified as non-health consumers decreased as age increased.</p> <p>Significantly more females were classified as health consumers, with 46% of these respondents fitting the definition of a health consumer, compared to 35% of males.</p> <p>Pensioners (not aged pension) were also more likely to be health consumers, with close to 7 in 10 respondents from this segment (69%) fitting the criteria for a health consumer.</p> <p>Given that it is one component of their definition, health consumers were more likely to be classified as 'frequent users' (i.e. visit a pharmacy to buy something, get advice or browse at least once a month) than non-health consumers. As the frequency of use increases (i.e. moves from occasional to frequent use of pharmacies), the number of health consumers increases, whereas the number of non-health consumers decreases.</p> <p>South Australia had the highest instance of health consumers, with 51% of respondents from this State meeting the criteria as a health consumer. The smallest percentage of health consumers was found in Victoria (24%).</p>
Pharmacist/ Assistant Advice	Health consumers were more likely to seek advice from <u>both</u> the pharmacist and pharmacy assistant (54%) during their visit, in comparison to non-health consumers (46%). Comparatively, just 19% of health consumers reported that they did not speak to either the pharmacist or pharmacy assistant during their visit.
Loyalty/ Relationship	Health-consumers were more likely to frequent one particular pharmacy for their healthcare needs, despite having a range of pharmacies to choose from (54%).

Table 16: Profile of health customers

6.3.2.2 Profile of non-health customers

Non-health Consumers	Shared characteristics
Demographics	<p>Non-health consumer customers tended to fall into the nation's younger age brackets, with the vast majority (81%) of 15-24 year olds and 78% of 25-34 year olds classified as non-health consumers, compared to 34% of 65+ year old respondents.</p> <p>Males were also more likely to be non-health consumers (65%), compared with 54% of female customers.</p> <p>Respondents engaged in part-time work (79%), those who are unemployed (74%) or who are engaged in home duties (72%) were more likely to be classified as non-health consumers.</p> <p>Victoria had the highest proportion of non-health consumers, with 76% of this State's population defined as non-health consumers. The smallest proportion of non-health consumers in the six States and Territories involved in this research was South Australia, where 49% of the sample was classified as non-health consumers.</p>
Pharmacist/ Assistant Advice	<p>Interestingly, a higher proportion of non-health consumers sought advice from the pharmacist (60%) compared to health consumers (40%). But non-health consumers also had a lower incidence of seeking advice from either the pharmacist or pharmacy assistant, with 81% of these respondents reporting that they spoke to none of these staff members during their visit to the pharmacy.</p>
Loyalty/ Relationship	<p>Non-health consumers are more likely to be classified as 'repertoire' buyers (68%), defined as pharmacy users who access whichever pharmacy is convenient to them at the time, regardless of group (compared to 32% of health consumers).</p>

Table 17: Profile of non health customers

6.3.3 Experiences

6.3.3.1 Reason for Visit

For one quarter of the total sample (26%), the main reason for visiting the pharmacy where they were surveyed was to have a prescription filled and collect the medication in the same visit.

Following this, an additional 18% indicated that their primary reason for visiting the pharmacy was to purchase a non-prescription or over-the-counter (OTC) medicine, whilst 11% were collecting and 9% dropping off a prescription.

Health consumers were more likely (35%) to be having a script filled and collecting the medication in comparison to non-health consumers (20%).

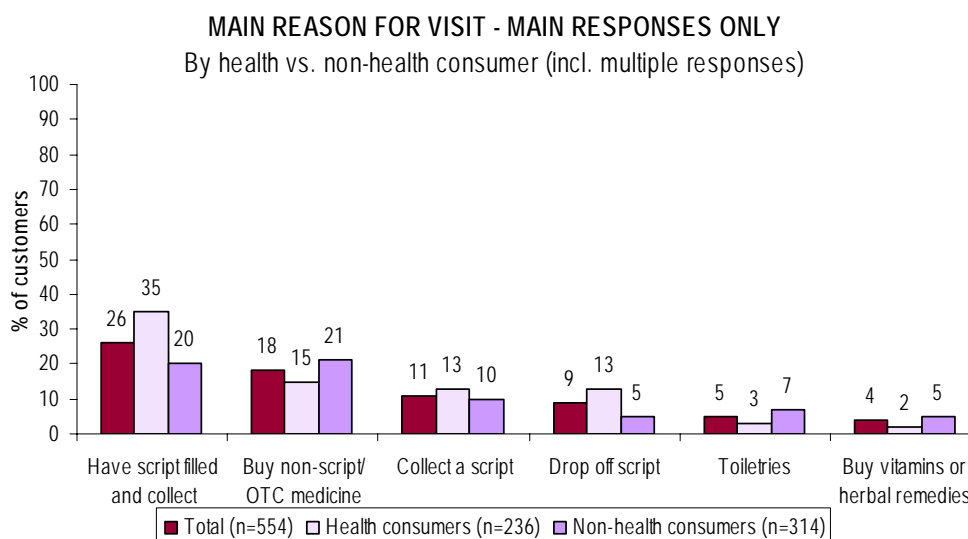


Fig 37. Exit survey: Main reason for visiting pharmacy - main responses (n=554)

There was also an associated pattern between respondents when classified as either frequent, regular or occasional users of pharmacies. As frequency of use of pharmacies increased, the likelihood that the respondent was having a script filled and collecting it also increased, whereas the likelihood that a respondent was purchasing a non-prescription or OTC medication during their visit increased as their frequency of usage decreased.

The graph overleaf illustrates this trend.

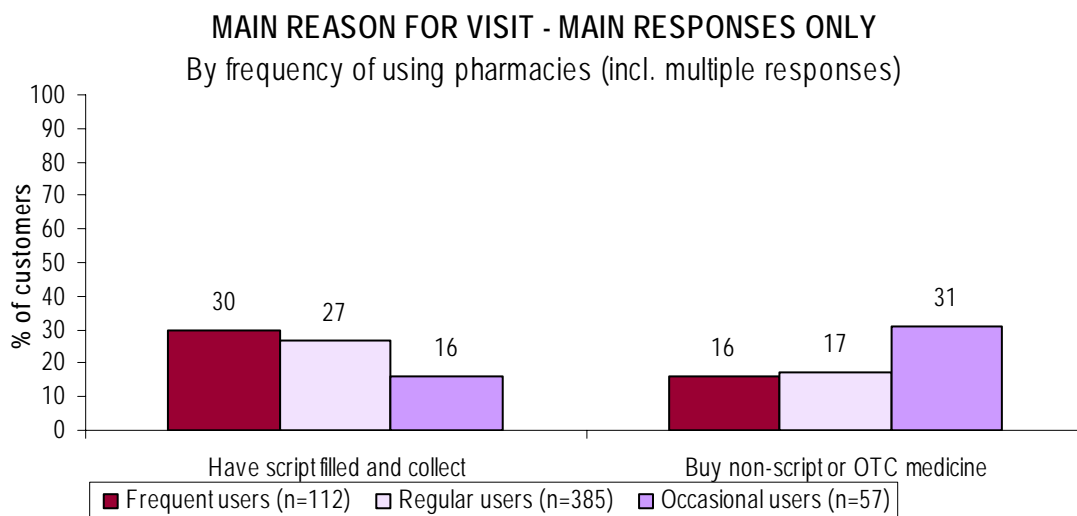


Fig 38. Exit survey: Main reason for visit - Main responses, by frequency of use of pharmacies (n=554)

Respondents in the nation's regional areas were more likely to be collecting a prescription (17%), in comparison to respondents from the metropolitan area (5%).

In order to analyse this pattern further, responses were grouped into two categories- prescriptions and other products. It emerged that respondents in regional areas were more likely to use their pharmacy to access prescriptions (51%) than other products, whilst metropolitan respondents were more likely to be accessing a range of other products than scripts (61% vs 42%). A multitude of other products were mentioned, but, as a guide, the most often listed, albeit by 1-2% of the total sample, included:

- Cosmetics
- Film processing
- Advice from the pharmacist or pharmacy assistant
- Baby care items (e.g. nappies, formula)
- Wound dressings
- Gifts and cards
- Shoes
- Perfume
- Dietary supplements

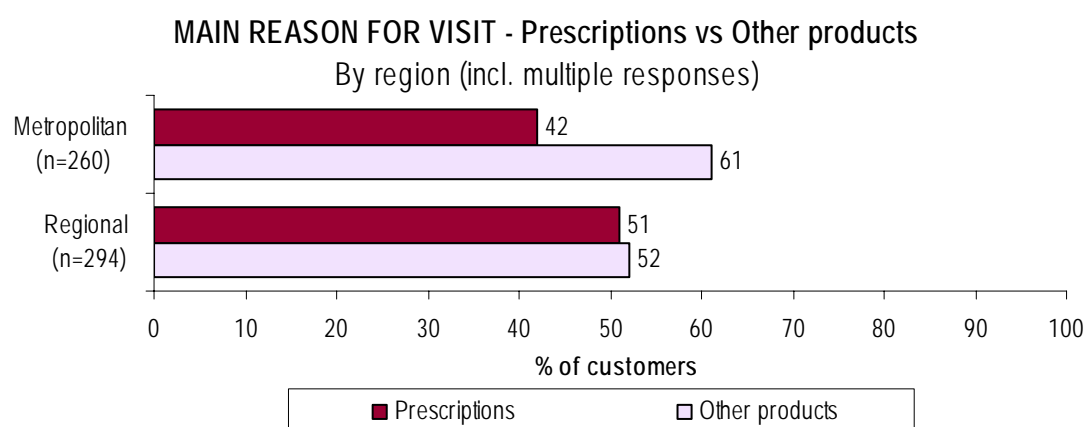


Fig 39. Exit survey: Main reason for visit - Prescriptions vs. other products (By region) (n=554)

The majority (81%) of respondents did not do anything else during their visit to the pharmacy on the day they were surveyed. For those respondents who did do something else during their visit:

- 2% sought advice from the pharmacy assistants on health issues
- 2% purchased cosmetics
- 2% bought a non-prescription or OTC medication

6.3.3.2 Frequency of Obtaining Prescription Medication

Three-quarters of respondents who were collecting a script had received the medication before, a figure which was significantly higher among the health consumers sample, where 88% had had the medication dispensed to them on a previous occasion (compared to 61% of non-health consumers). Comparatively, 36% of non-health consumers were receiving the medication for the first time, whilst just 10% of health consumers were in this situation.

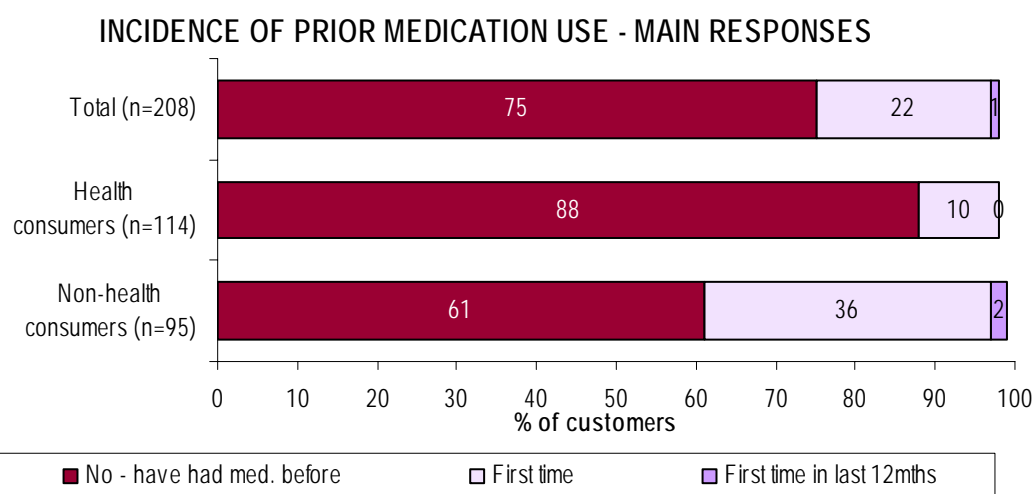


Fig 40. Exit survey: Instance of receiving medication, main responses - customers there for a prescription (n=208)

Respondents who were receiving the medication for the first time were more likely to speak to the pharmacist about using the medication (55%) in comparison to respondents who had received the medication on a prior occasion (22%). These respondents were more likely to speak to the pharmacy assistant (83%, compared to 69% of first-time users of medication).

Repertoire buyers (respondents who used whichever pharmacy was convenient to them at the time), were more likely to be receiving their medication for the first time (35%), compared to respondents who only frequented one particular pharmacy (14%), and those who shopped at two to three pharmacies within a chain (13%). Conversely, respondents who only used one pharmacy were more likely to have received the medication on a previous occasion (83%), in comparison to respondents who are loyal to a chain of pharmacies (63%) and repertoire buyers (62%).

6.3.3.3 Pharmacy Loyalty

With regard to pharmacy usage patterns, two behaviours were equally common. Specifically, the use of one pharmacy exclusively, despite having a choice of others (44%), and the use of whichever pharmacy is most convenient at the time, regardless of group (44%).

Respondents in the metropolitan region were more likely to identify with the statement 'I use whichever pharmacy is convenient at the time...', nominated by 54% of respondents from the metro areas. Not unexpectedly, a significantly higher proportion of respondents from the regional areas of Australia were likely to indicate that they only use one pharmacy as it is the only one in their area (11%, a significant 10 percentage points higher than the 1% of metropolitan respondents who gave this response).

Health consumers were more likely to remain loyal to one pharmacy, despite having the choice of others (57%, compared to 34% of non-health consumers), whereas non-health consumers prefer pharmacies that are convenient to them (52%, compared to 33% of health consumers).

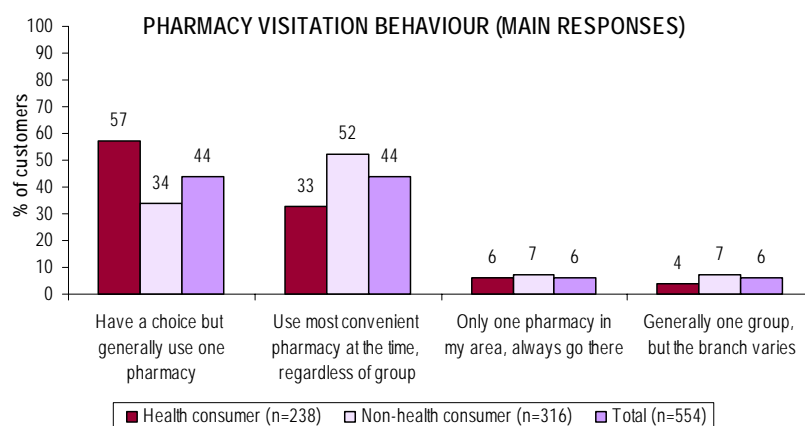


Fig 41. Exit survey: Pharmacy visitation behaviour (n=554)

An interesting pattern of behaviour was detected between heavy, medium and light pharmacy usage. Frequent users were more likely to frequent one particular pharmacy, despite having a choice (50%), and the incidence decreased as in line with usage. Comparatively, respondents who were classified as occasional users of pharmacies were more likely to select a pharmacy based on convenience (47%), than regular users (45%) and frequent users (37%). The graph below illustrates this pattern.

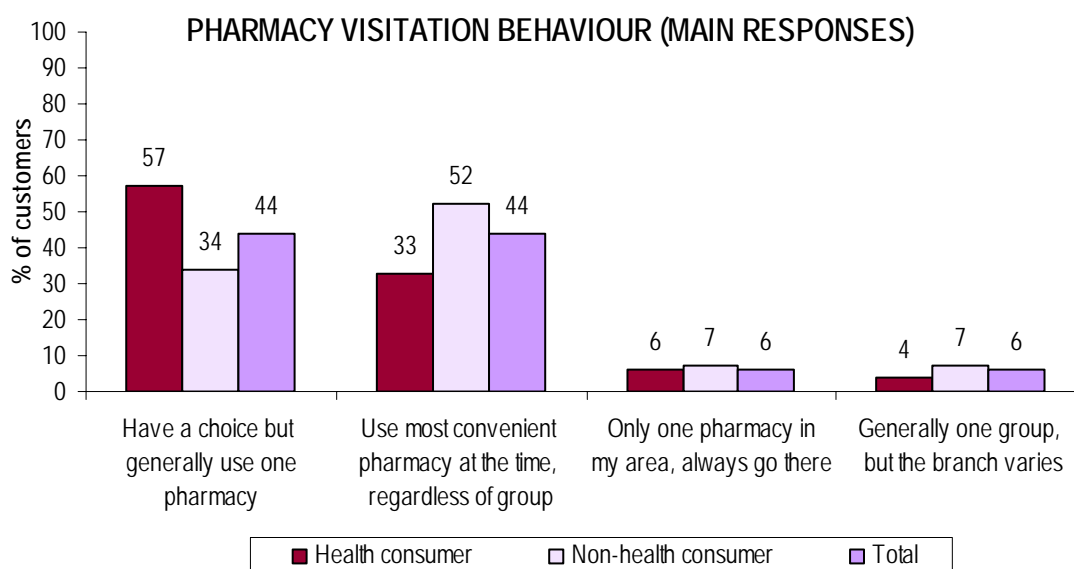


Fig 42. Exit survey: Pharmacy visitation behaviour - Main responses (By frequency of use of pharmacies) (n=554)

A similar pattern was also witnessed with regard to the age group respondents fell into, with the use of one particular pharmacy more common among older respondents (69% of 65+ respondents, compared to 21% of 15-24 year olds), and the use of the most convenient pharmacy at the time more common among younger respondents (74% of 15-24 year old respondents and 22% of 65+ respondents).

6.3.3.4 Consumer Purchase Behaviour

Respondents were presented with seven pharmacy-related activities and asked how often they personally undertake each of them. Key outcomes are provided below for each activity, while the next few pages show graphically the differences between key segments in prescription and OTC purchase behaviours.

Overall, 54% of customers visit a pharmacy approximately once a month to either buy something, get advice or browse. Notable sub-groups variations include:

- Females (23%) were more likely than males (12%) to make a weekly visit to a pharmacy to buy something, receive advice or browse; however, no other differences between demographic groups were observed for this behaviour.

46% of customers visit a pharmacy about once a month to purchase prescription medicine. Notable differences include:

- People using just one pharmacy were more likely to buy prescription medications often (11% do this frequently) compared with 0% loyal to a chain and 2% of repertoire buyers.

One third of respondents visit a pharmacy about once a month to buy OTC medicines, whilst 31% did so quarterly and 19% biannually. Key variations to this pattern were:

- Respondents in the nation's regional areas were more likely to purchase non-prescription or OTC medicines biannually (23%) in comparison to respondents in metropolitan areas (15%)
- Males tended to purchase non-prescription or OTC medicines less frequently than females, with 38% of females purchasing these items monthly, compared to 21% of males. 28% of males purchased these items biannually, whereas only 15% of females did this.

Purchasing other products at pharmacies was less common, with 38% of customers saying they never access products such as vitamins and herbal remedies there and 41% never buying non-health-related products there.

Few respondents regularly visit to receive advice from the pharmacist, and visiting to receive advice from pharmacy assistants was even less common. 32% consult their pharmacist for advice once or twice a year and 18% do so quarterly. Pharmacy assistants were rarely visited for advice, with 28% mentioning that they seek their advice once or twice a year and 41% less often than that.

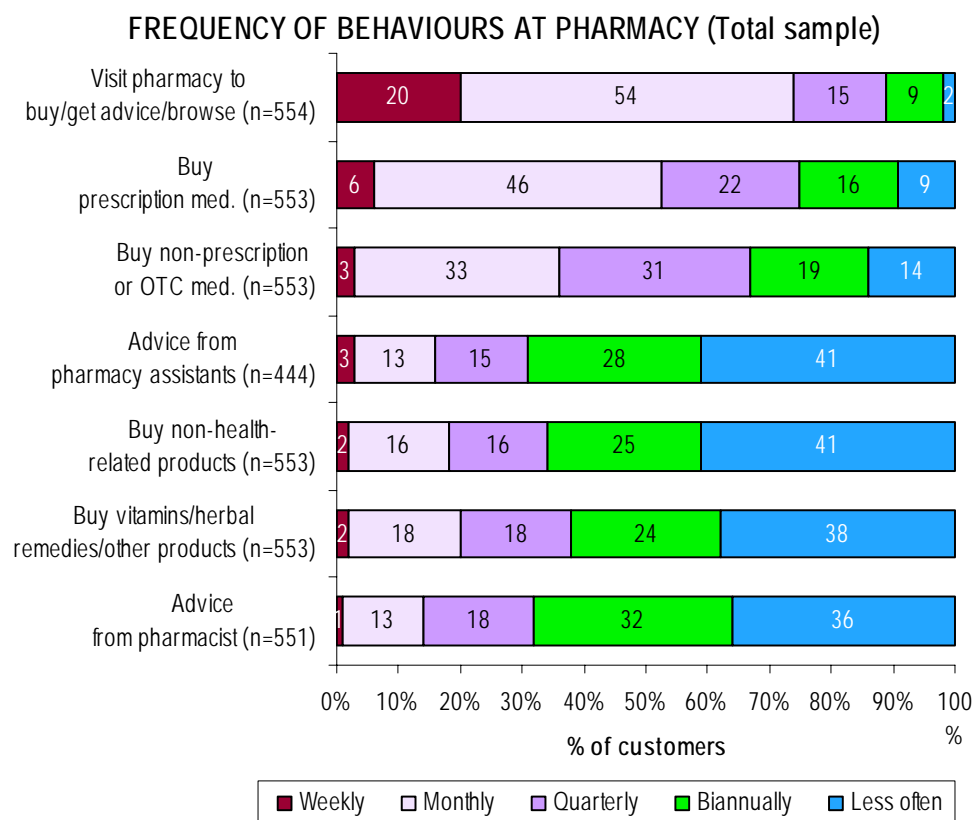


Fig 43. Exit survey: Frequency of seven behaviours at pharmacy (Total sample) (n=554)

The next graph shows the differing pattern of behaviours recorded for health versus non-health consumers. Bearing in mind that all health consumers, by definition, visit pharmacies at least once a month, it is very clear that prescriptions drive this attendance rate.

FREQUENCY OF BEHAVIOURS AT PHARMACY

By health vs non-health consumer

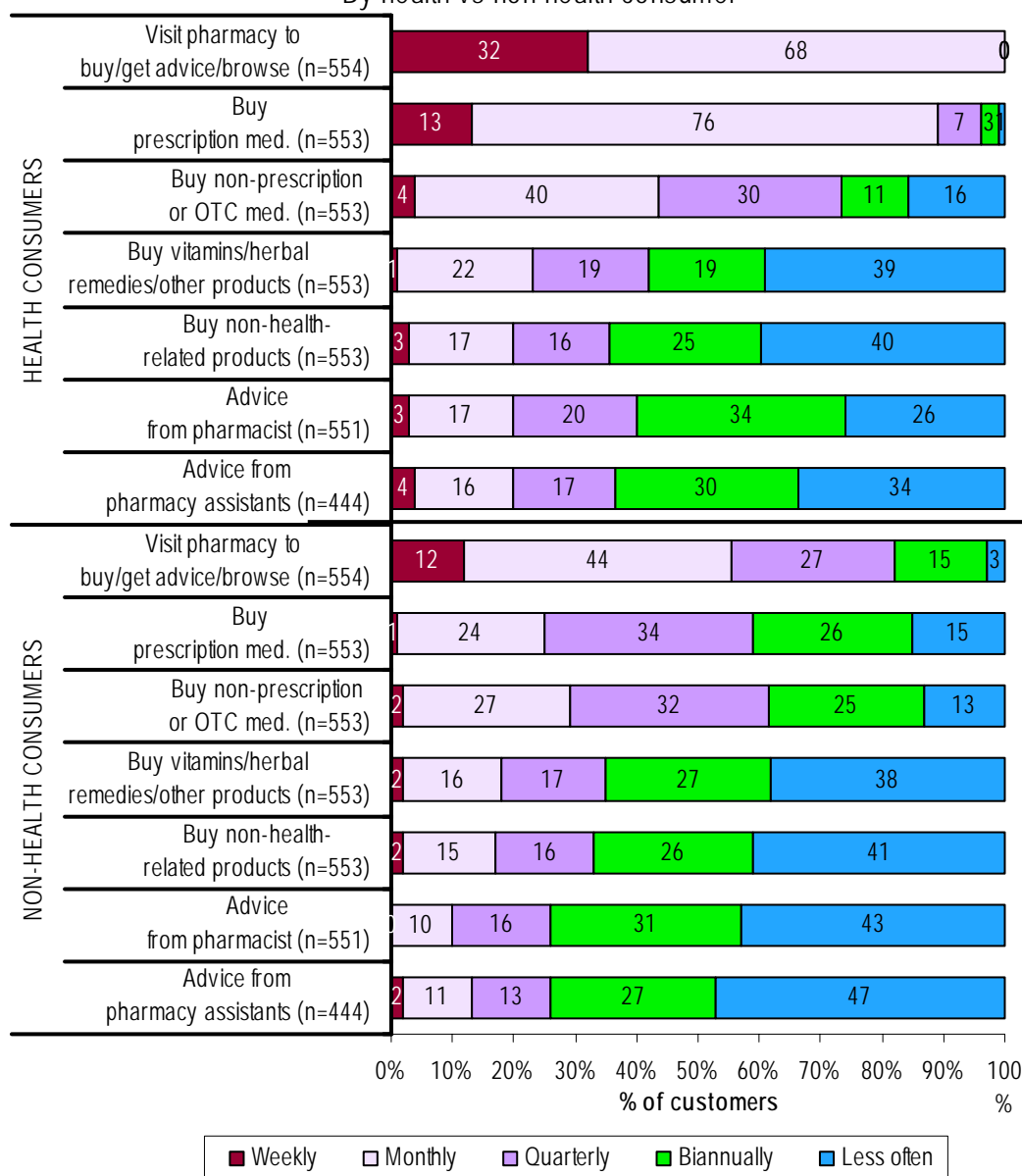


Fig 44. Exit survey: Frequency of seven behaviours at pharmacy (Health vs. non-health consumers (n=554))

The four graphs on the next two pages highlight the significant differences noted between other sub-groups relating to buying prescription and OTC medicines.

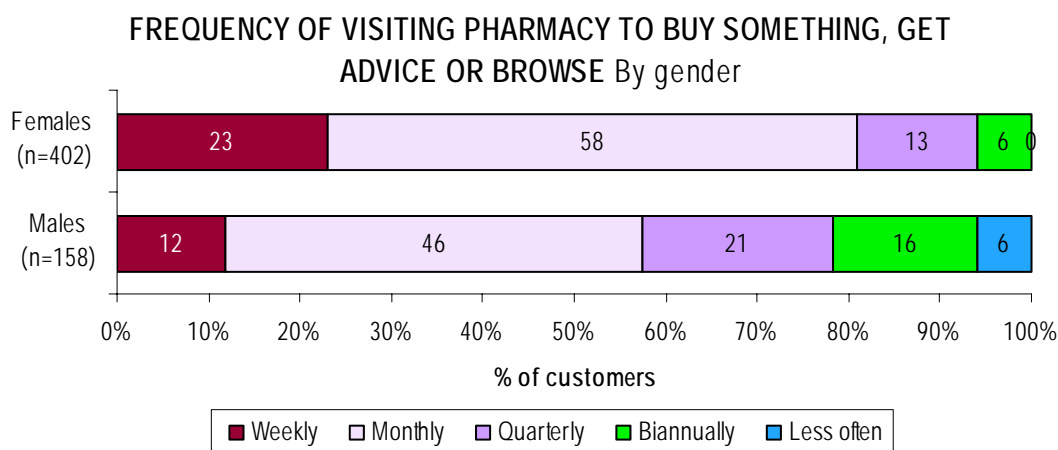


Fig 45. Exit survey: Frequency of visiting pharmacy to buy something, get advice or browse (By gender) (n=554)

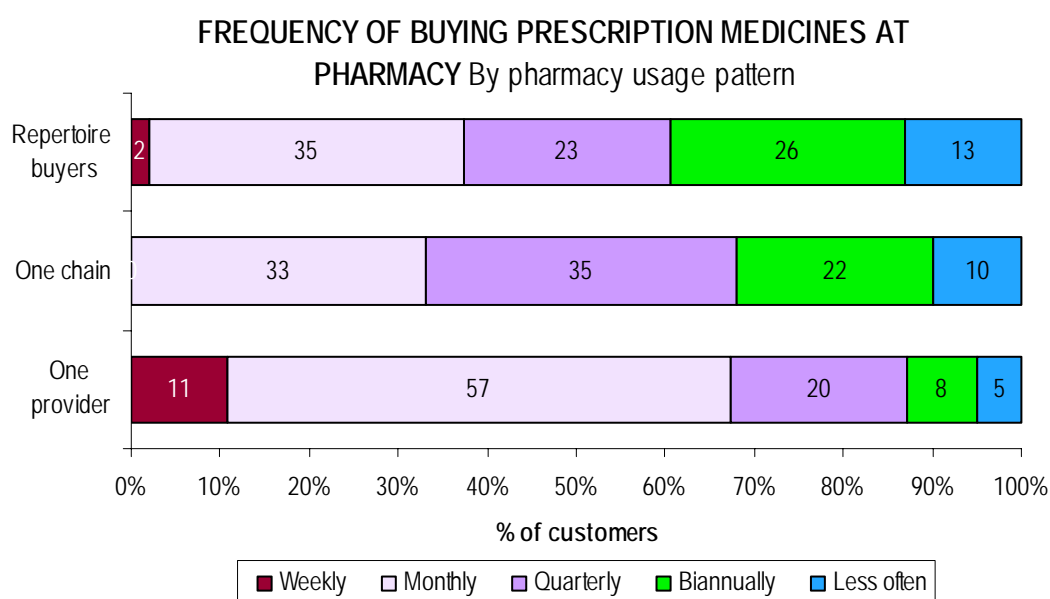


Fig 46. Exit survey: Frequency of buying prescription medicine at pharmacy (By pharmacy usage pattern) (n=554)

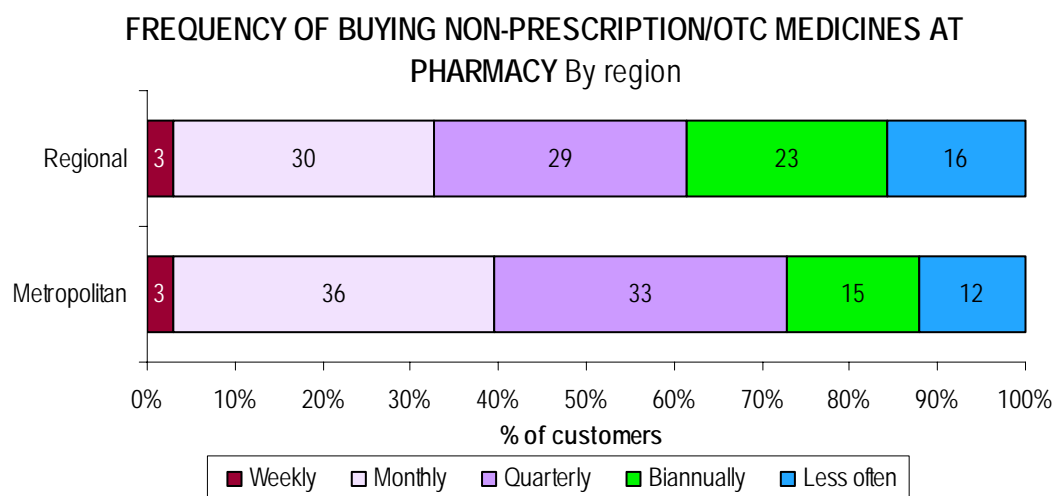


Fig 47. Exit survey: Frequency of buying non-prescription/OTC medicines at pharmacy (By region) (n=554)

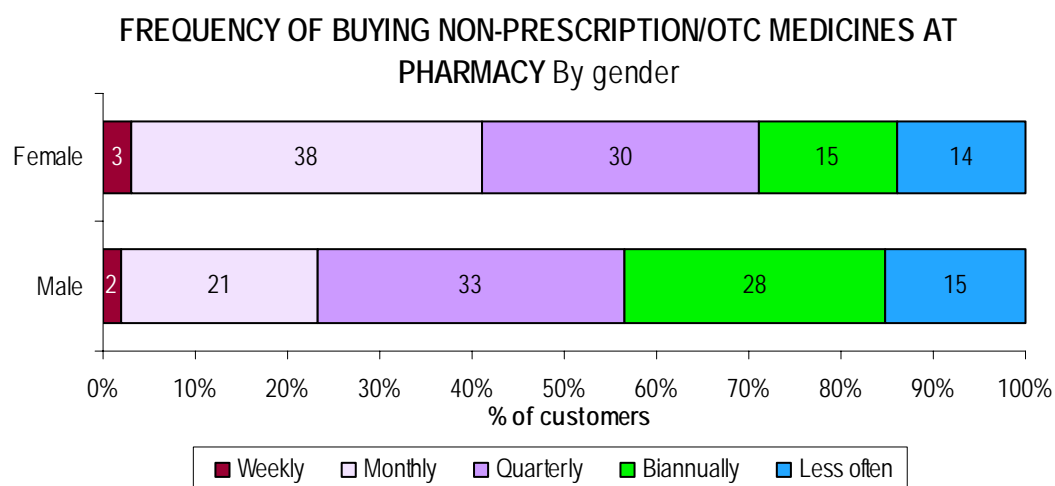


Fig 48. Exit survey: Frequency of buying non-prescription/OTC medicines at pharmacy (By gender) (n=554)

6.3.3.5 English as first language

For the vast majority of respondents, English was their first language (96%); however, this figure was marginally higher among respondents in regional areas (98%) compared to metropolitan respondents (94%).

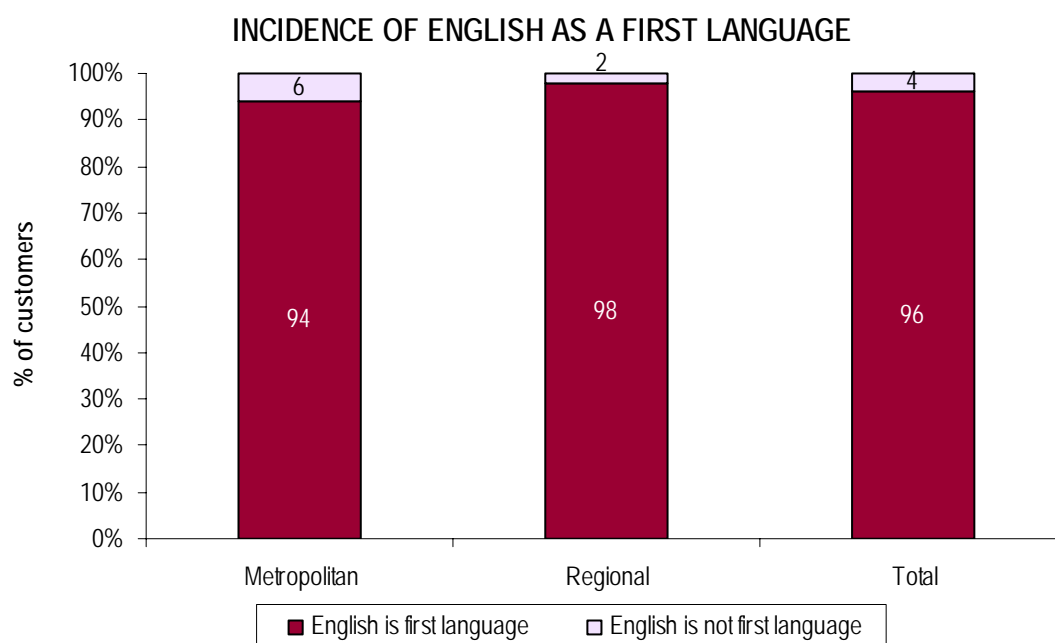


Fig 49. Exit survey: First language spoken (n=554)

Interestingly, respondents whose first language was not English were no less likely to speak to either the pharmacist or pharmacy assistant, suggesting that language barriers are not a primary driver of or barrier to interactions with pharmacy staff.

One third of NESB customers said that there had been someone there that day who spoke their language. A notable two thirds, however, stated this was not the case.

6.3.3.6 Service Experience: Prescriptions/Medications

The vast majority (87%) of exit survey customers who were lodging or collecting a prescription said that the pharmacy had their medication in stock or was able to get it in quickly. However, this implicitly means that, for one in every seven to eight prescription-related customers interviewed as they left the stores (13%), this did not happen - they had to wait for their medication.

In total, one in five of those leaving or collecting a prescription (19%) spoke with the pharmacist, including 12% who did so at the pharmacist's instigation and 7% who asked to speak with the pharmacist. Interestingly, an almost equal proportion (15%) said they spoke with an assistant about their medication or the related health issue, including 8% where this conversation was initiated by the assistant.

Among the 13 respondents (5% of those lodging and/or collecting prescriptions) who received written instructions on the medication apart from what was on the bottle or packaging (i.e. CMI - Consumer Medicine Information), half (7 out of 13) were first-time users of that medication and half (6/13) had received it before. Conversely, these 7 people mean that 15% of the 46 first time users received such instructions, while 4% of the 159 customers getting their prescription medicine for the second or subsequent time received CMI.

EXPERIENCE WITH PRESCRIPTION MEDICINES - MAIN RESPONSES

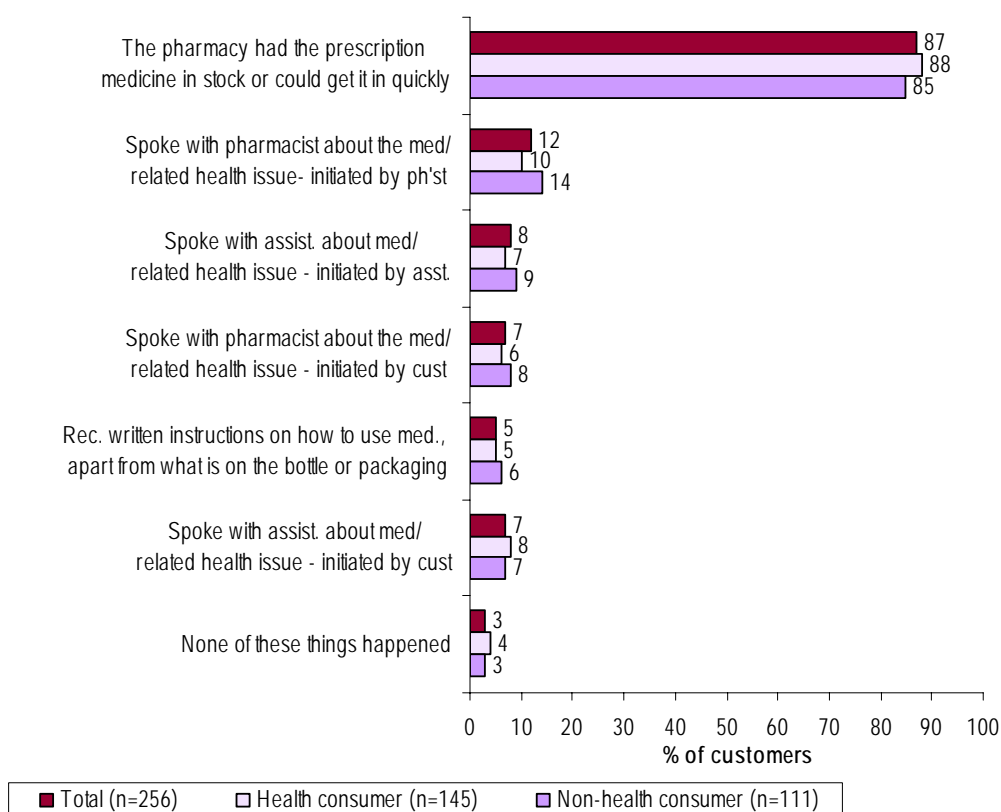


Fig 50. Exit survey: Experience at pharmacy when lodging or collecting a prescription (n=256)

There were significant differences between the six States/Territory canvassed in this module of the study, with NSW clearly providing the most negative results.

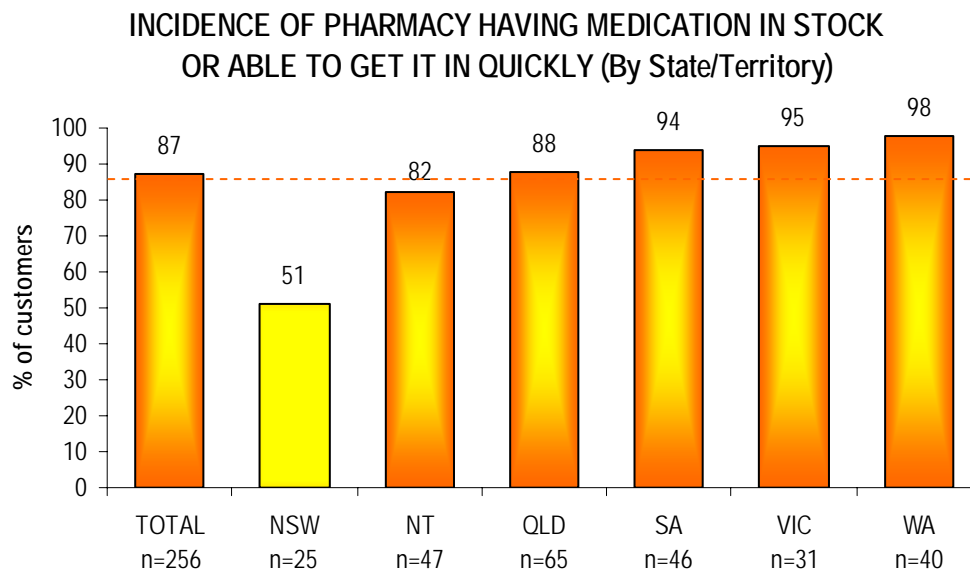


Fig 51. Exit Survey: Incidence of having medication in stock or readily accessible, by State (n=256)

Despite these State variations, overall the results were statistically identical at the metro versus regional level, with 86% and 87% of the 256 respondents collecting a script reporting that the pharmacy was able to supply them promptly with the product they required. As can be seen from the previous graph, the State sub-samples are too small to permit a more detailed breakdown of the metro/regional results by State.

6.3.3.7 Service Experience - Over the Counter Medicines

Two thirds (64%) of the 131 respondents who went in to purchase OTC medicines indicated that the pharmacy had the medication in stock or was able to bring it in quickly, the converse of which means that one third of OTC medicine customers did not get what they wanted when they wanted it.

Close to half (45%) spoke with a pharmacy assistant. Most of these interactions (36% out of the 45%) were initiated by the customer. Assistant interactions were followed distantly by the 6% who spoke with the pharmacist about the medicine or related health issue that had brought them to the pharmacy, with this discussion initiated by the customer in all recorded cases.

As the following graph shows, health consumers showed a somewhat greater incidence of seeking to speak with pharmacy assistant than non-health consumers, but the difference is not statistically significant due to the smaller sample size.

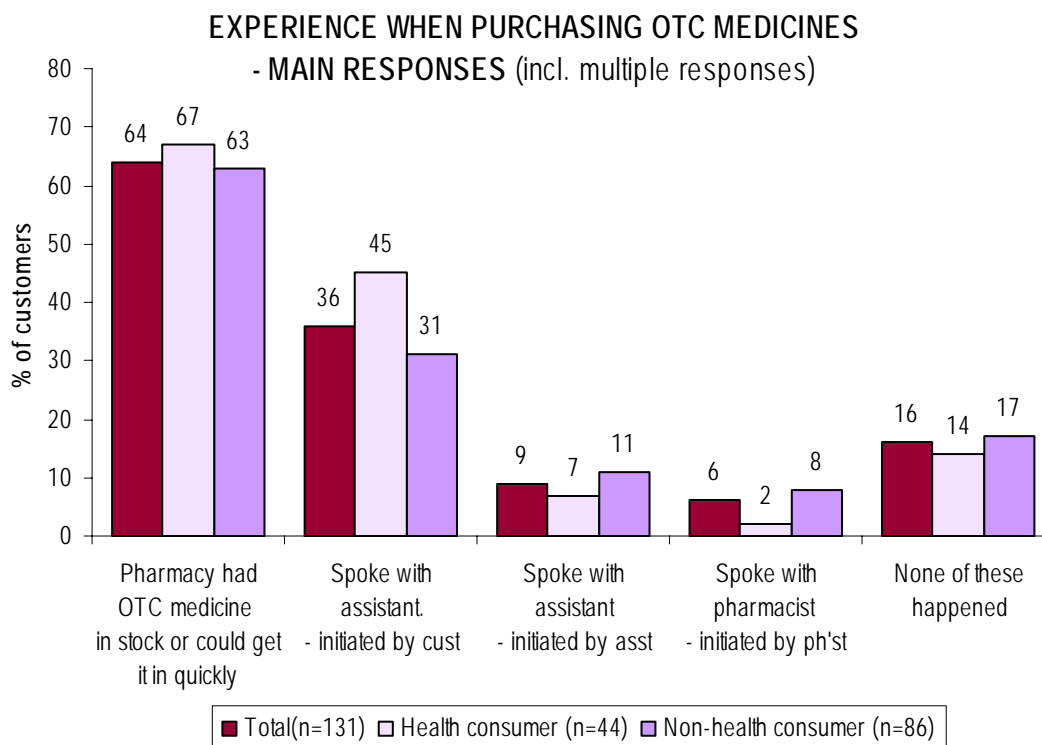


Fig 52. Exit survey: Experience when purchasing OTC medicines. (n=131)

The sub-sample size of just 131 respondents means reliable segmentation of the results is limited, but it is interesting nevertheless to note that, in both NSW and VIC, just 1 of the 10 customers in each of these States who went in for OTC medicines indicated that the pharmacy had what they wanted in stock.

For OTC medicines, regional pharmacies seemed better supplied than metropolitan ones, with 74% of the 71 regional customers confirming that the item they sought was stocked or readily accessible, compared with 53% of the 60 metro customers.

6.3.3.8 Consumer Privacy

The 92 respondents who spoke to either pharmacists or pharmacy assistants on the visit for which they were interviewed were asked to rate how well or poorly their privacy was maintained during the visit. The vast majority of these respondents (94%) said their privacy was maintained either quite or very well, including 76% who said very well.

Proportionally, more health consumers indicated that their privacy was maintained very well (91%, compared to 58% of non-health consumers); conversely, the incidence of nominating quite well rather than very well was significantly greater among non-health consumers (31% vs 7% of health consumers).

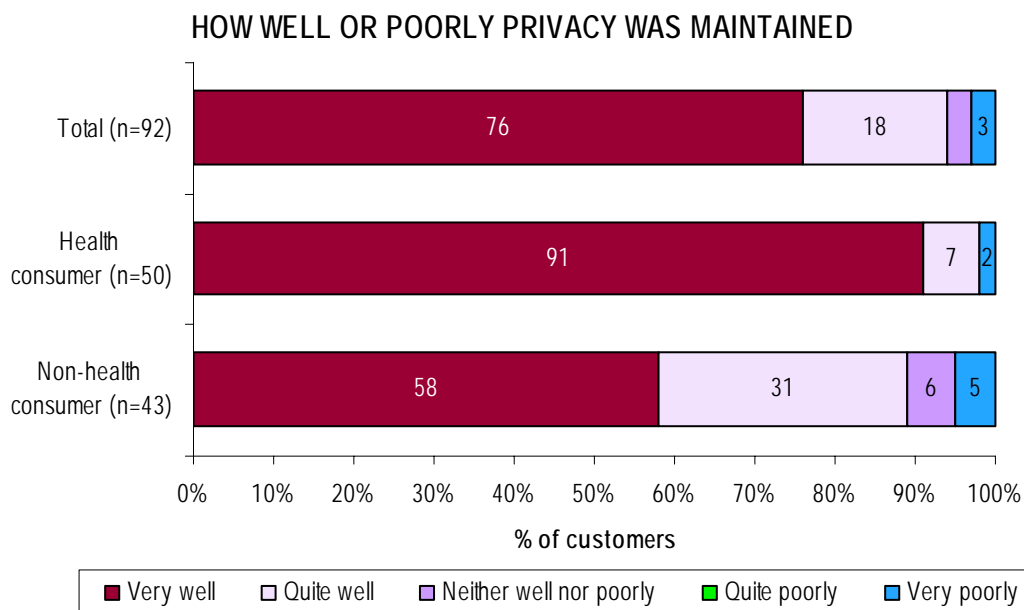


Fig 53. Exit survey: Perceptions of how well privacy was maintained (n=92)

The small sub-sample of just 92 again limits the segmentation that can be done. However, the 'very well' response was marginally lower among:

- regional respondents (72% vs 81% for metro)
- 15-55 year olds (65% vs 92% of those aged 55+)

No difference was observed between those who spoke with the pharmacist versus the pharmacy assistant.

6.3.3.9 Waiting Period for Prescriptions

The 256 respondents who lodged or collected a prescription were asked what waiting time had been advertised or stated when they lodged it. For analysis purposes, respondents who could not recall or were not aware of the predicted wait time have been excluded from the calculations, leaving a sample of 219 customers.

Overall, around eight in ten (79%) expected to wait less than 10 minutes, whilst a further 8% were told this time would be 10-14 minutes. There was little difference in the advertised waiting time given to health and non-health consumers, nor were there any variations between categories of pharmacy usage (e.g. between heavy, medium and light users). There were also no major differences detected between demographic groups such as location, gender or age.

However, there were significant differences by State, with waiting times significantly longer in the NT and shortest in WA and NSW (caution: small sub-samples in NSW and VIC).

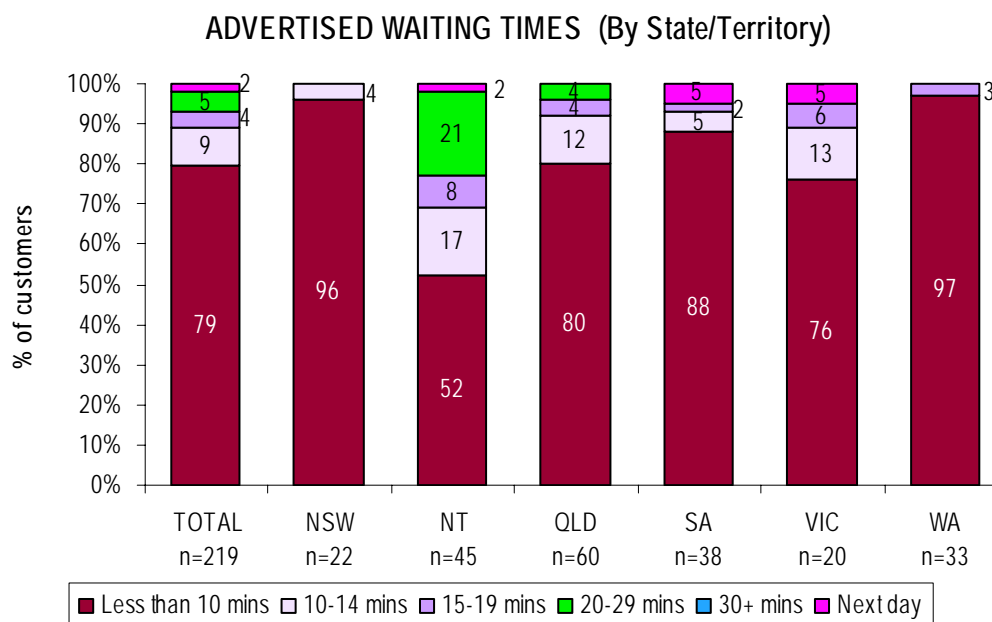


Fig 54. Exit Survey: Advertised or stated waiting times when lodging prescriptions (n=219)

Subsequently, people who either waited for their script or who came back when the pharmacy had said it would be ready (158 respondents) were asked how long they had *actually* waited; again, people who could not recall have been excluded, leaving a sub-sample of 143.

Eight in every ten (81%) waited less than 10 minutes, 12% waited between 10-14 minutes, 4% waited 15-24 minutes and 4% waited 25 minutes or longer, including one person who had originally been expected a 10 minute wait time but was then asked to come back the next day as the medicine was out of stock.

The next graph shows the actual wait time juxtaposed with the advertised or stated wait time; it emerged that nine people in ten are being served within the predicted time; however one in ten waits longer than expected.

Health consumers tended to experience a slightly longer actual waiting time, with 22% of these respondents having to wait longer than 10 minutes (compared to 17% of non-health consumers).

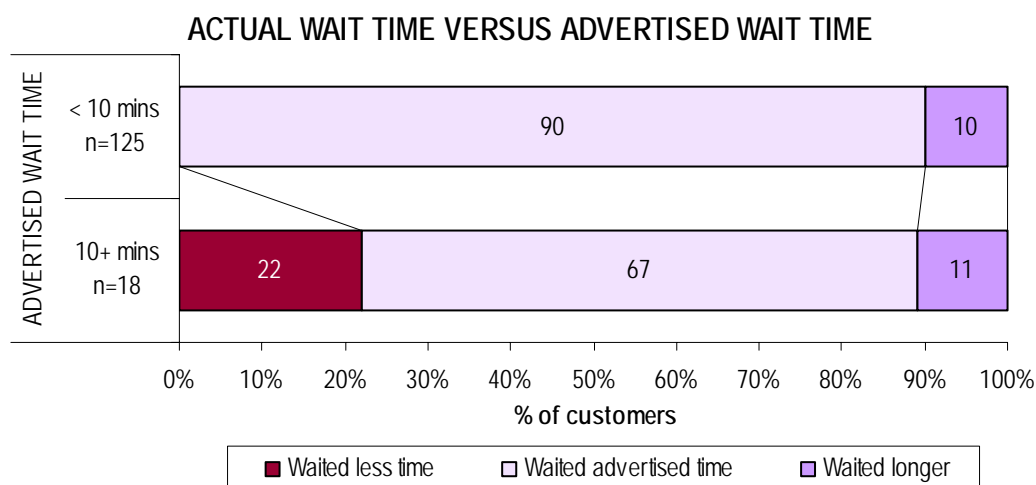


Fig 55. Exit survey: Advertised versus actual length of wait time (n=155)

Respondents who spoke to both the pharmacist and pharmacy assistant(s) were more likely to wait less than 10 minutes for their medication, whilst customers who spoke only to the pharmacist were second most likely to wait this length of time (93%). Interestingly, when respondents spoke to just the pharmacy assistant(s) or spoke to neither the pharmacist or pharmacy assistant(s), their actual waiting time was more likely to be greater than 10 minutes (21% of respondents who spoke to the pharmacy assistant(s), 43% who spoke to neither).

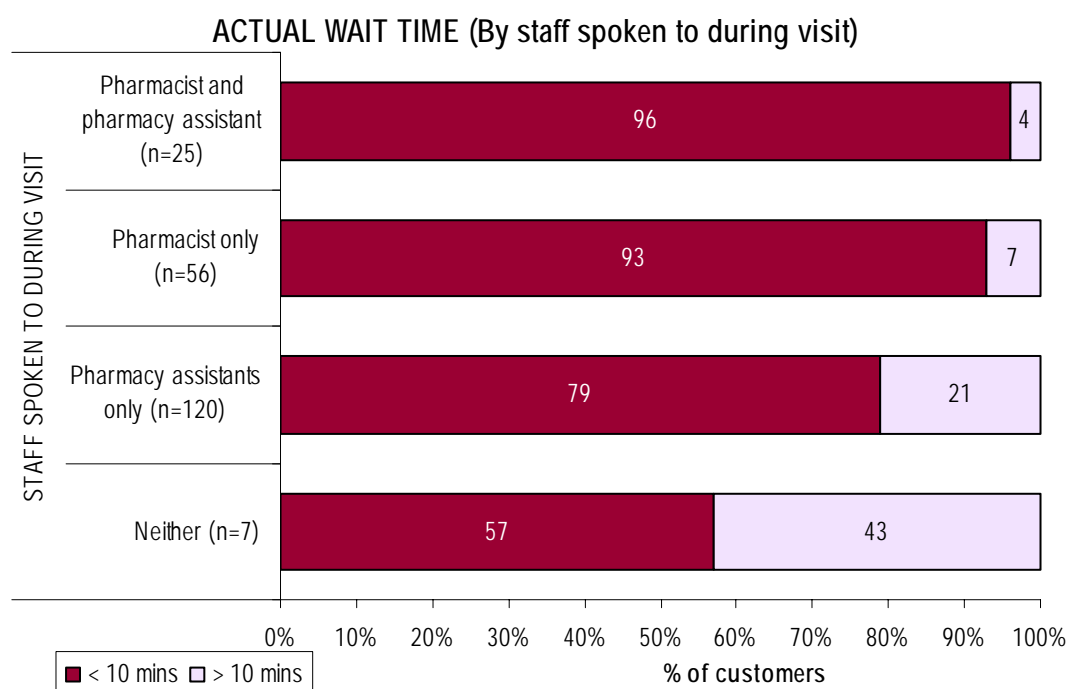


Fig 56. Exit survey: Actual wait time (by staff spoken to during visit) (n=155)

Females were also more likely to wait longer than 10 minutes, with 23% of these respondents indicating that their waiting time exceeded 10 minute, compared to 15% of males.

The questions regarding advertised and actual waiting time were cross-tabulated to gain an idea of whether actual waiting time falls within the range given by pharmacy staff. Generally, staff were accurate in the waiting times they give to customers, with 90% of customers who indicated that they were told the wait time would be less than 10 minutes actually receiving their prescription within this timeframe. Pleasingly, the majority of respondents received their medication either within, or before, the time period specified to them by the pharmacy staff, with just two customers waiting longer than they had been told they would need to by pharmacy staff.

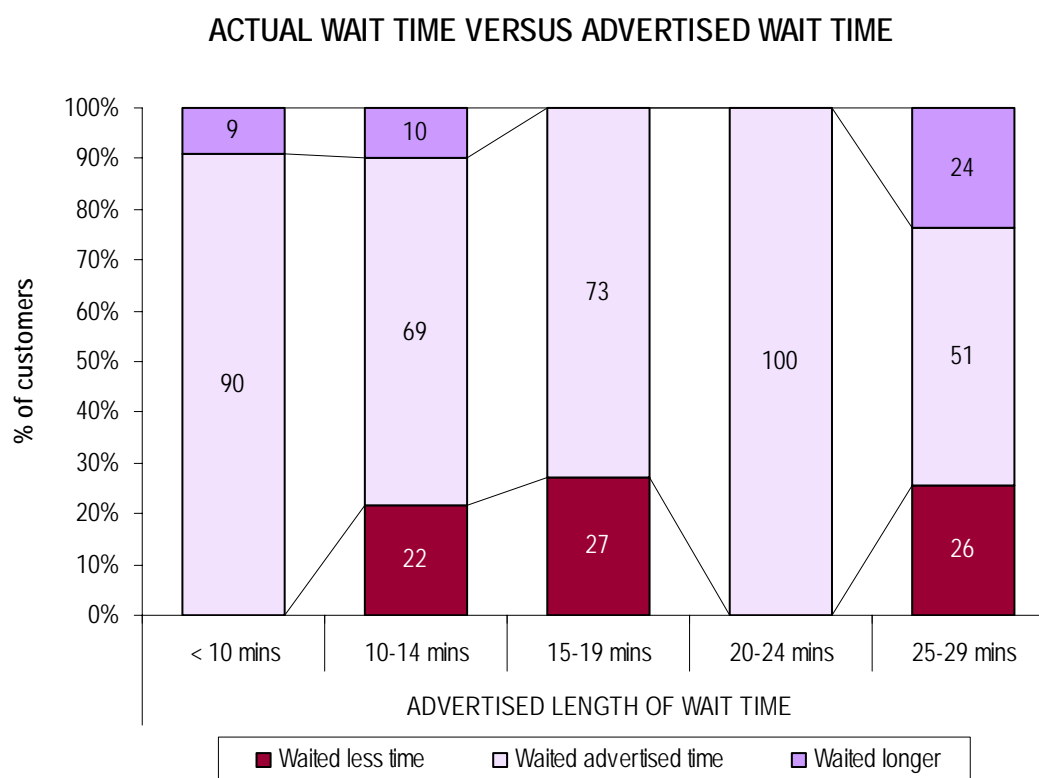


Fig 57. Exit survey: Actual waiting time (By advertised waiting time) (n=143)

Respondents perceived the waiting time for their prescriptions as extremely reasonable, with the average rating at the total sample level equalling 9.3. Health and non-health consumers did not differ significantly in their ratings of the waiting time, nor were there any differences between various demographic groups, or between factors in customer experiences at the pharmacy such as who they spoke to, or what they did while waiting for the script.

Given these remarkably high ratings for waiting time, there was little room to move when respondents were asked to consider the amount of paperwork that needs to be

done by pharmacy staff when filling a script, and then rate the waiting time again. Once interviewers made customers aware of the time taken for pharmacy staff to complete relevant paperwork for scripts the average rating reached 9.4 at the total sample level.

For ratings of waiting both before and after respondents were made aware of the paperwork involved in filling scripts, no sub-group recorded a rating below 8.5, indicating a perception by customers that waiting time for scripts is extremely reasonable.

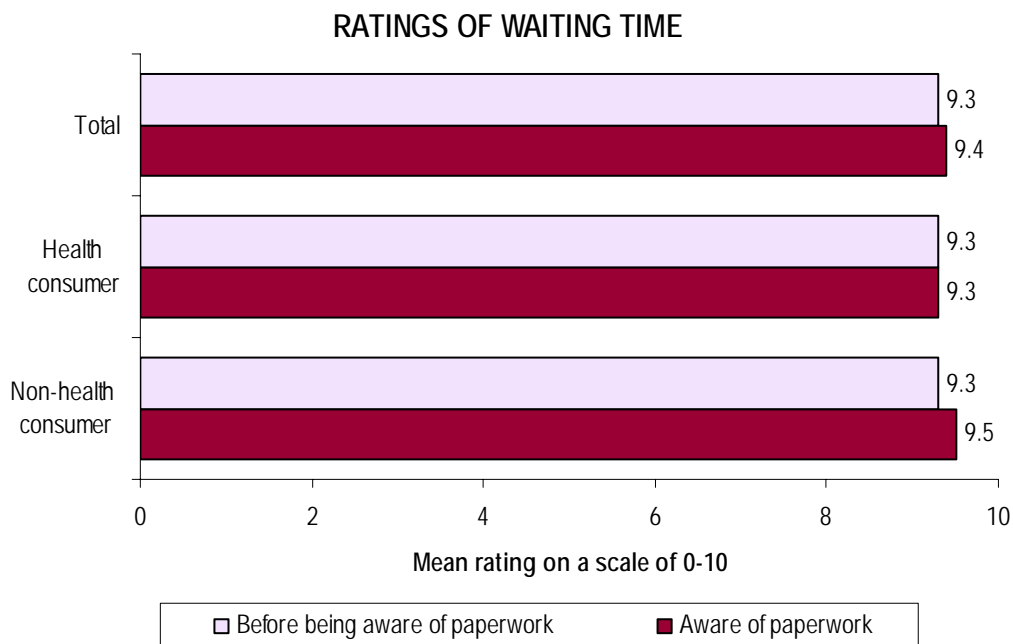


Fig 58. Exit survey: Ratings of waiting time, before and after being made aware of paperwork (n=159)

6.3.3.10 Staff Contact

Just over three-quarters (77%) of the total sample spoke to the pharmacy assistant(s) only during their visit to the pharmacy, whilst 10% spoke to the pharmacist only. Respondents who spoke to both the pharmacist and his or her assistants constituted 6% of the total sample, whilst 6% indicated that they spoke to neither the pharmacist nor the pharmacy assistants.

Interestingly, health consumers were slightly less likely to speak to the pharmacist, despite these respondents having medical conditions which require ongoing treatment, medication or monitoring. 8% of health consumers spoke to the pharmacist during their visit to the pharmacy, compared to 12% of non-health consumers. Health consumers were slightly more likely to speak to the pharmacy assistants (82%, compared to 74% of non-health consumers), yet non-health consumers were more likely to indicate that they spoke to neither the pharmacist nor the pharmacy assistants (8%, compared to 3% of health consumers).

Respondents who used one pharmacy only were slightly more likely to have spoken to the pharmacist during their visit (13%, in comparison to 10% of respondents who are loyal to one chain and 7% of repertoire buyers).

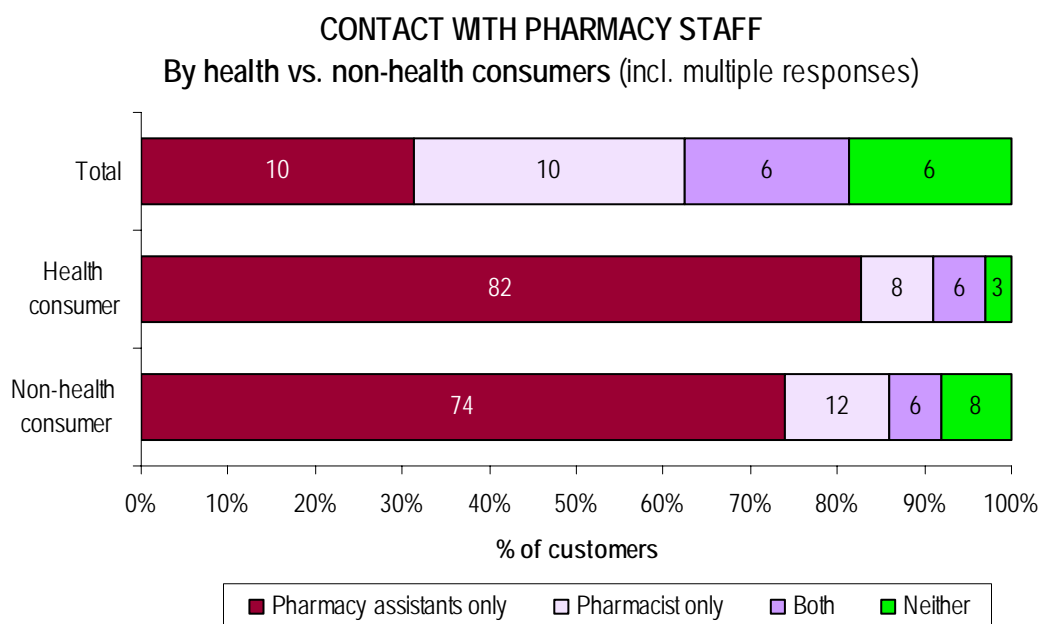


Fig 59. Exit survey: Contact with pharmacy staff (n=549)

6.3.3.11 Staff Performance Ratings: Pharmacy assistant

Respondents who indicated that they had had contact with the pharmacy assistants at some stage during their visit were asked to rate these staff members for their performance on the following attributes:

- Making you feel welcome
- Calling you by name when you are leaving or collecting a script
- Being polite and courteous
- Being able to offer advice on other products or services
- Listening to what you have to say
- Maintaining your privacy

Pharmacy assistants were rated extremely well for all six attributes, with no attribute recording an average rating of below 9.1. At the total sample level, the highest rating obtained was 9.7, which was given to two attributes – ‘being polite and courteous’ and ‘maintaining your privacy’. The graph below displays the average ratings obtained for the total sample.

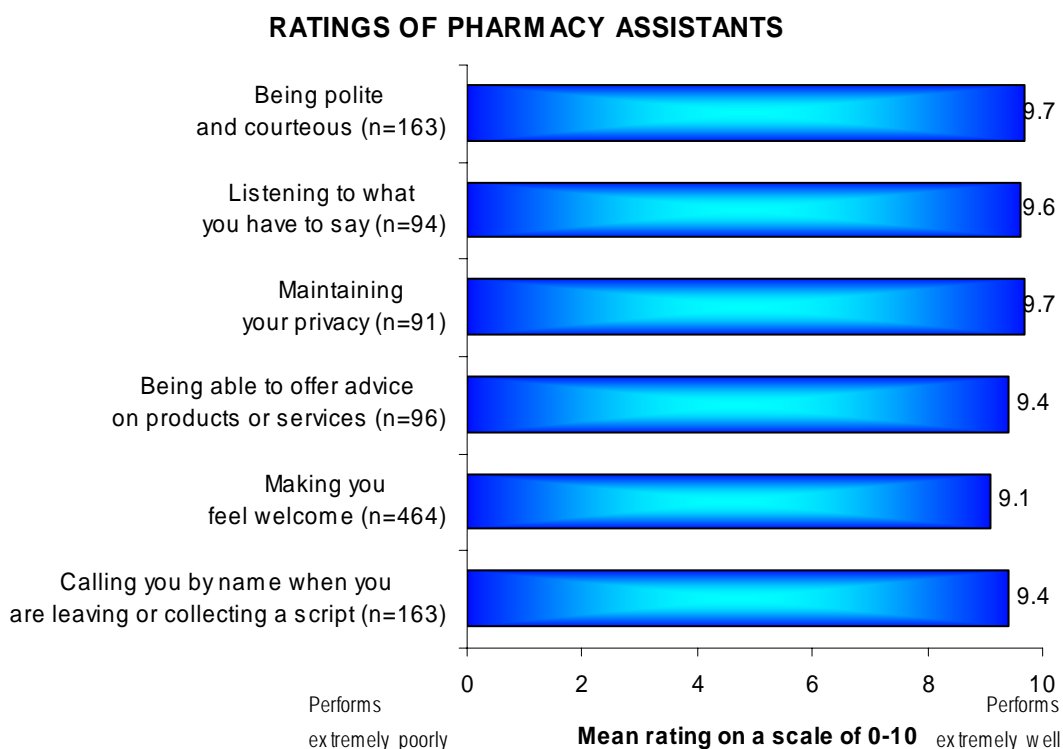


Fig 60. Exit survey: Mean ratings of pharmacy assistants (n=464)

Some slight differences in the mean ratings given to pharmacy assistants were observed between health and non-health consumers. For example, health consumers rated the performance of assistants on the attribute 'calling you by name when you are leaving or collecting your script' 9.7, whereas non-health consumers rated these staff members 9.0 for this attribute. Health consumers were also slightly more satisfied with the pharmacy assistants' attempts to maintain their privacy, with these respondents rating the assistants 9.8, compared to the 9.5 average rating recorded by non-health consumers. These differences, and other less notable ones, are illustrated in the following graph.

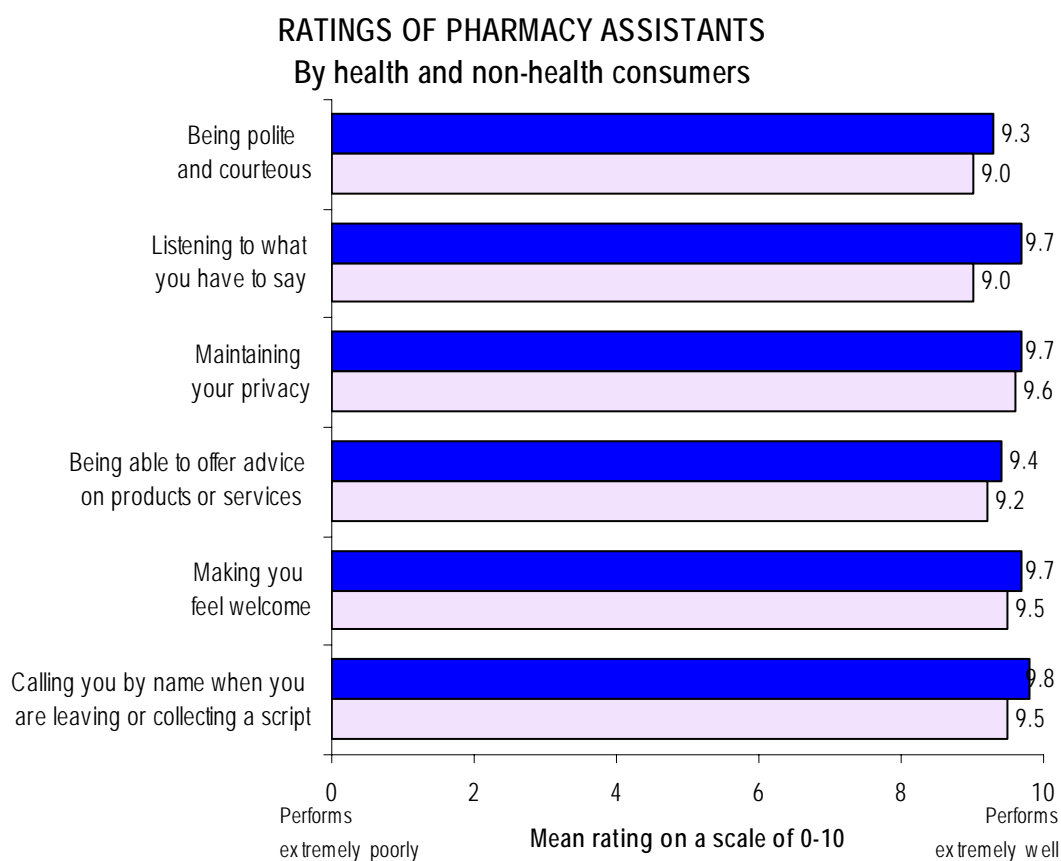


Fig 61. Exit survey: Ratings of pharmacy assistants (By health and non-health consumers) (n=464)

Notably high results were obtained within the following segments:

Making you feel welcome, rated notably high by:

- 65+ year olds (9.5 out of 10)
- Regional NSW respondents (9.5 out of 10)

Calling you by name when leaving or collecting a script, rated notably high by:

- Regional NSW and QLD (Townsville) respondents (10 out of 10)
- Metropolitan VIC respondents (10 out of 10)

Being polite and courteous, rated notably high by:

- Regional NSW and QLD (Townsville) respondents (10 out of 10)
- Metropolitan VIC respondents (10 out of 10)

Being able to offer advice on other products and services, rated notably high by:

- Regional NSW (10 out of 10)
- Metropolitan SA and VIC (10 out of 10)
- 15-24 year olds (10 out of 10)
- Respondents engaged in part-time employment or home duties (10 out of 10)

Listening to what you have to say, rated notably high by:

- Regional NSW (10 out of 10)
- Metropolitan NT, SA and VIC (10 out of 10)
- 15-24 year olds (10 out of 10)
- Respondents engaged in part-time work or home duties (both 10 out of 10)

Maintaining your privacy, rated notably high by:

- Regional NSW, QLD (Townsville) and WA (all 10 out of 10)
- Metropolitan NT, SA, VIC and WA (all 10 out of 10)
- 15-24 year olds (10 out of 10)
- Respondents engaged in part-time work or home duties (10 out of 10)

6.3.3.12 Staff Performance Ratings: Pharmacists

Respondents who indicated that they had had contact with the pharmacist on duty during their visit to the pharmacy were asked to rate the performance of these staff members on the following attributes:

- Giving clear information or advice
- Being polite and courteous
- Maintaining your privacy
- Being available when you need to speak with a pharmacist
- Listening to what you have to say
- Inviting questions

As was the case for pharmacy assistants, extremely favourable ratings were achieved by pharmacists on all six attributes, with the average rating not dropping below 9.6 for any attribute. At the total sample level, the areas where pharmacists performed best were 'listening to what you have to say' (rated 9.9 out of 10), 'being polite and courteous' (rated 9.8 out of 10) and 'being available when you need to speak with a pharmacist' (rated 9.8 out of 10). The graph below displays the average ratings for all six attributes at the total sample level.

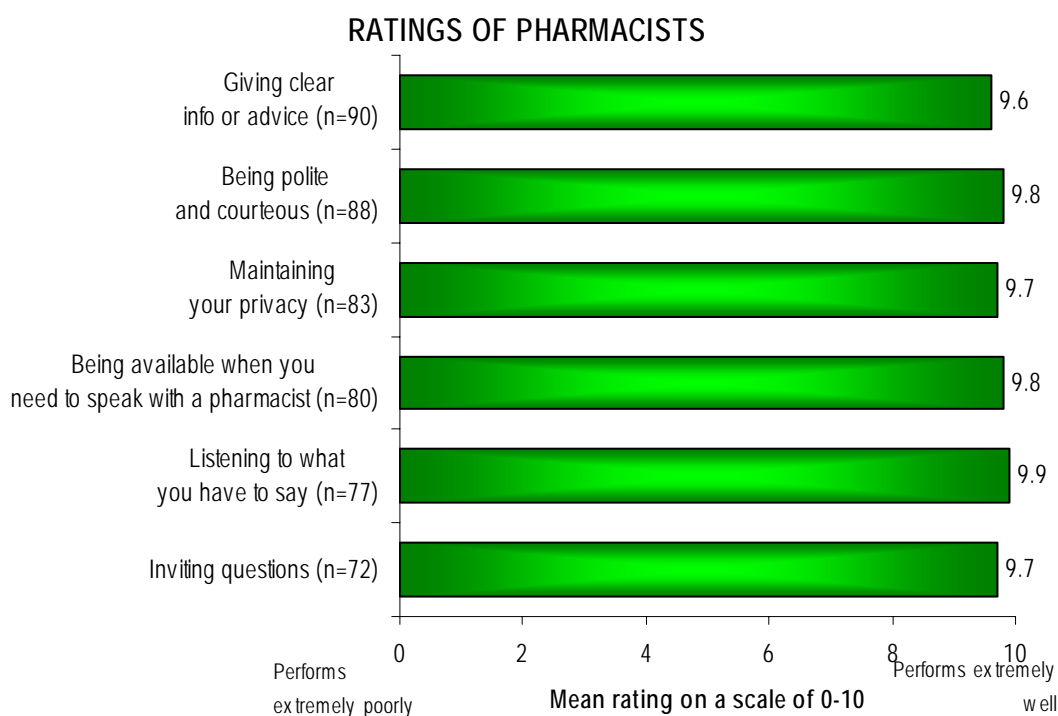


Fig 62. Exit survey: Ratings of pharmacists (n=90)

Ratings given by health consumers, in comparison to non-health consumers, varied by the smallest of margins, however given the important distinction between these two groups for the purpose of this research, the graph below illustrates the ratings given by these two segments on the six attributes.

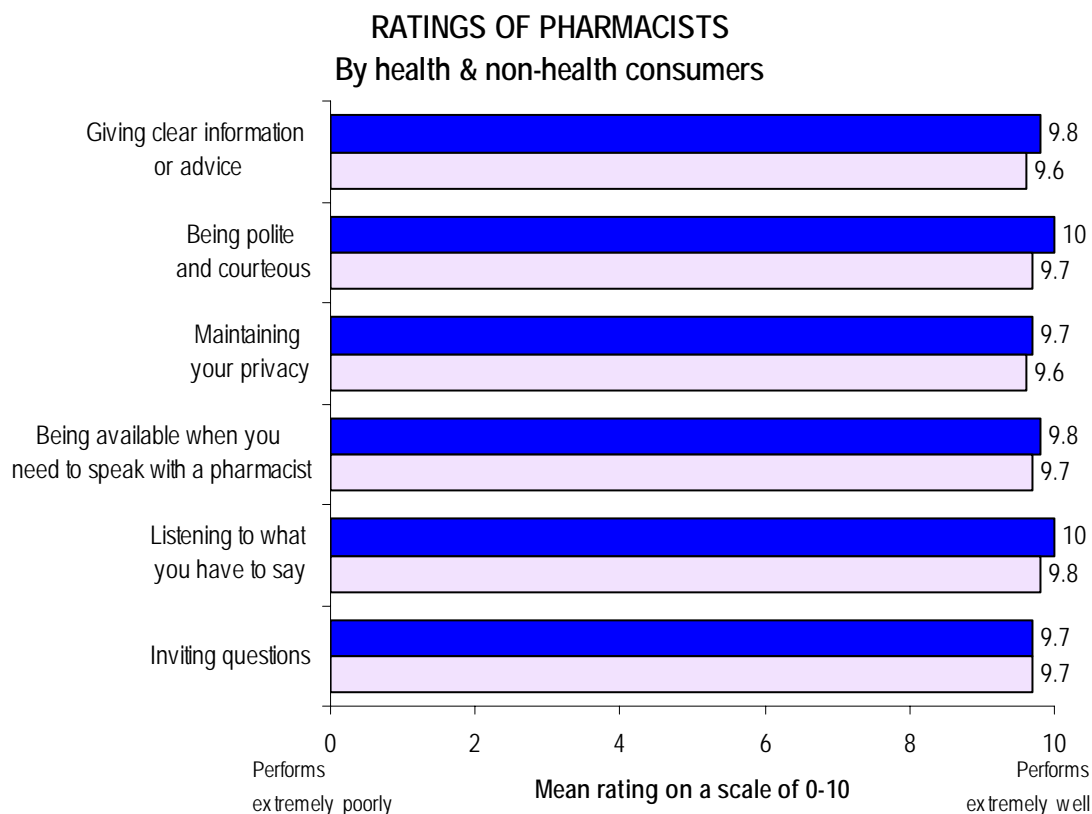


Fig 63. Exit survey: Performance ratings of pharmacists on six attributes (n=90)

Several segments rated pharmacists remarkably high (gave a rating of 10 out of 10) on one or more of the six attributes. Specifically:

Being polite and courteous, rated remarkably high by:

- Regional Northern Territory, Queensland (Cairns), South Australian and Western Australian respondents
- Metropolitan Northern Territory and Western Australian respondents
- 'Heavy' users of pharmacies
- Health consumers
- Respondents who are loyal to one pharmacy chain
- 35-44, 55-64 and 65+ year olds
- Pensioners (not on aged pension)

Giving clear information or advice, rated remarkably high by:

- Regional Queensland (Cairns) and Western Australian respondents

Maintaining your privacy, rated remarkably high by:

- Regional Northern Territory and Queensland (Townsville and Cairns) respondents
- Metropolitan Northern Territory and Western Australian respondents
- 15-24 and 55-64 year olds
- Respondents engaged in part-time employment or pensioners (not on aged pension)

Being available when you need to speak to a pharmacist, rated remarkably high by:

- Regional Northern Territory, Queensland (Cairns), Victorian and Western Australian respondents
- Metropolitan New South Wales, Northern Territory and Western Australian respondents
- Respondents who are loyal to one chain of pharmacies
- 15-24, 35-44 and 65+ year olds
- Respondents engaged in part-time employment

Listening to what you have to say, rated remarkably high by:

- Regional Northern Territory, Queensland (Townsville and Cairns), Victorian and Western Australian respondents
- Metropolitan Northern Territory and Western Australian respondents
- 'Heavy' users of pharmacies
- Health consumers
- Respondents who are loyal to one chain of pharmacies
- 35-44, 55-64 and 65+ year olds
- Pensioners (not on aged pension)

Inviting questions, rated remarkably high by:

- Regional Northern Territory, Queensland (Cairns), Victorian and Western Australian respondents
- 35-44 year olds
- Respondents engaged in part-time employment

6.3.3.13 Purchase Behaviour – while waiting for prescription

At the total sample level, 38% of respondents, while waiting for a script, sat and waited for it to be filled, whilst 24% browsed the shop while waiting. An additional 22% left and returned when it was convenient to them, and 15% left and returned closer to the time when pharmacy staff had said it would be ready.

Some interesting differences were noted between metropolitan and regional areas, which may represent differences in the products stocked in pharmacies in these regions. Respondents from regional areas were more likely to sit and wait for their script to be filled (40%, compared to 35% of metropolitan respondents), whereas metropolitan respondents were more likely to browse while waiting (29%, compared to 21% of regional respondents).

Regional respondents were also more likely to leave the pharmacy and come back, either at a time convenient to them, or closer to the specified waiting time, (39%, compared to 35% of metropolitan respondents). This may represent the wider variety of products offered in metropolitan areas compared to regional areas.

Respondents in the metropolitan area may have the ability to browse for a number of other products such as make-up, perfume, gifts and cards, hence their increased tendency to browse while waiting for scripts, whereas regional pharmacies tend to cater primarily to pharmaceutical needs such as prescription and non-prescription medications, thus regional pharmacy customers do not have the ample browsing opportunities available to metropolitan residents.

Regional respondents therefore, tend to be more likely to leave the pharmacy and come back at a later time, as there are few other points of interest within the pharmacy while waiting for scripts.

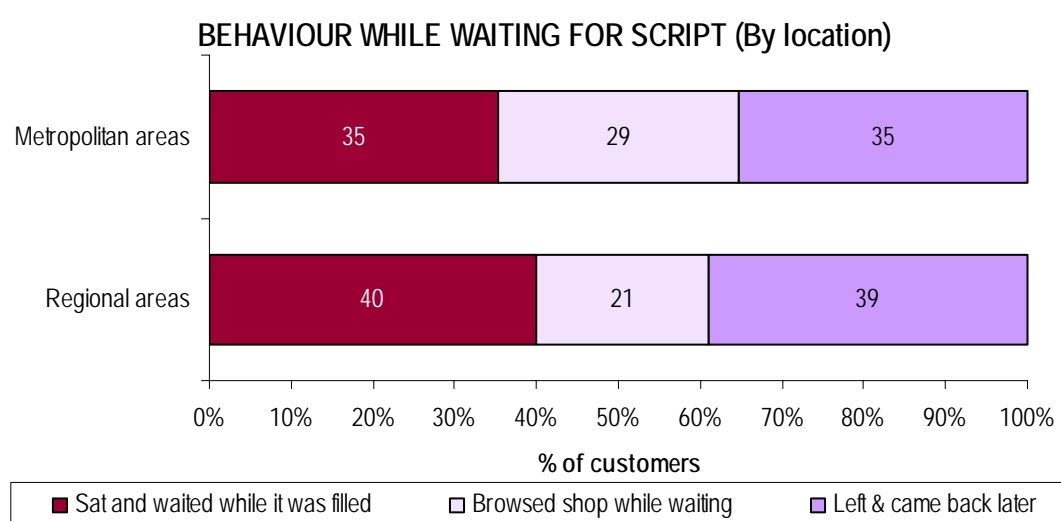


Fig 64. Exit survey: Behaviour while waiting for script (By location) (n=208)

Interestingly, the nation's repertoire buyers (respondents who shop at the pharmacy most convenient to them at the time) were no more likely to drop off a script and collect it at a later time. It might be expected that these respondents opt for pharmacies which are convenient to them as they have several other errands to run, thus drop scripts off while they attend to other business, however this was not the case. Respondents who shopped at several pharmacies within the one chain were more likely to browse while waiting for scripts (66%, compared to 17% of respondents who only ever went to one pharmacy, and 30% of repertoire buyers). It may be the case that respondents who are loyal to a chain of pharmacies prefer the product range at their chosen pharmacy chain, and thus enjoy browsing whilst waiting for their scripts.

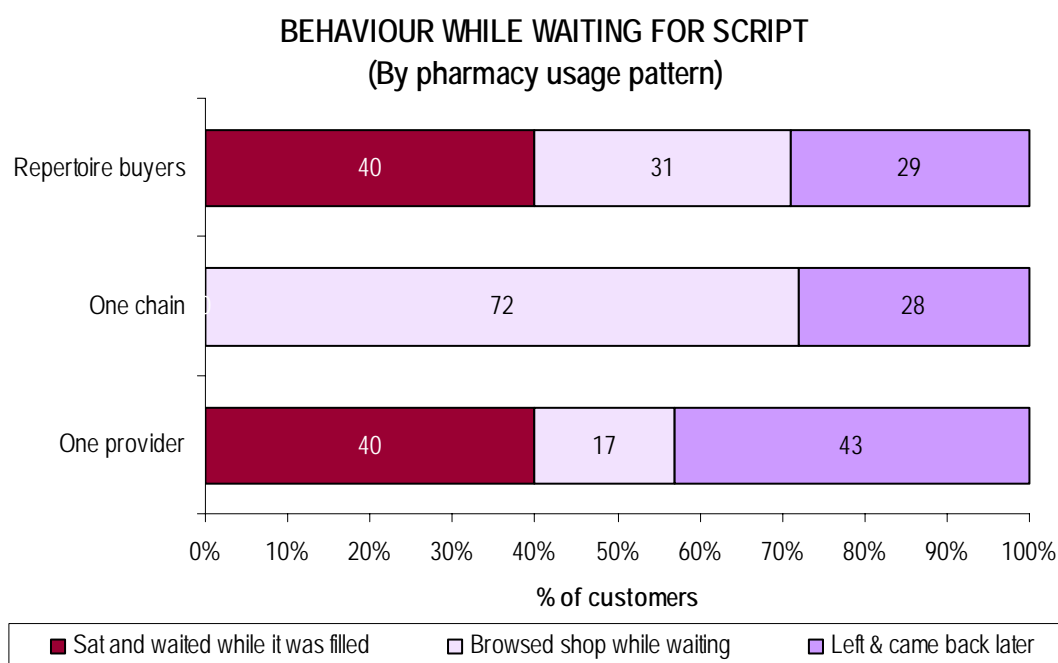


Fig 65. Exit survey: Behaviour while waiting for script (By pharmacy usage pattern) (n=206)

6.3.4 Needs

At the total sample, an outstanding 91% of respondents could not think of anything that could have been done to improve on their visit to the pharmacy they were questioned about. This high percentage was maintained throughout the majority of demographic groups and other variables included in analysis, such as contact with various staff members and behaviour while waiting for scripts. 93% of health consumers could not think of anything that could have been done to improve their visit, whilst 89% of non-health consumers agreed with this statement.

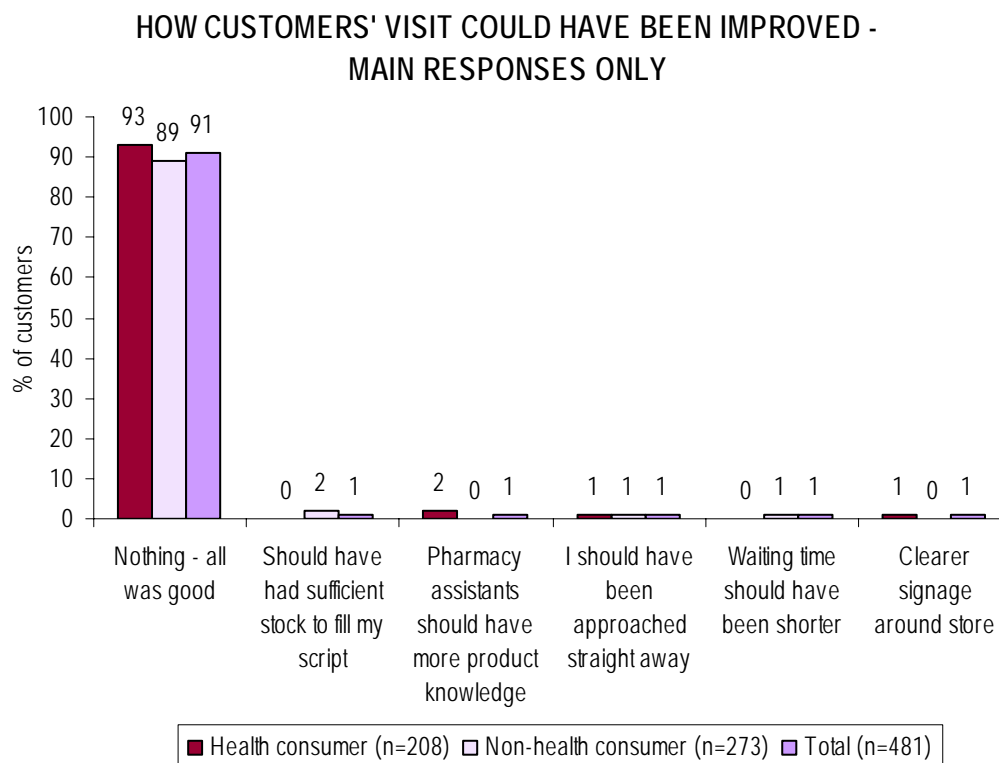


Fig 66. Exit survey: How customers' visits could have been improved, main responses only (n=481)

Given the high percentage of respondents indicating that nothing more could have been done to improve their visit, those respondents who did actually offer suggestions constituted a very small section of the total sample, where individual responses achieved only 1% mentioning rates in a sample of 481 (or 554 including respondents who gave a can't recall response to this question). As a result, responses to this question were analysed again by removing the responses of the 437 respondents who could not think of any ways that their visit could have been improved. This allowed the researchers to investigate needs among that small section of the total sample (n=44) who did in fact specify that something could have been done to improve their visit.

Suggestions mentioned by these 44 respondents included:

- Should have had sufficient stock to provide me with my medication/product, (n=6, 14%)
- Pharmacy assistants should have more product knowledge (n=5, 12%)
- When I enter the store, someone should have approached me straight away (n=5, 11%)
- Waiting time for scripts/service could have been shorter (n=5, 11%)
- Signage around store (to indicate where products are kept) should be clearer (n=3, 7%)
- Should have been more seating for those waiting for scripts (n=3, 7%)
- Should have been a private area to talk with the pharmacist (n=3, 6%)

SUGGESTIONS FOR IMPROVING CUSTOMERS' VISITS - MAIN RESPONSES ONLY (incl. multiple responses)

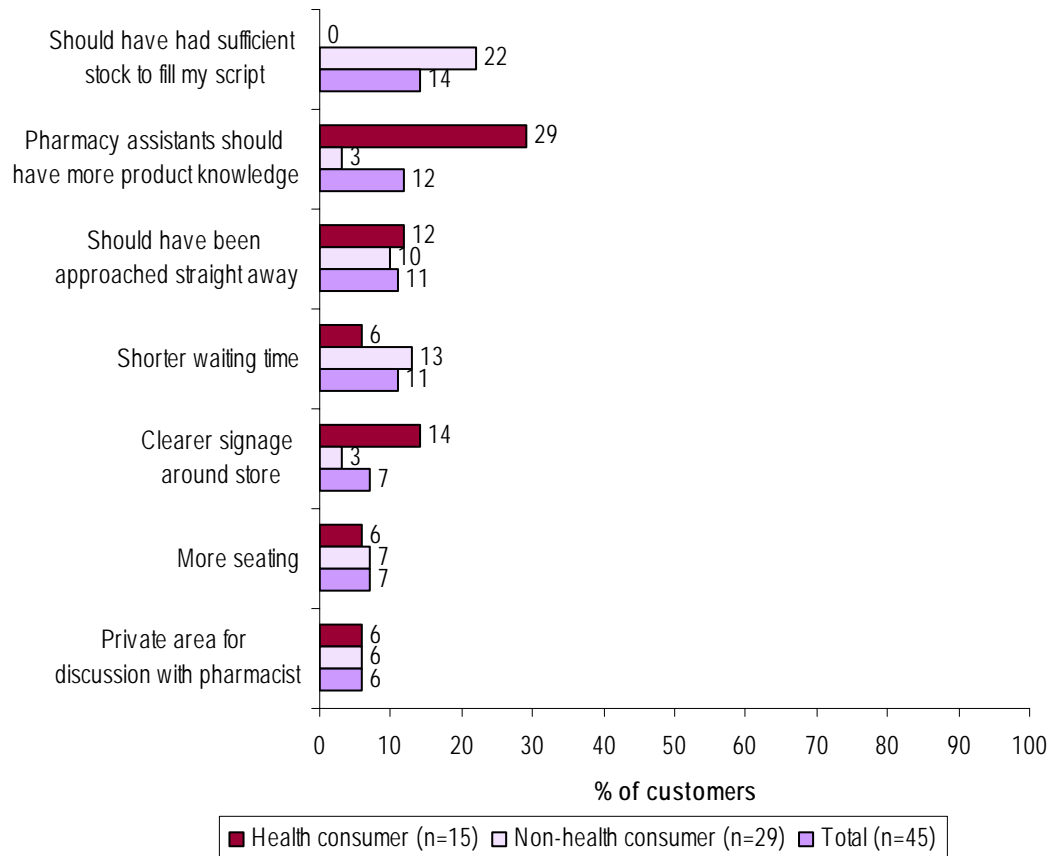


Fig 67. Exit survey: How customers' visits could have been improved, actual suggestions offered, main responses only (n=44)

6.4 Telephone survey of pharmacists

This module commenced on Wednesday 15 June and was completed on Wednesday 22 June. (n=506 unweighted)

6.4.1 Sampling

Telephone interviews, using CATI technology, were conducted with 507 pharmacists, who were selected by contacting a random selection of pharmacies from the Guild's membership list and speaking with the pharmacist on duty at the time. Arrangements were made, as required, to call back at a time of their choosing.

Only one pharmacist from each pharmacy was interviewed. Quotas were not set for State or region, nor any other distinguishing features, and data were not weighted by any factors.

6.4.2 Survey length

The actual survey length averaged at 11 minutes, somewhat longer than the anticipated 5 minute duration. This survey focused on how pharmacies currently or could involve consumers in evaluating and shaping service delivery and facilities.

6.4.3 Profile of respondents

The 507 pharmacists interviewed were distributed across all States and Territories, although New South Wales and Victoria accounted for half the sample (55%), as can be seen in the graph following. One respondent came from the Northern Territory, but as this comprises less than 0.5% of the sample it does not show in the graph.

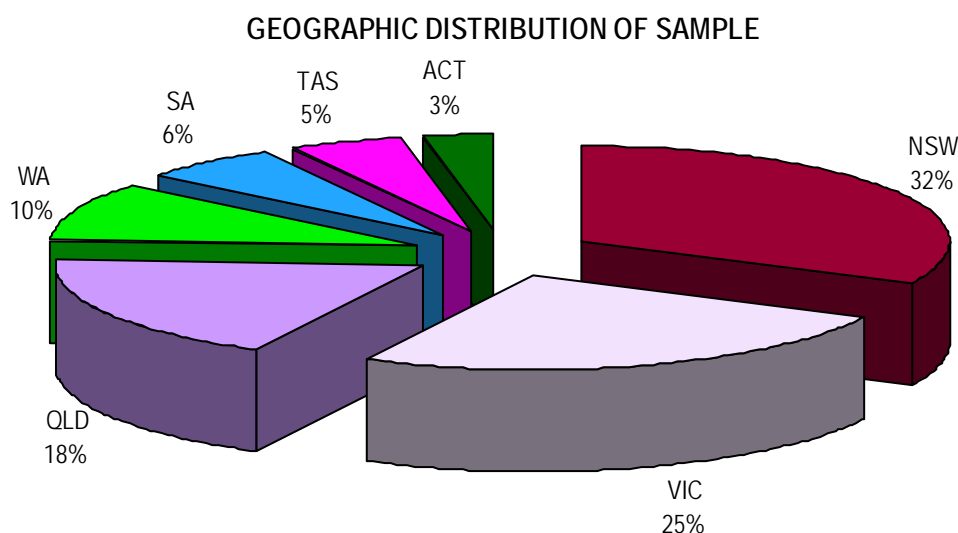


Fig 68. Pharmacists Survey: location of respondents by State or Territory (n=507)

Just under half the pharmacists sampled practice in a capital city (45%), one third in a regional or rural town (33%) and one fifth in a regional city (22%).

The next graph shows the overall distribution of independents versus group member pharmacies in the sample, and the variation in each region's sub-sample. Queensland shows the highest level of group membership, followed by South Australia.

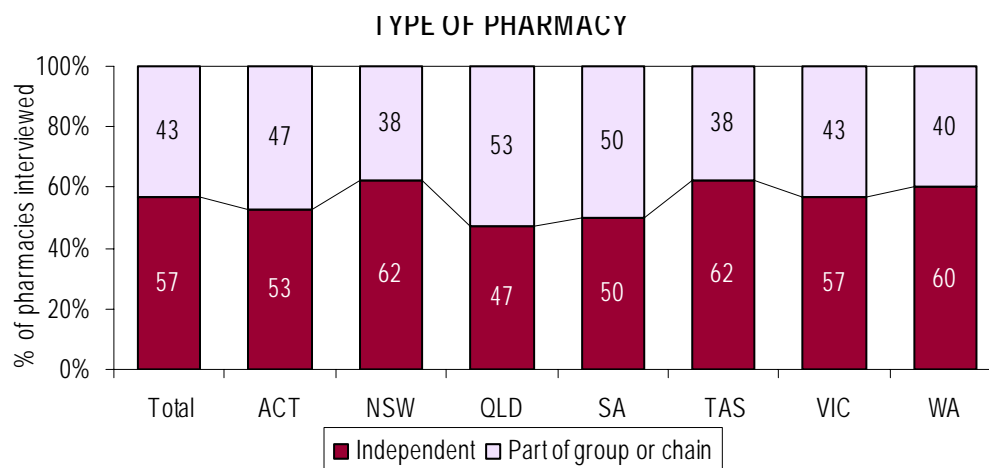


Fig 69. Pharmacists Survey: self-reported incidence of respondent pharmacies being independent or part of a group or chain (n=507).

Bearing in mind that respondents were the pharmacists on duty or, if more than one were available, the senior pharmacist on duty at the time, it emerges that half the interviewees were owners, with managers and regular staff comprising just under one quarter each; just a small proportion of respondents were relieving staff. With close to three quarters of the sample being owners or managers, the data capture during this survey should accurately reflect pharmacy practices regarding customer involvement.

As the next graph clearly reveals, the incidence of the owner being the pharmacist on duty was significantly higher at the independent pharmacies.

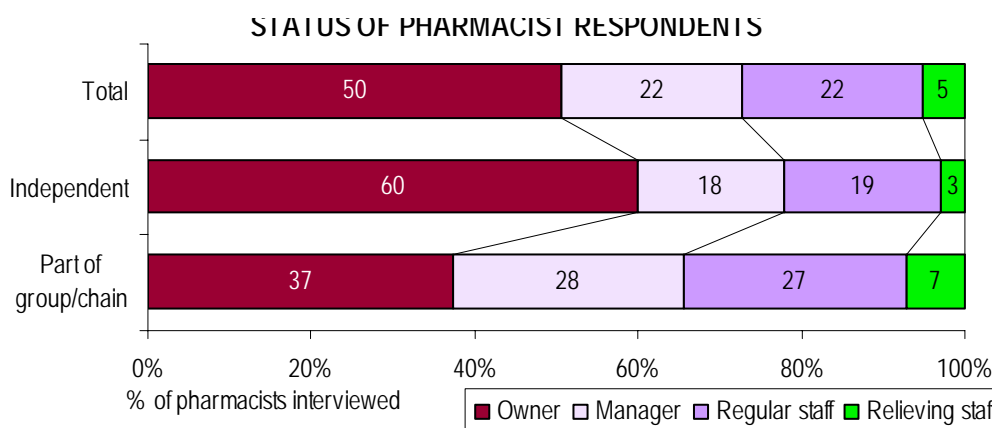


Fig 70. Pharmacists Survey: Employment status of respondent pharmacists, segmented by position of pharmacy as independent or part of a group (n=507).

Eight in ten respondents had been working in community pharmacy for more than five years, including nearly half (44%) who had worked in this field more than twenty years. However, the distribution was more even when respondents were asked how long they had worked in the pharmacy in which they were interviewed, with fewer than half being there more than five years.

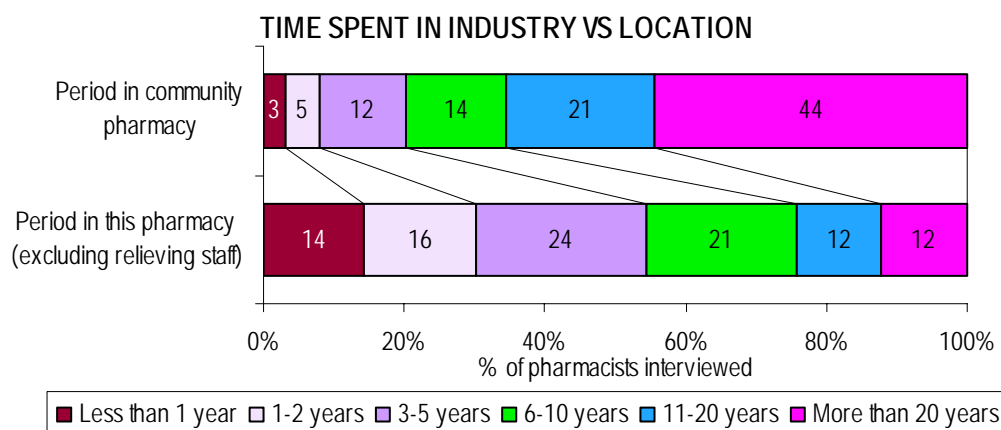


Fig 71. Pharmacists Survey: Period spent in community pharmacy (n=507) and at the pharmacy in which they were interviewed (n=481 regular staff or management only).

One third of the pharmacists indicated they had received formal management training (33%). Of these, one third of them received management training through university, college or TAFE and one third through their group's internal training. Equating these and other training sources as percentages of the total sample shows the following distribution:

Type of management training (includes multiple responses)	% of total sample	% of respondents have received management training
No management training	67	-
Uni/college/TAFE	12	37
Group internal training	11	34
Diploma	3	9
MBA	2	7
Aust Inst of Pharmacy Management	2	7
FMRC	2	6
Course(s) arranged by Pharmacy Guild	1	3

Table 18: Pharmacists Survey: sample distribution of training sources

13% of the pharmacists interviewed have English as a second language, with Cantonese (34% of ESL respondents), Vietnamese (22%) and Mandarin (13%) most often mentioned.

6.4.4 Current community involvement practices

6.4.4.1 Consumer input in evaluating services and facilities

Seven in ten pharmacists (69%) indicated that they currently invite customers to give feedback or evaluation of the facilities or services provided. This was highest in Victoria and WA and notably below average in Queensland.

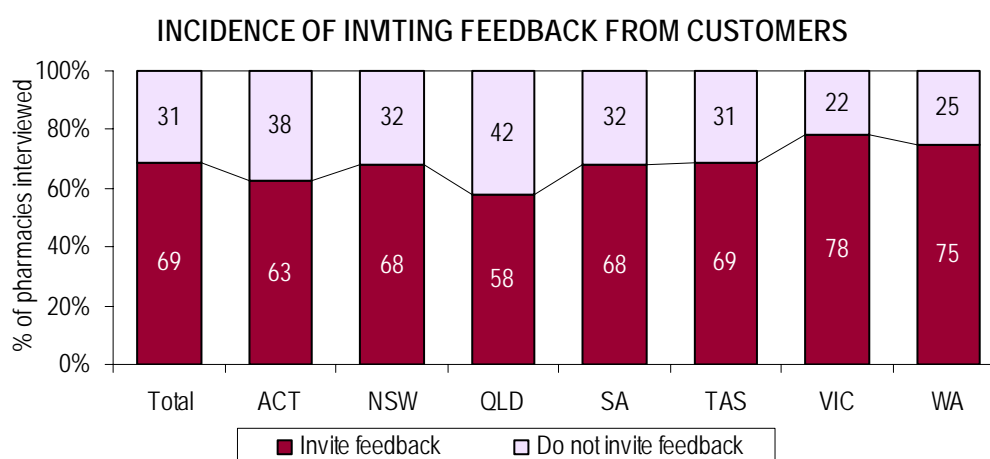


Fig 72. Pharmacists Survey: Incidence of pharmacies inviting customers to give feedback or evaluate facilities or services (n=507).

The most common form of consumer input was obtained from discussions with regular customers (69%), followed by consumer feedback forms (31%) and regular surveys (17%). It should be noted that this latter proportion encompassed telephone, face to face and self completion surveys. All three methods were used by a significantly higher proportion of independent pharmacies.

Discussions with regular customers provide a very biased reflection of service needs, given the skew toward frequent visitors. As such, this method would cater only for the 54% of loyal pharmacy users and fail to capture the needs and preferences of the remaining 46% of customers who use a variety of pharmacists. While this base of respondents visit the pharmacy less frequently and most definitely contribute less to the revenue generation of pharmacists generally, this group should not be neglected in developing better health outcomes.

For this reason, it is recommended that pharmacists be educated on the limitations and merits of different consumer feedback methodologies. Further, both independent and group pharmacies should be encouraged to employ more 'rounded' research techniques.

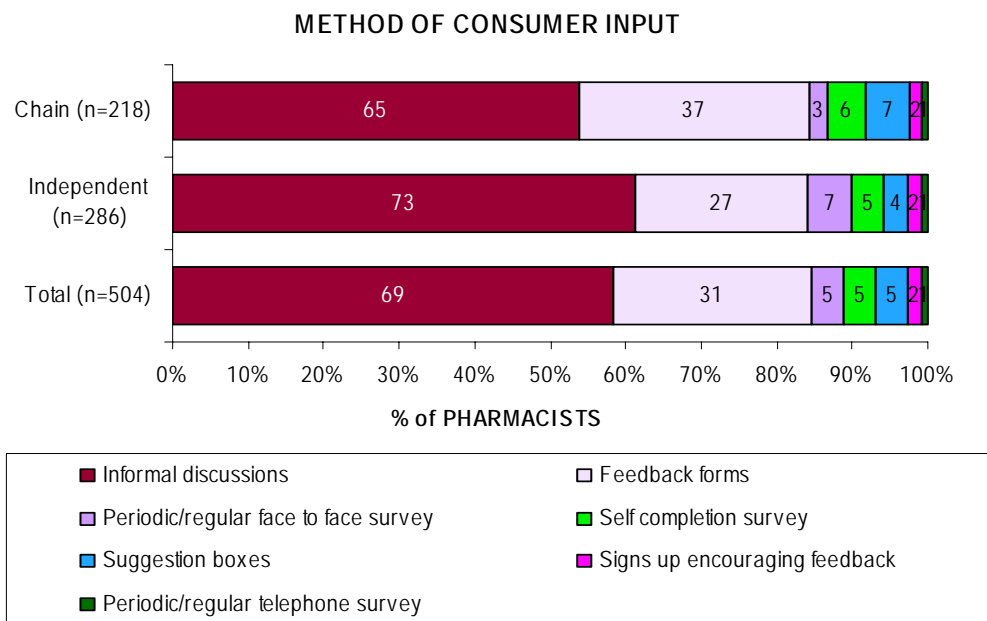


Fig 73. Pharmacist Survey: Current method of consumer input, Base: those who get feedback on services, n=349

Those respondents who indicated that they conducted regular surveys were asked how frequently they captured data from their customer base. Approximately, one third of respondents (34%) suggested that they conduct their surveys biannually, or rather, about twice a year.

For respondents who indicated that they gain customer feedback using surveys, one third (34%) are doing this about twice a year, whilst an additional third (31%) are doing so annually. A further 31% claimed to carry out their surveys on an annual basis.

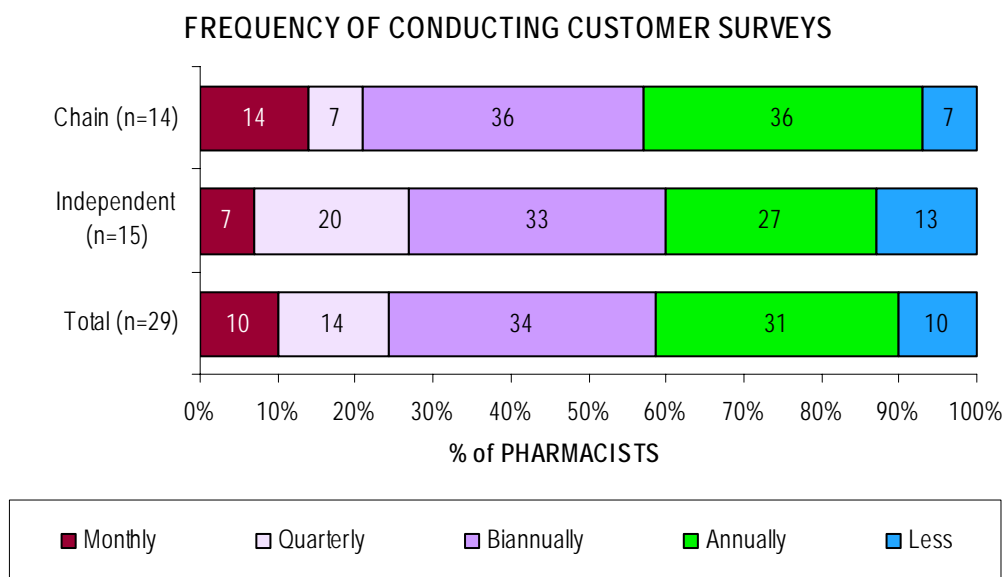


Fig 74. Pharmacist Survey: Frequency of customer surveys, Base: those who conduct surveys, n=29

6.4.4.2 Consumer input in developing services and facilities

Pharmacists were then asked whether they involved customer feedback in determining which services and facilities should be included within their offering. A total of 40% of the pharmacists surveyed indicated that they involved their customers in decision making regarding the facilities and services that could be provided within the pharmacy.

So whilst 69% of pharmacists were obtaining feedback from customers, a significantly lower proportion actually used this feedback or involved the customer when developing their service structure (40%).

PROPORTION OF CUSTOMERS INVOLVED IN SERVICE/FACILITY
DEVELOPMENT

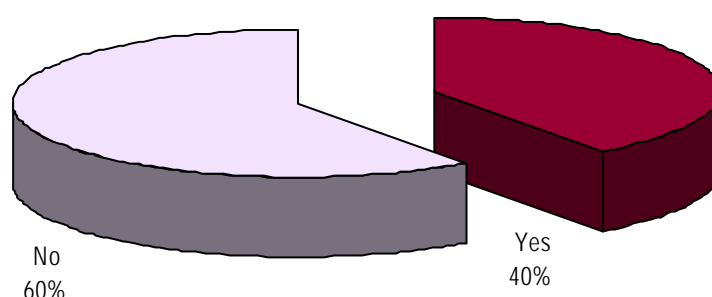


Fig 75. Pharmacist Survey: Proportion of customers involved in service/facilities, Total Sample, n=498

Those who claimed to use consumer input in developing services were asked to indicate how consumer feedback was obtained for this purpose. The majority of feedback means were proactive (93%), rather than reactive. As such, most feedback was obtained by the pharmacist actively seeking information from the customer, rather than awaiting feedback.

More specifically, the majority of this consultation took the form of informal discussions with customers (69%), followed by the provision of feedback forms (31%).

There were no significant differences between independent pharmacies and those that belonged to a chain.

METHOD OF CONSUMER INVOLVEMENT RE SERVICES

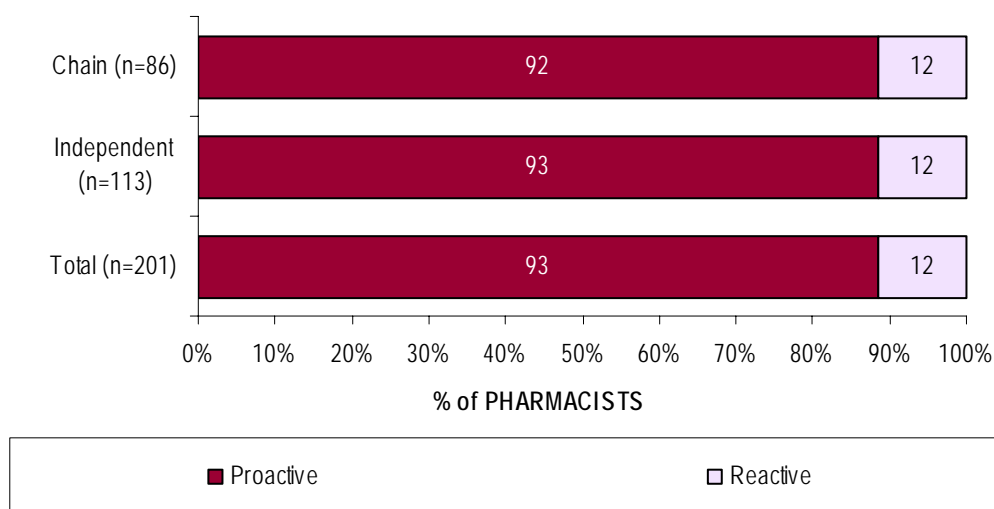


Fig 76. Pharmacist Survey: Method of consumer involvement in reviewing services: Base: those who involve customers in determining services and facilities, n=199

The following chart illustrates the frequency with which reviews used in the development of services took place. On average, approximately half of the reviews took place twice a year (50%), with a further 42% claiming to obtain information for this purpose annually. A significantly higher proportion of chain pharmacies claimed to conduct research twice a year (75%).

FREQUENCY OF INPUT INTO PREFERRED SERVICES

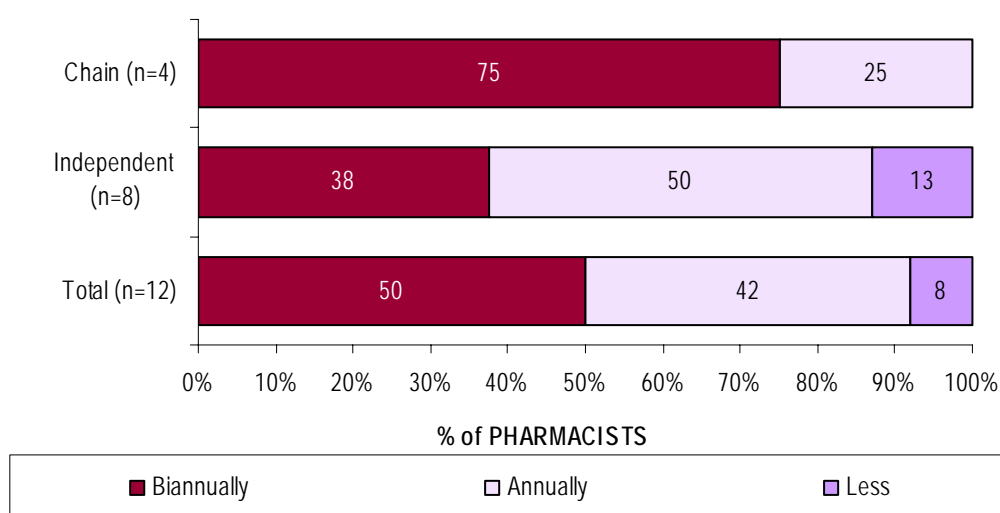


Fig 77. Pharmacist Survey: Frequency of input into services, Base: those involving customers, n=199

6.4.5 Perceived Utility of Customer Feedback

- The vast majority of pharmacists (90%) perceived feedback from customers to be useful in shaping the services or facilities provided at the pharmacy. There were no significant differences noted between independent and chain pharmacies for this question.
- This is a key finding, suggesting that those who do not currently carry out any means of capturing consumer feedback and involving the data in pharmacy level decision making are not opposed to doing so. This suggests that there are no barriers to adopting this behaviour if, and when encouraged to do so.

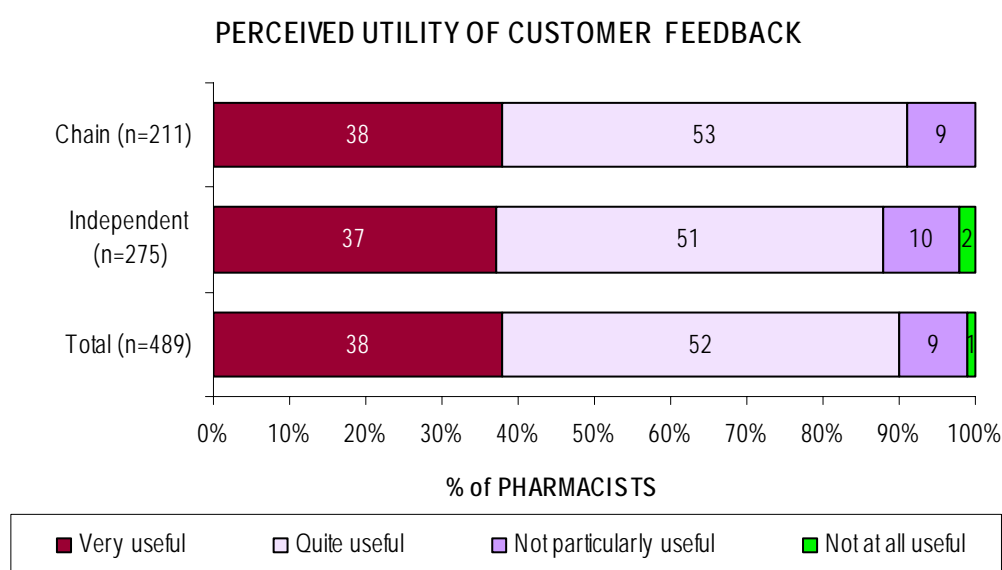


Fig 78. Pharmacist Survey: Perceived usefulness of customer feedback, Base: Total Sample, n=507

The four key reasons presented by pharmacists for perceiving customer feedback to be useful included the ability to better manage demand (64%), better understand customer needs (50%), know what to tell customers (14%) and obtain guidance in improving practices (7%). A significantly higher proportion of pharmacists in South Australia perceived that customers were the best source of information regarding how to meet their needs (74% compared to the 50% average).

REASONS FOR FINDING CUSTOMER FEEDBACK USEFUL - TOP RESPONSES ONLY

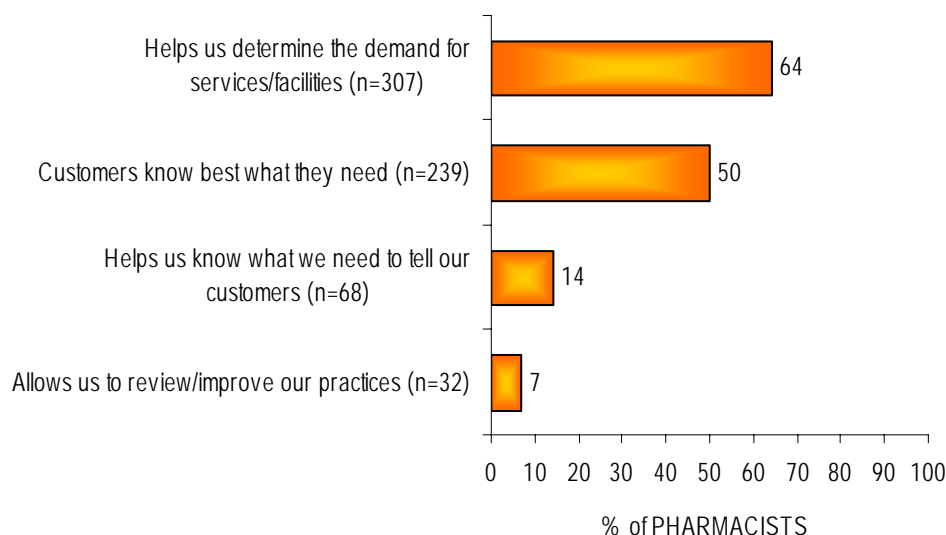


Fig 79. Pharmacist Survey: Reasons for usefulness rating, Total Sample, n=507

6.4.6 Perceived best means of obtaining customer feedback

Interestingly, the methods most commonly employed to obtain customer feedback were also most commonly purported to be the best means of discovering information regarding consumers in the future by individual pharmacies, with the top four methods being informal discussions (81%), suggestion boxes (74%), feedback forms (71%) and occasional surveys (70%).

Again, the high proportion perceiving that informal discussions, suggestion boxes and feedback forms are acceptable suggests that there is a need to educate pharmacists generally about the approaches required to yield valid and reliable feedback. As mentioned previously, informal chats are skewed toward frequent visitors, suggestion boxes and feedback forms are impacted by self selection biases and the likelihood of extreme respondents (i.e. those who are extremely positive or extremely negative toward the offering).

At the same time, the high proportion of pharmacists citing surveys at the total sample level is a promising result (70%).

CUSTOMER FEEDBACK SURVEY METHODS PERCEIVED TO WORK IN PHARMACY

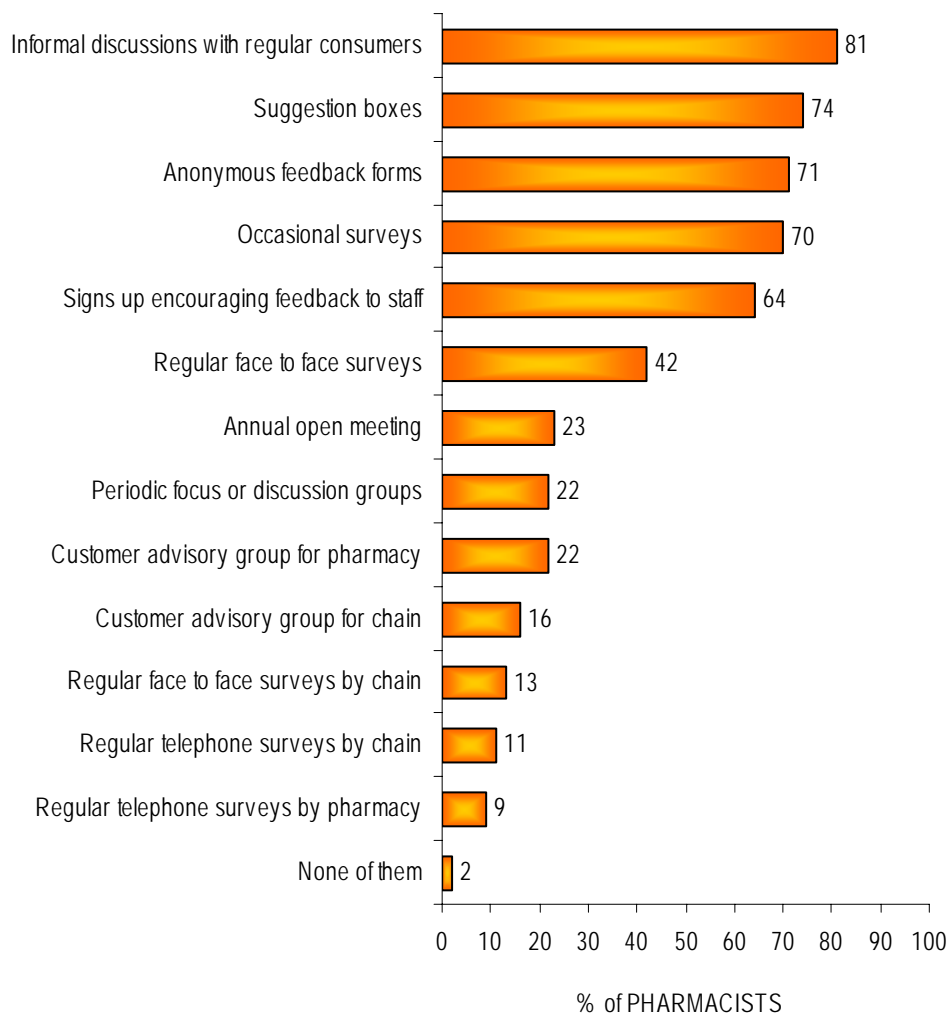


Fig 80. Pharmacist Survey: Perceived customer feedback methods purported to work well, Total Sample, n=507

6.4.7 Customer Involvement in Policy

61% of the pharmacists' surveyed believed customers should be involved in forming pharmacy policy and practices at an individual pharmacy level; however this figure dropped to 26% when the same question was asked regarding customer involvement at State level. 18% felt that customers should have no involvement at all in policy and practice development.

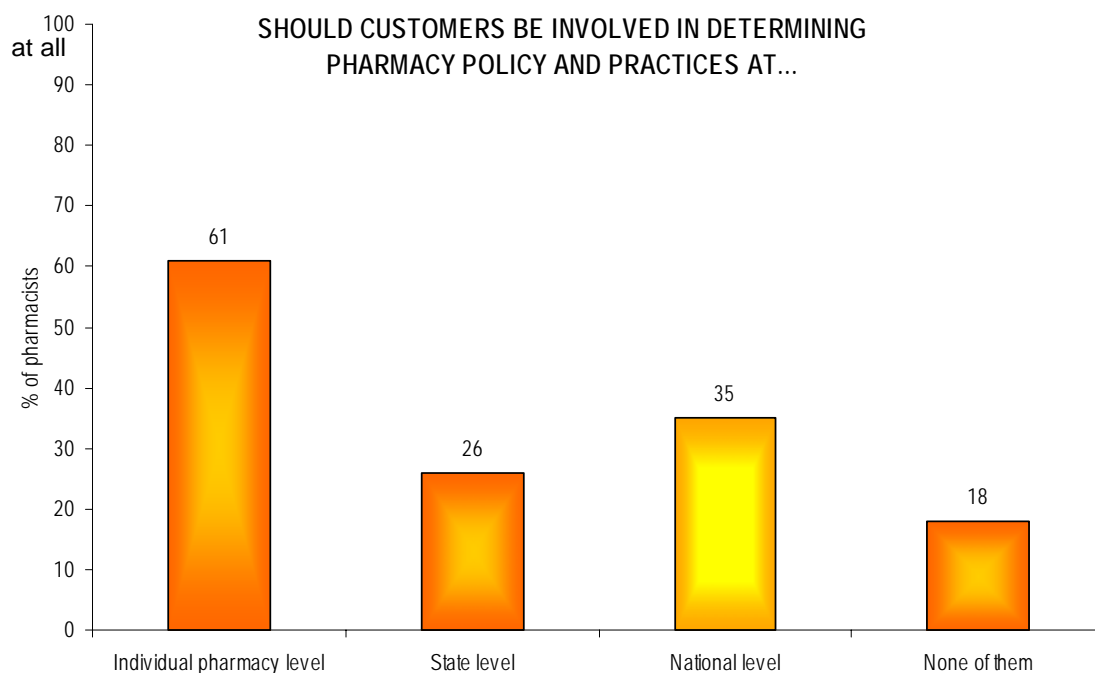


Fig 81. Pharmacists Survey: Incidence of pharmacists considering that customer should be involved in determining policy and practices (n=504)

6.4.8 Pharmacist Perceptions

- Pharmacists were asked to rate their agreement with nine statements relating to community involvement with pharmacies, and the requirements that should be in place for pharmacies generally. Pharmacists recorded moderate levels of agreement with all statements, as shown in the following table.
- While most of the scores were moderate within this battery of statements, there were several that stood out with higher levels of agreement. These included the need to establish of a Consumer Advisory Group (either state or national) for input on policy, quality and service development issues, and the benefit that pharmacies would enjoy if they had ongoing processes to involve their customers in service improvement and development.
- Pharmacists appear to recognise the need to communicate with their customers to achieve better outcomes, but require guidance from the Guild or Society at national level or State PGoA or PSA in order to successfully achieve it.

CUSTOMER FEEDBACK SURVEY METHODS PERCEIVED TO WORK IN PHARMACY

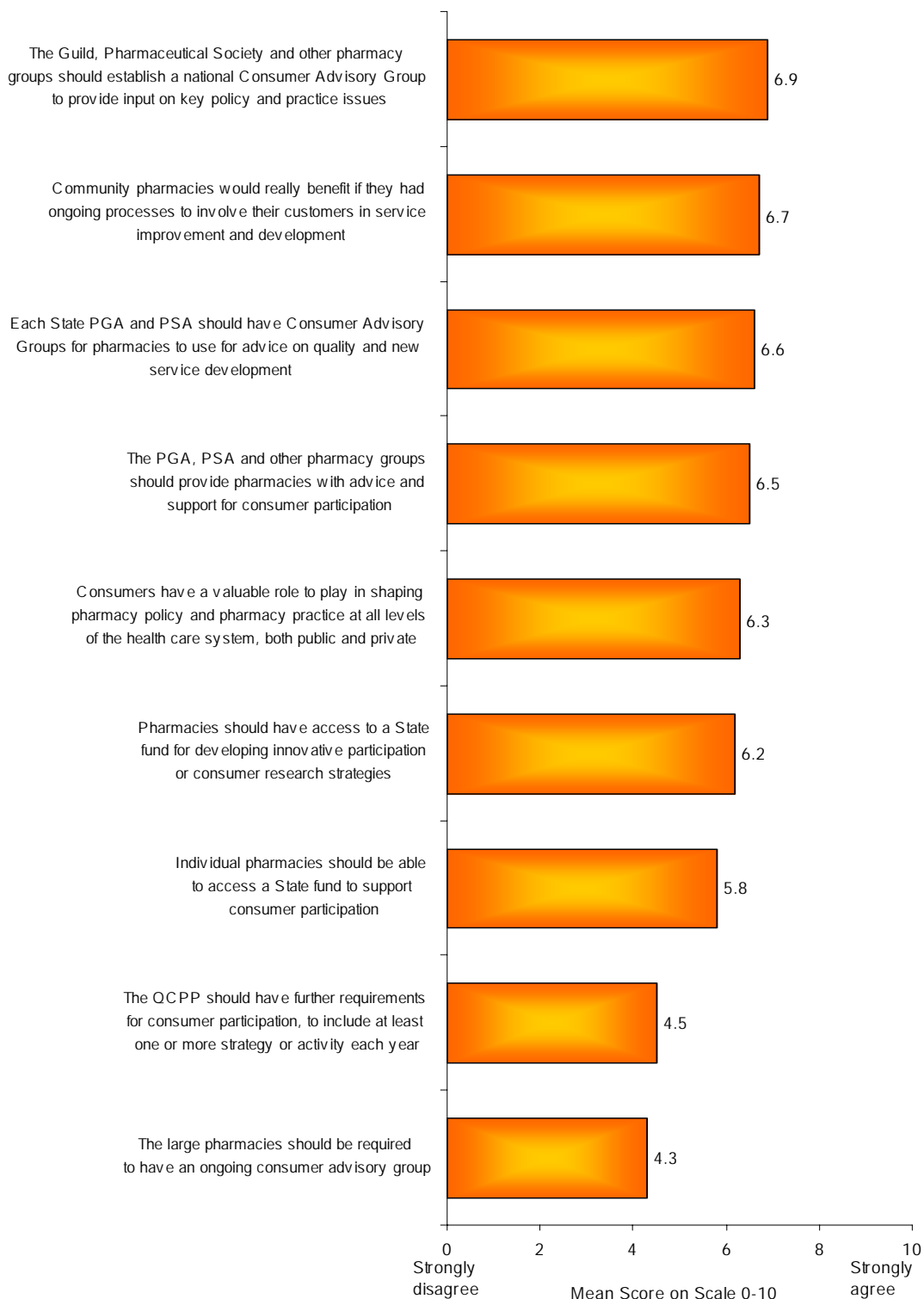


Fig 82. Pharmacists Survey: Rated agreements with listed statements, on a scale of 0=strongly disagree to 10=strongly agree. (n=504)

6.4.9 Other Comments

- One quarter of the pharmacists interviewed (27%) chose to make other comments regarding community involvement at pharmacies. The top three responses were:
 - The community needs more education about the role of pharmacies, 4%
 - The community should be involved in gathering information about pharmacies, but not in the decision making.
 - Any research would need to take into account that every pharmacy has different needs, customers and challenges.
- One third (33%) of the pharmacists surveyed had undergone some type of management training. This training took the form of:
 - Uni/college/TAFE certificate, 37%
 - Group/chain internal training, 34%
- The majority of pharmacists surveyed (87%) spoke English as their first language.

6.5 Comparative analysis: Results drawn from General Public and Exit survey

Given that the component of this research that involved pharmacists focused on quite different issues to those explored in the General Public and Exit surveys, comparative analysis was conducted only between results from the General Public and Exit surveys. Please refer to the individual section of results concerning pharmacists for a comprehensive analysis of respondent opinions on community involvement in pharmacies.

6.5.1 General perceptions of community pharmacy

The majority of Australian pharmacy users were receiving both prescription and non-prescription medication either on the day that they lodged their script, or visited the pharmacy to purchase non-prescription medication, with 96% of respondents in the General Public survey indicating that this happens frequently. A somewhat lower percentage of respondents from the Exit survey indicated that this happened (87%), however it should be noted that this is still a very high proportion of the total sample.

Similarly, a notably lower percentage of respondents in the Exit survey (19%) indicated that they spoke to the pharmacist when purchasing prescription medicines, in comparison to respondents in the General Public survey (45% indicated that this happened frequently). Respondents from the General Public survey were also more inclined to indicate that they frequently received written instructions on how to use the medication they were purchasing (28% indicated that this happens frequently, compared to 5% of Exit respondents saying that this happened during their visit).

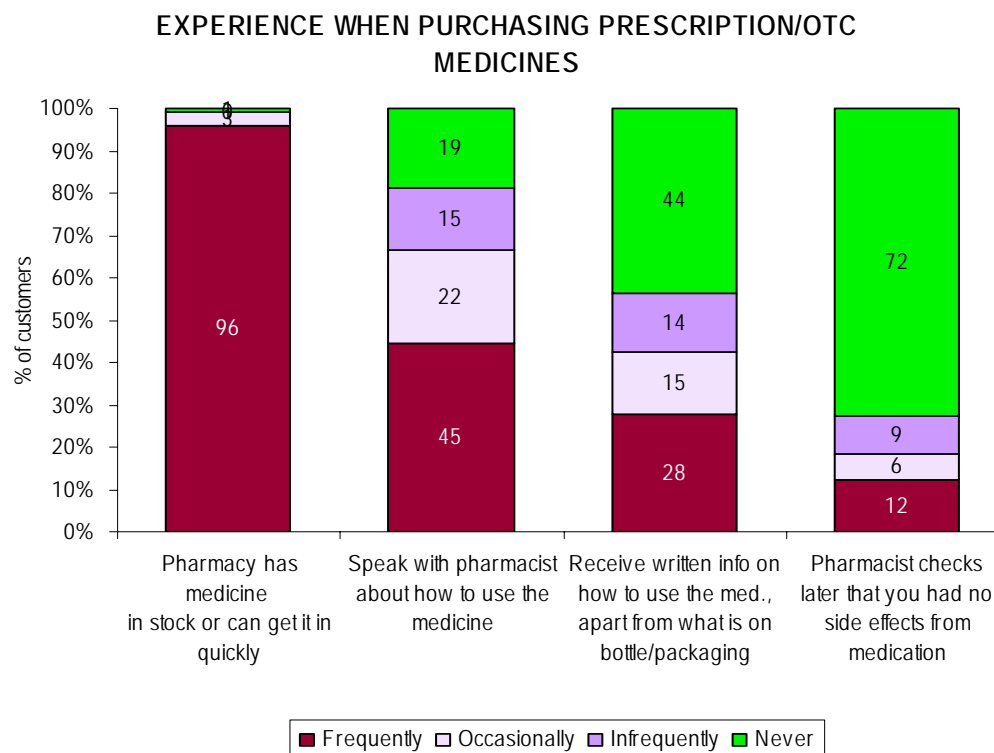


Fig 83. General Public: Experience when purchasing prescription/OTC medications (n=1874)

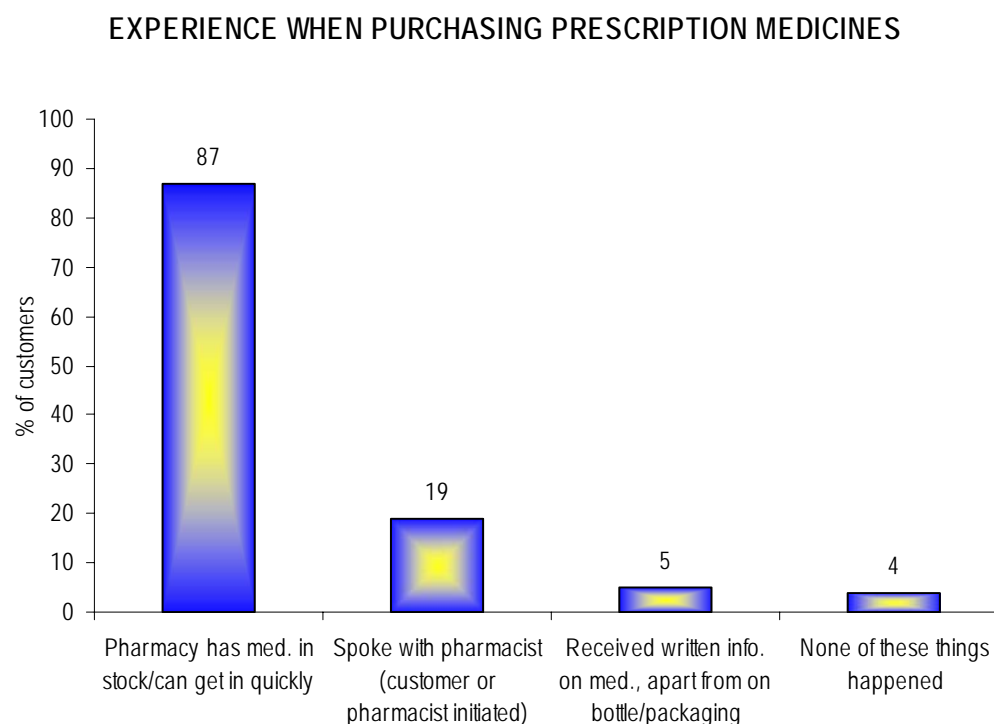


Fig 84. Exit survey: Experience when purchasing prescription medicines (n=256)

Whilst these differences between the General Public and Exit survey samples may, at first glance, appear an issue of concern, it is important to take into consideration the number of pharmacy experiences the two different samples are basing their responses on. Those who participated in the General Public survey were drawing on a number of experiences at pharmacies, whereas respondents in the Exit survey were asked to respond to the questionnaire based on their experience at the pharmacy immediately following the one encounter. As such, variables between the pharmacies involved in the Exit survey, such as how busy the store was on the day of interviewing, how many staff were on duty, whether the pharmacist was present or on break, and so on, should be taken into consideration when evaluating these results.

Pleasingly, services that pharmacy users have reported as happening frequently, such as receiving their medication at the time they need it or within a short time period thereafter, were identified by respondents in the General Public survey as being a real need for them. This gives some indication that pharmacies are largely meeting the immediate needs of their customers and providing a quality health care service.

The frequency with which a pharmacy customer received advice that the non-prescription product they were purchasing was appropriate for their needs was not measured in this section of the research, however this was identified as a real need by three-quarters (74%) of the General Public sample. Given that 45% of respondents in the General Public and 19% in the Exit survey indicated that they spoke to the pharmacist about how to use the medicine, it has been assumed that some, or all, of this conversation included confirmation that the medication respondents were purchasing was right form.

Services that were less likely to be provided frequently, such as the pharmacist checking that no side effects were experienced, or the receiving of written information on how to use medication, were not identified as a real need for most. Approximately 46% of respondents in the General Public survey indicated that they needed to receive written instructions from their pharmacist on how to use medication, aside from what is on the bottle or packaging, whilst 33% claimed to need the pharmacist to check with them later that they did not have any side effects from the prescribed medication.

However, when observing the results for services that were actually provided in pharmacies (in the exit survey), several failed to meet the level of need registered by pharmacy users in the General Public survey. For example, whilst 33% of respondents from this sample indicated that they needed the pharmacist to check with them later that they did not have any side effects from their medication, just 13% of respondents indicated that this happened frequently (given the methodology of the Exit survey, measuring frequency for this service was not possible). Furthermore, whilst 46% of respondents in the General Public survey indicated that they needed to receive printed information on how to use the medication, apart from what is on the bottle or packaging, only 28% of the General Public and 7% of the Exit survey sample reported this happening. The graph below illustrates not only these discrepancies, but

also the area where pharmacies appear to be performing extremely well, which is being able to provide medication to respondents at the time of their visit, or within a short period afterwards.

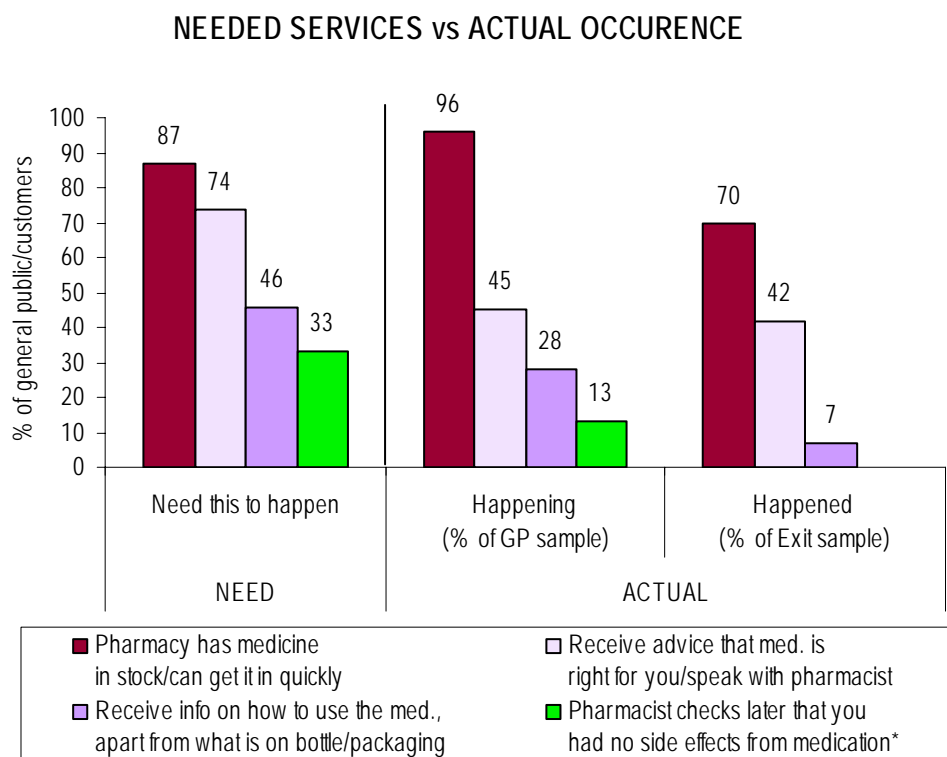


Fig 85. General Public & Exit survey: Needed services versus Actual occurrence (General Public needs n=1991, actual occurrence n=1874; Exit survey, actual occurrence n=131) *Question not asked of Exit survey respondents

6.5.2 Privacy

Ratings provided by respondents in relation to the level of privacy maintained by pharmacy staff were extremely favourable in both the exit interviews and general public survey. Within the general public survey, pharmacists were rated 7.8 out of 10 for their ability to maintain privacy during conversations with customers, and pharmacy assistants 8.0 out of 10. For the 559 respondents interviewed as part of the exit interview component, pharmacists were given a rating of 7.8 for their ability to maintain privacy, and their assistants a rating of 8.0.

The graph below illustrates the mean scores given to pharmacists and pharmacy assistants with regard to their level of ability of maintaining customer privacy during interactions with customers.

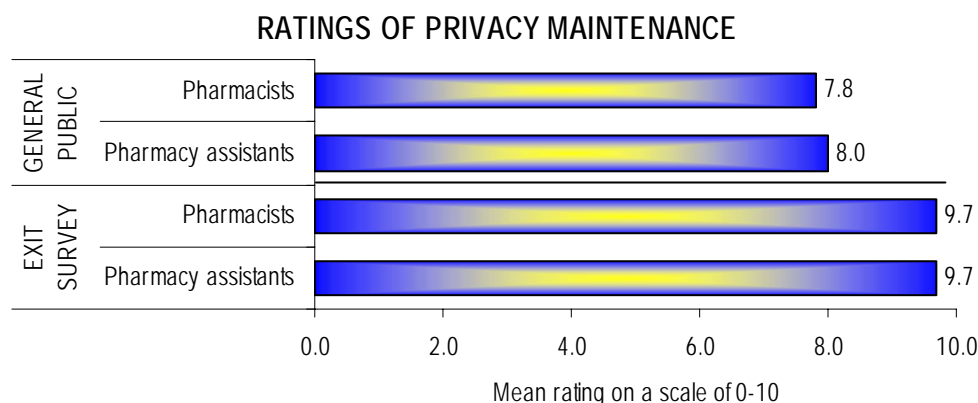


Fig 86. General public and Exit survey: Ratings of performance in privacy maintenance, on a scale where 0=performs extremely poorly and 10=performs extremely well. (General public n=1996; Exit survey n=464)

Customers who participated in the exit interview component answered an additional question pertaining to privacy. These customers were asked to again rate the level to which they felt their privacy had been maintained, but this time using a 5-point scale with written descriptors for each point (e.g. 1. very well, 2. quite well 3. neither well nor poorly, 4. quite poorly, and 5. very poorly). In alignment with the pleasing results obtained for numeric ratings of privacy maintenance, 94% of the total sample indicated that their privacy had been maintained to a standard they described as either very or quite well. The graph below illustrates these results.

HOW WELL OR OTHERWISE PRIVACY WAS MAINTAINED

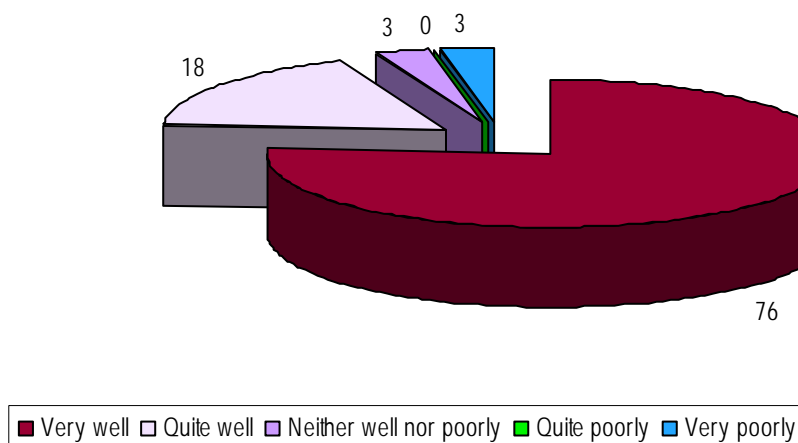


Fig 87. Exit survey: How well or otherwise privacy was maintained (n=92)

These findings indicate a very high level of consumer satisfaction with pharmacy staff's ability to maintain privacy during communication with customers. Furthermore, respondents from both the general public telephone, and exit surveys, were provided with the opportunity to comment on pharmacy services available to them, or in the

case of respondents from the exit survey, how their visit could have been improved. In these 'catch all' opportunities for respondents to raise any concerns, privacy was rarely mentioned. From the General Public survey, just 3% distinctly expressed a desire for a more private area to discuss issues with their pharmacist within the pharmacy, and a miniscule 1% communicated this in the Exit interviews.

Clearly, privacy is not a contentious issue for Australian pharmacy users. The overwhelming majority tended to feel they were provided with an adequately private environment in which to discuss their health issues with both pharmacists and pharmacy assistants.

6.5.3 Waiting time

Customer perceptions of waiting time, and their opinion on what is an acceptable level of waiting time, were explored in the current research. Given that the quantitative stage of this research dealing with pharmacy customers encompassed two components - General Public and the Exit interviewing- an extremely comprehensive picture of consumers' opinions on this topic was able to be drawn.

Within the General Public survey, which was lengthier than the Exit survey, interviewers were able to collect extensive data which provided a broad level perspective on waiting times. Respondents from the General Public survey were presented with three possible scenarios that might happen when waiting for prescription medicine - waiting less than 10, 20 or 30 minutes for prescription medicine. They were then asked to indicate how often they found themselves waiting these lengths of time at pharmacies. The following chart displays the frequency with which respondents indicated these three situations occurred. As can be seen from the graph, the majority of respondents tend to receive their medication within 10-20 minutes of lodging their script (71% indicating they wait less than 20 minutes, and by questionnaire structure, greater than 10 minutes).

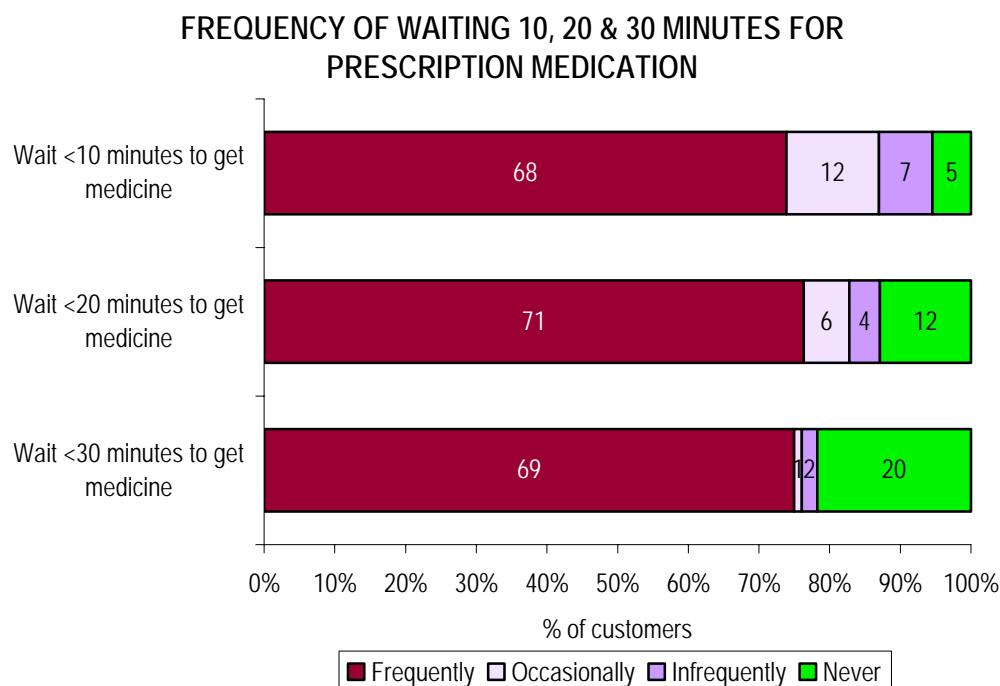


Fig 88. General Public survey: Frequency of waiting 10, 20 or 30 minutes for prescription medication (n=1876)

These findings were generally confirmed by results from the Exit survey, which, among its many advantages, allowed collation of 'top of mind' data. Respondents to the Exit survey were approached as they left the pharmacy, thus ensuring that the responses given were likely to be highly accurate and aligned with respondents' actual experience within the pharmacy. 80% of respondents indicated that they waited for 10 minutes or less for their prescription medicine, whilst 13% indicated that they had to wait between 10-14 minutes.

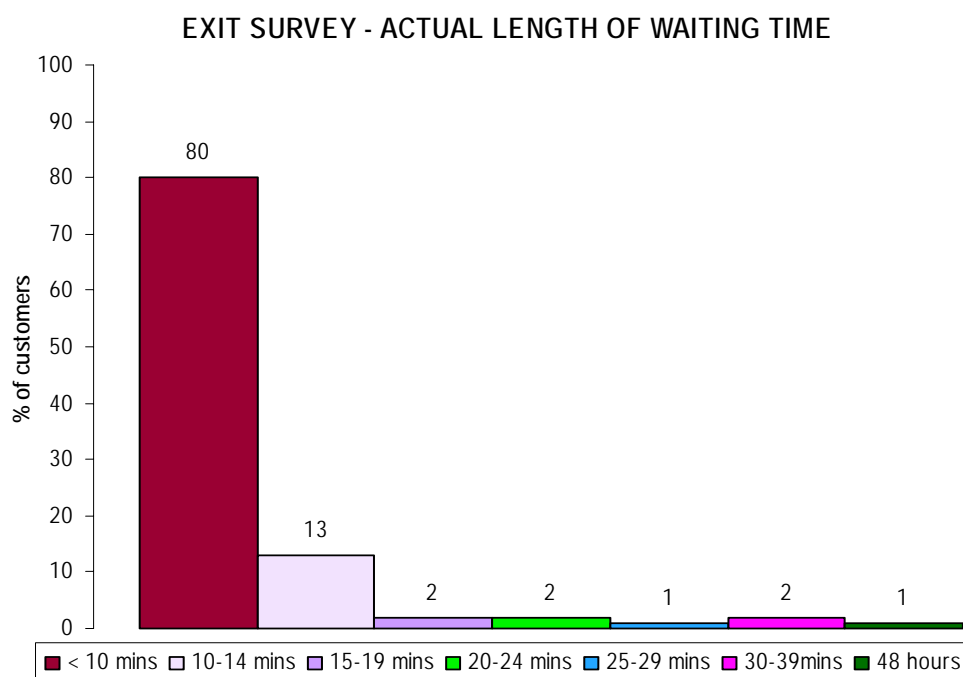


Fig 89. Exit survey: Actual length of wait time (n=155)

Respondents in the Exit survey were also asked about their perception of how reasonable this waiting time was to them, and results were extremely favourable, with the total sample giving an average rating of 9.3 out of 10, as the graph below illustrates.

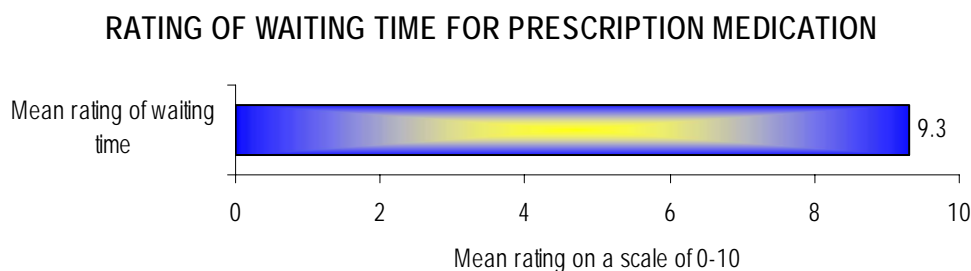


Fig 90. Exit survey: Rating of waiting time for prescription medications (n=159)

Generally, Australian pharmacy users appeared to be relatively satisfied with waiting times for prescription medications, and this makes sense, given that the majority of consumers are waiting less than 10 minutes for their medication.

6.5.4 Pharmacists

Pharmacists were rated exceptionally well by respondents in both the general public and exit surveys. The remarkably high ratings given to pharmacists by respondents in the Exit survey may be partly attributable to the fact that these respondents were rating the pharmacist immediately after their visit, when positive thoughts towards the experience could have been more prominent in the minds of respondents. Comparatively, respondents who participated in the General Public survey would have drawn on a number of experiences with pharmacists and pharmacies, thus these respondents may have taken some less positive experiences into consideration when rating pharmacists. Having said this, ratings of pharmacists remained undeniably high. For the General Public survey, the top performing attribute was 'being polite and courteous', where pharmacists achieved a performance rating of 8.6 out of 10. For the Exit survey, listening to what their customers have to say was pharmacists' strong point, with these staff member achieving a performance rating of 9.9 out of 10 for this attribute.

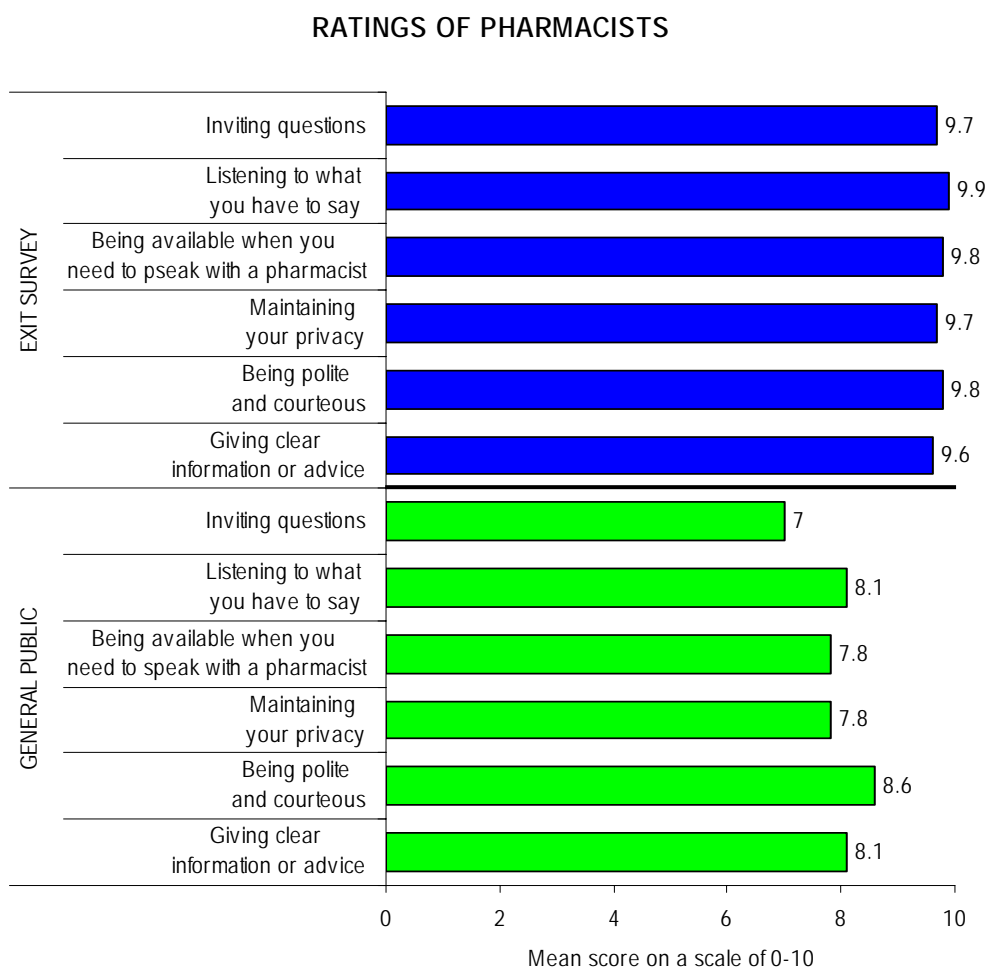


Fig 91. General Public & Exit Survey: Ratings of pharmacists performance on six attributes, on a scale of 0=performs extremely poorly and 10=performs extremely well (General Public survey (n=2001); Exit survey (n=90)).

Given the remarkably high ratings achieved by pharmacists in the exit survey, when identifying areas where pharmacists can improve upon in order to provide a quality health care service to Australian consumers, the researchers paid close attention to the ratings given by respondents in the General Public survey, whose responses most likely represented a higher level of reflection on a number of experiences with pharmacists. One attribute 'inviting questions' was rated notably lower in comparison to the other attributes. This attribute achieved a rating of 7.0 out of 10, indicating that there is room for improvement by pharmacists on this attribute. Despite this, pharmacists do appear to be performing extremely well in terms of serving their customers and providing a quality health care service.

6.5.5 Pharmacy assistants

Likewise, pharmacy assistants were also rated extremely well on the attributes regarding their performance. Again, the higher ratings were achieved among respondents from the Exit survey, whose pharmacy experiences were, presumably, most fresh in their mind.

RATINGS OF PHARMACY ASSISTANTS

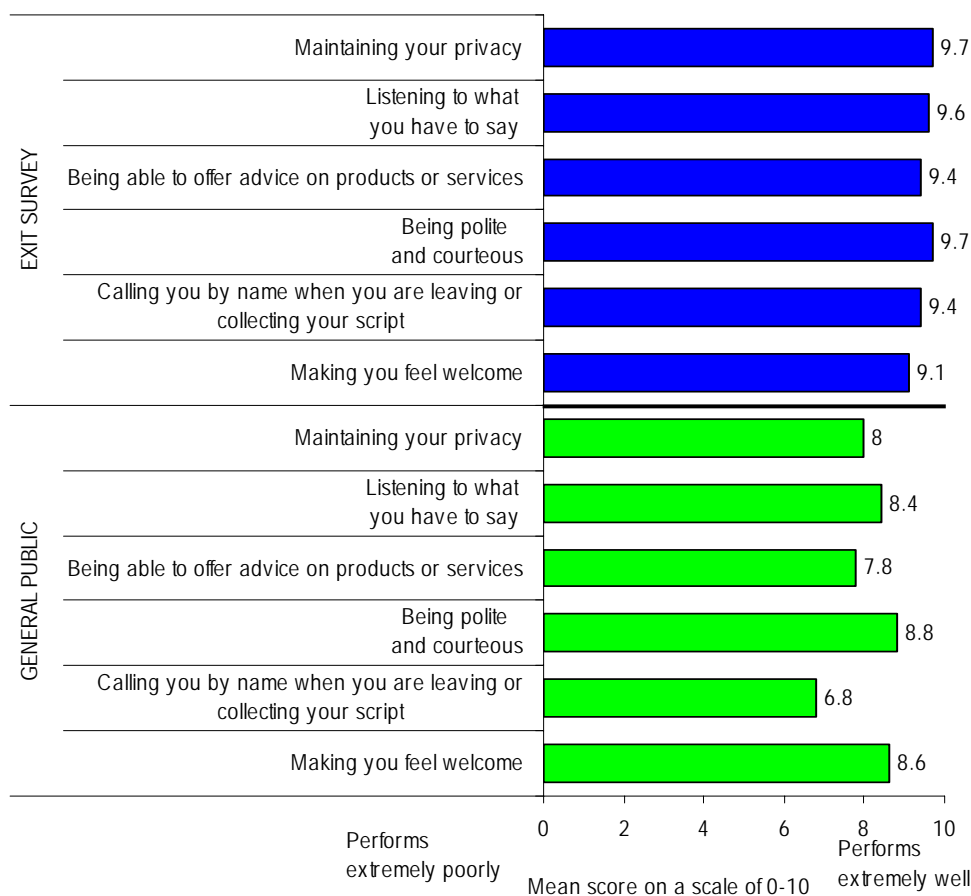


Fig 92. General Public and Exit survey. Ratings of pharmacy assistants on six attributes, on a scale where 0=performs extremely poorly and 10= performs extremely well. (General public n=2001; Exit n=464)

Given that these results follow the same pattern, in terms of differences between the General Public and Exit surveys, when pinpointing areas where pharmacy assistants may be able to improve their service, the researchers have focused primarily on the ratings given to pharmacy assistants in the General Public survey. Top performing attributes, and subsequently areas where pharmacy assistants should maintain their level of performance, include:

- Being polite and courteous (General public mean rating of 8.8 and Exit 9.7 out of 10)
- Making customers feel welcome (General public mean rating of 8.6 and Exit 9.1 out of 10)
- Attributes where assistants tended to perform less well, and therefore areas where the researchers suggest pharmacy assistants endeavour to improve, include:
- Calling customers by name when leaving or collecting a script (General public 6.8 and Exit 9.4 out of 10)
- Being able to offer advice on other products and services (General public 7.8 and Exit 9.4 out of 10)

6.6 Focus groups

6.6.1 Characteristics of the sub-sample of focus group participants

47 participants provided information using the form at Appendix C.

13 were aged between 20 and 40 years; 12 between 41 and 55 years and 22 aged over 55 years. There were 30 females and 17 males.

The most common conditions experienced by the participants or the person they cared for were heart disease (18); mental illness, including depression (16); diabetes (13); and arthritis (6). A range of other conditions were identified and most participants nominated more than one health condition.

The frequency of visits to community pharmacy was weekly or more frequent (18), fortnightly (10) and monthly (16) with the remainder visiting less frequently. By contrast, visits to other health professionals were less frequent with 12 people visiting weekly or more often; 8 visiting fortnightly and the remainder less frequently.

The consultants consider that the characteristics of this sample seem to be broadly consistent with those of the other focus group participants, suggesting that those who provided input to the focus groups are high users of medicines, often with multiple health conditions and are frequent users of community pharmacy.

6.6.2 Summarised findings from the focus groups

The distinction between needs, expectations and experiences was not easily maintained during group discussions, as participants tended to illustrate both needs and expectations with what they had experienced of community pharmacy. For this reason, results in this report are summarised according to key themes, with needs, expectations and experiences identified within these themes.

6.6.2.1 Access

Access issues were raised in several contexts. These included access to medicines, geographic access to pharmacies, opening hours and physical access within pharmacies.

6.6.2.1.1 Access to medicines

All participants identified community pharmacy as a key source for meeting their prescription medicines needs, and expected that supplies would be readily available. In many instances however, this availability was variable. Supply tended to fluctuate according to changes in regulation and in stock holdings. Items of particular variability in access were medicines for hypertension, asthma, arthritis, mental illness, opiate replacement, diabetes (including stocks of syringes and test strips) and for hormone replacement therapy, where supply of one product was only available through hospital

pharmacy. In these circumstances, some consumers reported having to incur considerable effort to locate alternative sources of supply. Instances of this supply difficulty occurred even where the person was a regular customer of the pharmacy and had their prescription records held on file.

Several groups noted the importance of informing consumers if medicines were likely to have supply problems. One example was of a monamine oxidase inhibitor which was withdrawn and the consumer had been taking this for many years. Other examples were cited in asthma and diabetes medicines.

Disruption to access for their needed medicines may have significant consequences for some consumers. For example, participants with mental illness cited experience of an annual “lithium drought” where stocks of this medicine seem to be restricted around the same mid-year period annually. In another example a consumer described a disruption to supply of their psychotropic medication. They were told it would be available in 2 days, but this delay resulted in a deterioration of their mental status and the consumer withdrew in their home for 4 days until a Crisis Team was called and the consumer was hospitalised.

People on opiate replacement therapy may have particular access barriers as not all pharmacies provide this service. In addition, opiate replacement dispensing may only be provided at certain hours – one example was cited of a 24 hour pharmacy which will only dispense methadone between midnight and 6am; other examples were cited of only one pharmacy in an area providing this therapy. In situations where these consumers have experienced quality or service problems and complained, they are told to “go somewhere else”, but alternatives are neither available nor practical. These access barriers inhibit the normalisation which is intended as a key purpose of this program.

6.6.2.1.2 Access to a choice of pharmacies and their services

A number of participants highlighted the varied concentration of community pharmacies, where some metropolitan and suburban areas seem to have large numbers, while smaller suburbs and regional and rural areas may have only one pharmacy. This has several impacts on consumers. Firstly it restricts choice on the basis of price, where consumers may benefit from shopping around for better prices on both medicines and other pharmacy products. Secondly it restricts choice on the basis of service and/or service quality. If the consumer is dissatisfied with the pharmacy or has concerns based on quality, the option to attend a competitor may not be available. This is a particular concern in rural areas.

For a number of rural consumers, there is no pharmacy in their immediate geographic area. Medicines supplies may come via services such as the Royal Flying Doctor Service, by mail or by services such as school buses. However in the latter cases, mail supplies can be disrupted and school holidays mean a disruption of the bus supply mechanism and ad-hoc arrangements such as a neighbor visiting town are used. The HIC supply amount restrictions are seen as unrealistic in times such as the

wet season when supply interruptions may last for two months. The lack of direct interaction with a pharmacy was described as “quite scary” on occasions, because there is no-one to consult for medicines information such as interactions. It was noted that Home Medicines Reviews are also very limited in rural areas and that some GPs do not believe in using these and may refuse them.

6.6.2.1.3 Access during opening hours

Opening hours of pharmacies were identified as restricted in many instances, especially in catering for the needs of working people and parents of young children. Participants noted that many pharmacies seem to open at 9am and close at 5pm, and these times are inconvenient for working people to access their local pharmacy. These restrictions also mean that a relationship is not developed with their local pharmacy but rather that access is to wherever is convenient in relation to the workplace or work transport routes.

While it was noted that some pharmacies may operate extended opening hours, these were often not convenient for consumers to access and may require them to drive quite long distances. After hours access to pharmacies was generally reported as both necessary and limited and a number of participants enquired whether there should be regional arrangements in place to ensure extended hours availability on a more consistent geographic basis.

It was noted in several groups that information about pharmacy locations and opening hours can be difficult to find.

6.6.2.1.4 Physical access within pharmacies

A number of participants were concerned about physical access, especially in parking and in access barriers such as steps and slopes up to entry. This is a particular problem for people with mobility limitations and extends into the pharmacy itself, with descriptions of the floor space as cluttered and overcrowded with displays which often have protruding shelves. One group raised the question whether there is a required ratio of floor space allocation to the pharmacy service compared to other product areas.

A participant with severe mobility limitations described how all their transactions with the pharmacy take place on the footpath as they are unable to get up stairs into the shop.

It was noted by many participants that the dispensing area is frequently raised from the floor and has the effect of placing the pharmacist/s on a “pedestal”. All of these constraints are particularly limiting for people in wheelchairs and mobility scooters, while others noted that a number of pharmacies do not provide seating for people who have to wait.

6.6.2.2 Information about medicines

Information was identified as a major need and expectation of community pharmacy. The type of information sought was about prescription, OTC and complementary medicine, how to take it, side effects, interactions and costs.

Participants consistently reported that information tends to be provided only in limited ways and on limited occasions. While some reported being given verbal and/or written information at the time of first dispensing of a new medicine, it was rarely offered on other occasions. It was suggested by one group that the National Medicines Line number should be placed on all medicines packets as a means of providing consumers with additional information support.

A number of participants had previously received written information as Consumer Medicines Information (CMI) or product inserts. However CMI was rarely offered; consumers had to ask for it which presupposed they knew this form of information existed. This was of particular concern to those organisations who offer peer support training on quality use of medicines to their members. One group noted that CMI is a relatively simple strategy and questioned why it is taking so long for this to be consistently available.

Product Information (PI) was described across the majority of groups as declining in provision, particularly as packet inserts. This raises concern that where CMI is not offered and PI is not provided, the consumer is left without any written information at all.

A major theme in most of the group discussions was that information should be provided in a context of dialogue with the consumer. However, the focus of the transaction around payment is seen as limiting the consumer's opportunity to ask questions. It was also noted that reading written material subsequently without dialogue with the pharmacist may cause alarm about side effects and adverse effects, which may result in the consumer deciding not to take the medicine at all.

Some people receiving medicines for mental illness felt they were given less information based on assumptions about their ability to manage the information and their condition.

Most participants reported that broader information about health conditions and their treatments is rarely drawn to consumers' attention. While some participants had identified information sheets and cards as available, these were rarely offered or suggested in their interactions with staff. They were also described as most commonly associated with product marketing such as vitamins and complementary medicines, rather than being from independent information sources.

Information about community pharmacy services such as Home Medicines Review, medicines delivery, or medicines records assistance was also described as absent. These services were rarely drawn to consumers' attention.

It was consistently suggested across the focus groups that community pharmacies should have prominent signage encouraging consumers to ask for both written and verbal information about their medicines; and that independent information brochures on health treatments (eg for the 10 most common conditions) and pharmacy professional services should be displayed.

One group noted that information about recent medicines issues such as risks associated with Ibuprofen had only been conveyed to consumers through the media and questioned why community pharmacy was not a vehicle for providing this type of information to consumers.

6.6.2.3 Service

All participants reported that personalised service from their community pharmacist was highly valued and a key need and expectation. Those participants who had developed such a relationship with their pharmacists found that they tended to get additional benefits such as written and verbal information, assistance with maintenance of their prescription records, and home delivery where required; and that other professional services were offered such as dose packaging and Home Medicines Review.

Pharmacies were consistently described as a more relaxed and less pressured environment than doctors' rooms, and that they provided an opportunity for provision of written and verbal information about health conditions, treatments and services. Pharmacists were also described as using more consumer friendly language than doctors when explaining health treatments.

Smaller pharmacies were seen by many participants as being more personalised in their service than larger outlets. One group noted that some pharmacies are too impersonal, are run like warehouses and are reluctant to provide general advice.

Packaging of dose administration aids was described as a valuable service by a number of participants, with the added benefit of an accompanying record of the medicines. However the cost of these aids was cited by some as a barrier, with these consumers electing to pack the medicines themselves rather than having the pharmacy do so. One group noted that these packs work well for tablet medicines but there seems no alternative for medicines in liquid form. One consumer with mental illness noted that on occasions when the consumer is in hospital the pharmacist has continued to prepare their medicine packs and then assumes the person has been non-compliant because the packs have not been collected.

Home delivery was frequently cited as a valued service, especially for those experiencing debilitating illness, disability and/or mobility problems. Where this was not available, some participants described significant access limitations. For example, the carer of a person who was immobile had to arrange a temporary carer each time they had to go to the pharmacy, which incurred both service and transport costs. One group suggested that if the pharmacy could not provide home delivery, they could

liaise with community services, such as home nursing as an alternative delivery mechanism.

Return of unwanted medicines was described as a needed service but many participants were unclear about whether this was available.

Holding prescription records on file was seen as a significant assistance to a number of participants. Being able to receive a printout of all their current medicines was highly valued, especially for those on multiple medicines. A number of groups asked whether this service could be expected and if not whether medicines records cards could be made available. One group noted that some pharmacists complain about the time and cost of maintaining such records and refuse to do so. It was also noted that carers should be able to access such records when they are the person administering the medicines and this was particularly the case if Home Medicines Review was not available.

A number of participants focussed on the “commercial” nature of the service transaction. The emphasis to these participants seemed to be on purchasing the product, rather than the quality aspects of the transaction such as checking the persons understanding of the medicines and their need for information.

A number of groups cited concerns about the extent of focus on OTC and complementary medicines. Some participants saw this as promoting “a pill for every ill”, while others felt the amount of floor space taken up by these products diminished the emphasis on prescription and professional services. As noted earlier, some participants such as people with mobility problems or parents with prams and strollers found the sheer volume and “clutter” of these products limited their access to the pharmacist who was inevitably placed at the rear of the store.

The tension between the retail and professional roles of community pharmacy was a topic frequently raised by participants. While acknowledging commercial imperatives, many felt that the balance had moved too far toward non pharmaceutical products. One participant noted that when they go in and find “...hair care items, gifts, candies – I ask, what’s the focus here?” Some participants described this as a move away from pharmacists’ “core business” to products that might otherwise be found in supermarkets. Some participants suggested that given that pharmacy receives subsidy from government for their medicines, it is reasonable to expect that this remains the major focus. Accompanying these changes was a perceived loss of personalised service and attention in larger pharmacies.

The current debate on pharmacy location in supermarkets was raised in most groups without prompting by the consultants. In each case, while participants noted potential cost savings, there was considerable concern expressed about a loss of personalised relationships with the local community pharmacist and consequent reduction in the provision of information and advice. Several groups identified similar concerns with both discount and mail order pharmacies where the consumer was seen as losing information and personal contact in favour of price. However some participants had

experience of supermarket pharmacies operating in the UK and were of the view that these were satisfactory and convenient especially for those who work or need access outside usual operating hours.

6.6.2.4 Pharmacy assistants

Pharmacy assistants were consistently described as variable in their interactions with consumers. While many assistants were reported to be knowledgeable and effective in checking and referring to the pharmacist where appropriate, a number of instances were cited in which the assistant was seen as a barrier to accessing the pharmacist, were not discreet in talking with the consumer and relaying their request to the pharmacist, and on occasions provided incorrect advice.

A number of participants noted they will not deal with pharmacy assistants and request to speak only to the pharmacist. Experienced and/or older age group pharmacy assistants were cited as preferred by a number of participants. One participant commented “they don’t realise what an important job they have”.

Some participants noted that pharmacy assistants may act as translators for consumers who do not speak English, and while this is valued, it is dependent on the quality of the assistant’s knowledge and information.

In rural and remote areas, pharmacy assistants may be the only person present and the consumer is reliant on them for information and assistance. In one group a participant noted with approval how they were routinely introduced to new staff members in the store.

There was concern about pharmacy assistants’ knowledge about medicines interactions with OTC and complementary medicines. It was suggested that assistants need specific training in this regard and should know when to refer to the pharmacist for advice.

There was a general enquiry across groups about the training standards and requirements for pharmacy assistants and concern that they were principally trained by product suppliers to promote those products. There were a number of participants who felt that products were being pushed on to them - “you should take this” - and that this approach was less about their health needs than the pharmacy’s sales targets. One group suggested that pharmacy assistant training should be mandatory as part of pharmacy accreditation.

6.6.2.5 Costs

The cost of both prescription and non-prescription medicines was reported by many participants to vary between pharmacies within the same region. While shopping around for the best price was an option, this was seen as prohibitive for older people and those with transport or mobility problems.

Many participants were at a loss to understand why the price should vary so much between pharmacies for the same product. Price variation examples given included a \$4 difference for a pharmacist formulated skin cream; a \$6 difference for asthma inhalers; a \$7 difference for a nasal decongestant; and a \$14 difference for asthma spacers. These differences also extended to medicine administration packs ranging from \$3 to \$7 for the same medicines being packaged by three different pharmacies.

Another group commented that they expect the price they pay in a community pharmacy will guarantee proper advice and continuity of care, including the provision of information.

Records of subsidised medicines through “safety net stickers” were reported to be inconsistent by a number of participants; and several reported additional charges being levied over the safety net price. One group noted they would prefer a separate record of these for tax purposes as putting them on the prescription means they are sometimes lost. Another group noted that there may be a difference between the safety net price and the dispensed price and there is a need for transparency to the consumer on any additional charges levied by the pharmacy.

For those people who are not eligible for subsidy, the costs of medicines was a significant burden with some participants reporting weekly costs of between \$60 and \$110. This results in a trade-off at times between medicines purchase and other costs of living.

Some participants identified the costs of buying whole packets of products such as dressings and cotton products. They felt that single products could be made available, rather than incurring the cost of a packet which can be a significant burden to people on low incomes.

People on opiate replacement therapy described substantial dispensing costs, with examples cited of \$84 per fortnight, a significant burden when on a pension. People buying syringe packs may be charged up to \$9, which one participant suggested “almost guarantees needle sharing”.

A number of consumers were sympathetic to the costs incurred by pharmacists and felt they are not adequately remunerated for additional services such as maintaining medicines records for the consumer. It was also noted that some hospitals now use group purchasing arrangements for medicines such as eye drops and that these incur additional supply charges to consumers, while reducing the viability of local pharmacies.

6.6.2.6 Professional role, standards and quality

Pharmacists were seen by most participants as experts in medicines, more so than doctors. Pharmacists were seen as much easier to access and more approachable for information and advice than doctors. A number of participants described the pharmacist as a first stop for primary health care enquiries, with some older

participants noting that this role seemed to have declined over the years. The role of pharmacists in preventative health care was also seen by a number of participants as important.

Some concerns were identified by a number of participants. A common concern was of inconsistent practice and advice between two or more pharmacists working in the same outlet. For example, one participant described being given a medicine with a warning label on the packet alerting the consumer not to take the medicine with grapefruit juice. On a subsequent visit the medicine was dispensed by a different pharmacist without this label. When the consumer enquired, they were told “not all of us believe in that” which left them feeling confused by such contradictory information.

There were a number of instances cited of concerns about pharmacists’ standards and response to quality concerns. A consumer on opiate replacement therapy described being given a dispensing cup with lipstick on the rim; when they asked for a clean cup they were told “if you don’t like it go somewhere else”. Another consumer received the wrong medicine and learned that theirs was given to a 6 year old child with the same name. When they questioned the error, the pharmacist laughed and said: “well we won’t charge you for this”. Concerned by the response and the risk to the child having received their medication, they contacted the state Pharmacy Board and were told “this happens all the time – there is nothing we can do about it”. One consumer had a double dosing error identified by their GP and found the pharmacist had altered the dose. When challenged, the pharmacist refused to acknowledge the error and argued with the consumer, who subsequently stopped using this pharmacy. A consumer on opiate replacement therapy objected to the pharmacist handling tablets without washing their hands and cited the guidelines for dispensing. The pharmacist’s response was: “you’ve swallowed the guidelines have you?”.

A number of participants described experiences of rudeness and stigmatisation. One participant noted that pharmacists sometimes treat sick people with disdain: “...they don’t want to know you after the commercial transaction has concluded”. People with mental illness reported negative attitudes to them from both pharmacists and assistants, which they felt was based on the type of medicines, rather than the person receiving it. Some participants had felt so concerned about this that they had tried unsuccessfully to shop around for an alternative pharmacy and when they returned to the original one felt they were treated with even more disdain based on the suspicion they were noncompliant. Young people on opiate replacement therapy reported being referred to as “junkies” and being treated suspiciously if they try to purchase other medicines products.

A number of groups noted that the age of the pharmacist may be relevant and that some older pharmacists may not be up to date. Examples were cited of pharmacists dispensing asthma medication without knowing the product or its recommended use and side effects.

Some groups reported they did not feel they were treated with respect by the pharmacist. Opiate replacement consumers consistently described feeling stigmatised and treated with suspicion “as though you were a shoplifter”. Another example cited was of a young person attending opiate replacement who was also attending TAFE. Two friends from TAFE came into the pharmacy, unknown to the consumer. The pharmacist said “don’t bring your junkie friends in here with you” and kicked them all out. The friends were not aware of the consumer’s condition, nor were they on opiate replacement.

A number of consumers with chronic illness felt they were not credited with knowing their own conditions and were “being treated like an idiot”. One person with Parkinson’s disease felt they were consistently talked to by pharmacy staff as though they were a “dodderly old person”. Another person receiving the first dispensing of an antipsychotic medication was asked by the pharmacist: “do you know what this stuff will do to you?” which they felt was hardly reassuring.

A consistent enquiry in many of the focus groups was about the nature of mechanisms that are in place for consumers to make complaints about problems in community pharmacies. With few exceptions, participants could not identify any mechanism or processes for making a complaint and those that did so, such as in the examples cited above, did not find the process effective or satisfactory.

6.6.2.7 Privacy

Many participants noted the lack of privacy and consequent concerns about confidentiality in community pharmacy. As cited in one group: “we don’t want the pharmacist talking to us about our personal medical history in front of other customers, but this happens a lot”. Many examples were cited of overhearing other people’s medicines histories. People with mental illness also highlighted their concerns about psychiatric medicines being discussed with them in an open shop environment.

One example cited was hearing a young female being questioned at length in a crowded shop about her sexual activity after a request for emergency contraception. In another example, a mother on opiate replacement therapy had a young son attending the local school. On attending the pharmacy, the pharmacist called out “Mrs X your methadone is ready” while holding the dose container aloft. Several other customers were present whose children also attended the school, and the consumer is convinced that for this reason alone her son has not been invited to attend peers’ birthday parties and other activities.

There were particular barriers for people with HIV and opiate replacement therapy attending rural pharmacies where that person was known in the local community. It was noted by one group that Medicare On-line had been made aware of the need for privacy for claiming areas in rural pharmacies and this should extend to other health transactions.

6.6.2.8 Generic medicines

Generic substitution was raised by all the groups. It was noted that generic substitution involves a significant trust in the pharmacist providing a genuine equivalent.

Participants expressed concern that the emphasis on generics is usually focussed on cost benefits rather than therapeutic equivalence, with a number believing that generic substitutes in their experience were either not as effective or had different side effects. There was particular concern in a number of groups about differences in fillers and additives in generic medicines; and about frequent changes in appearance and brand name within short time periods of supply. One group questioned whether generic medicines are always cheaper.

Some participants described differential decision making with generics – they were willing to use generics for OTC and medicines such as antibiotics, but not for “serious” medicines when ongoing therapy is required. For example, participants with mental illness noted that they were unwilling to take a risk with generics as they felt their continued good health was associated with taking the brand medicines.

One group also questioned whether brand prescribing resulted from pharmaceutical company incentives to doctors.

6.6.2.9 Labels

Participants identified concerns with labelling generally, especially around font size. A particular concern in relation to community pharmacy was pharmacy labels obscuring important packet information such as doses and expiry dates. This was cited as particular problem with packaging of eye- and ear- drops, but also extended to other medicines.

A number of participants described label instructions, such as “take as directed”, as unhelpful, especially if one could not remember the original instructions at the time of prescribing.

6.6.2.10 Linkages

A number of participants suggested much closer working relations and interactions need to be developed between local pharmacists and GPs. Where they are closely located, these arrangements are seen by consumers often to work well in practice. Additional options identified by some participants included more systematic engagement possibly facilitated through Divisions of General Practice.

Community pharmacy is seen as part of a continuum of health services, but in practice participants find they often tend to operate in isolation. Where good links occur, the benefits to consumers are apparent, with additional quality controls over administrative errors and cross referrals for information and advice. A number of groups noted the ageing population and growth of services such as Hospital in the

Home, and wanted to see community pharmacists much more engaged as a part of the “total health care team”.

It was noted in one group that some pharmacies are using nurse educators in areas such as diabetes and heart conditions, which were seen as good developments.

6.6.2.11 Consumer engagement and quality improvement

We asked 86 of the participants whether they had ever been asked for feedback by their community pharmacy either verbally, or in writing such as a survey. Four participants reported ever being asked for feedback, while eight participants recalled being asked to sign a petition about supermarket entry into pharmacy.

There was limited knowledge of the extent to which community pharmacy systematically engages with consumer organisations at local, regional or national levels. One group suggested that the only time pharmacists engage systematically with consumers is when they feel under threat (such as the supermarkets issue). A number of participants who have been actively involved as health system representatives noted they had never seen pharmacists engaged in working groups on systemic issues.

There were a few examples cited of particular pharmacists being involved as a speaker for local groups; while in rural areas they were identified as participants in service clubs. However it was noted the membership of such organisations tends to be older males, so engagement with female pharmacists was limited.

National engagement with consumers where identified by a small number of participants, was mostly through the National Prescribing Service Community Quality Use of Medicines activities, which were seen as valuable and relevant, especially in peer support and education.

A participant who was part of a State Working Group on preventing falls, and represented a large aged sector consumer group, approached the local office of the Guild about speaking to a group of pharmacists. The consumer reported that the Guild response was that such sessions were usually provided by pharmaceutical companies who paid for this opportunity and if their group also wanted to talk to a group, they would have to pay a similar fee to do so.

More engagement was seen by participants as being highly desirable, especially in identifying and working to meet the needs of particular groups of consumers; as well as being a potential mechanism for community pharmacy to inform consumers about the range and quality of services offered. It was suggested by a number of participants that such engagement should be on the basis of mutual respect and consideration.

It was suggested that pharmacists at local levels could engage more in providing education sessions for local community groups and participating in QUM activities, engage with local government organised groups, and take part in disease and

community awareness weeks. Several groups noted the opportunity for pharmacists to refer consumers to local support groups for health conditions which would assist consumer education and concordance.

It was also suggested that pharmacists would benefit from undergoing more specific training from groups with specialist educators such as asthma and diabetes, to help support these consumers. In Victoria, it was suggested that community pharmacies could be better engaged with local government who are a key provider of home based services.

For consumers from non-English speaking backgrounds, it was suggested that community pharmacies should have links with interpreter services as required and that at State and national levels, more information about community pharmacy could be disseminated through language specific newspapers and electronic media.

A simple anonymous service questionnaire and return box in pharmacies was seen by many participants as desirable in demonstrating a commitment to ongoing quality improvements. However it was noted that pharmacists would need to act on these results otherwise it would be seen as “tokenism”. One suggestion was that such survey activity should be conducted and reported by an independent third party.

Future options included the placement of computers in pharmacies to provide information, and the option of email contact with regular customers to provide reminders and information updates.

It was also suggested that this project could be repeated subsequently to see if change has occurred and for example to measure whether information provision has improved.

6.6.2.12 Quotes on consumers’ needs, expectations and experiences

A number of quotes from participants illustrate their needs and expectations of community pharmacy and reflect generally supported views of participants:

“A good pharmacist gives information without you having to ask for it all the time”.

“A good pharmacist is valued – they have a personal relationship with consumer; offer good advice; help the consumer identify solutions to their problems”.

“A good pharmacist listens, provides a service, gives information”.

“My current pharmacist is good: efficient, kind, courteous and very helpful”.

“My pharmacist is very considerate and professional, checking new medicines for potential interactions, explaining requirements and providing CMI. They also advise if medicines can be obtained on authority for multiple packs at a single pack price to save me money”.

“We expect to be treated with respect; not judged because you don’t know how we came to be this way; and look at the long term benefits to your business of us as customers”.

“It’s not just a business activity, it’s a health service”.

6.6.3 Muna Paiendi Community Health Centre Focus Group

The distinction between needs, expectations and experiences was not easily maintained during the group discussion, as participants tended to illustrate both needs and expectations with what they had experienced of community pharmacy. For this reason, results in this report are summarised according to key themes, with needs, expectations and experiences identified within these themes.

6.6.3.1 Access

Access issues were raised in several contexts. These included access to medicines, geographic access to pharmacies, opening hours and physical access within pharmacies.

6.6.3.2 Access to medicines

All participants identified community pharmacy as a key source for meeting their prescription medicines needs, and expected that supplies would be readily available. In many instances this availability was not an issue except in the case of access to contraceptives and opiate replacement therapy. It was reported that some pharmacists are refusing to supply contraceptives to the Indigenous community but this was a general perception and not quantified by any measure.

As identified in other focus groups people on opiate replacement therapy have faced particular access barriers as not all pharmacies provide this service. It was reported only a small number of pharmacies in the area provide this therapy. People are required to travel long distances and some have been told to go to Hospital for administration. It was reported that a pharmacist advised that they were not participating in methadone program any more and no alternative was suggested. However it was reported one pharmacy administered methadone behind closed doors hence protecting the privacy of the people concerned.

6.6.3.3 Access to a choice of pharmacies and their services

Participants highlighted the lack of a selection of community pharmacies in the area and particularly available in reasonable distances for community members who do not have access to public or private transport. It was suggested that community members are required to travel significant distances to access community pharmacies.

6.6.3.4 Information about medicines

Participants reported that information is generally volunteered by pharmacists and in most instances this is appropriate. However, it was reported that from observations made by people waiting in queues to be served, the attitude of pharmacists to the Indigenous community appears to be different to other people. It was reported that in some instances pharmacists ask additional questions of members of the Indigenous community about the reasons they require particular medicines which are not asked of other customers. It was suggested that in general the Indigenous community do not want to be asked questions about their medication unless they request it and that when this occurs there is an undertone of racism.

Information about additional community pharmacy services such as Home Medicines Review, medicines delivery, or medicines records assistance was not provided. The group indicated they were not aware of any additional services (or products) that may be provided by community pharmacists.

6.6.3.5 Service

All participants reported that personalised service from their community pharmacist was highly valued and a key need and expectation. While some participants had developed a relationship with the same pharmacy none reported that it was a particularly friendly or welcoming relationship.

It was reported that pharmacist staff make a number of assumptions about members of the Indigenous community as observed by their body language. It was also reported that staff talk aggressively and “talk down” to Indigenous people and they ask questions that they do not ask other customers.

It was suggested that it would be an improvement if staff smiled at customers and this would make a difference to the attitude to people needing to use community pharmacy.

One participant stated – “I would like the pharmacist to treat me decent. I smile and be nice and I expect that to come back to me”.

The Community Health Centre staff indicated that at various times they had to intervene with pharmacies and advocate on behalf of their clients to achieve the outcomes being sought.

By contrast, a participant who is a diabetic has a dosette filled regularly by the pharmacist they attend regularly, and they are satisfied with the service they receive.

6.6.3.6 Costs

The cost of both prescription and non-prescription medicines was reported by many participants to vary between pharmacies within the same region. While shopping

around for the best price was an option, this was seen as prohibitive for many members of the Indigenous community.

Many participants were at a loss to understand why the price should vary so much between pharmacies for the same product. One participant commented that they could not “get over” the price variation between pharmacies in the same area. It was suggested that people have to shop around in order to obtain the “best” prices, but this is confined to those who have the capacity to do so. However, there are a large number of people who because of their lower socio economic status are not able to take advantage of this situation and hence because of limited choice could be paying more for the same products.

The group expressed concern about the prices of many medicines. While many centre clients have health cards the costs are still reported as being very high and particularly if they are required to have repeat scripts filled on a constant and regular basis. It was also reported that some medicines are not on the free list and clients have to pay full amount.

It was also reported that while many GPs know what is on the PBS list people often have conditions that require medicines not on the free list thus making “life very difficult” for people on low incomes.

As a consequence the Community Health Centre has at times been required to attend pharmacies with clients and assist in paying for medicines either because they do not have sufficient funds to cover the cost or they have exhausted their supply of medicines a day or two before they get paid.

6.6.3.7 Professional role, standards and quality

Some concerns were identified by a number of participants. A number of participants described experience of rudeness, aggression, stigmatisation and racism. They reported that they were not treated with respect and a common assumption was that because they were “black” they were also “poor”.

As previously stated it was felt that the approach by pharmacists to the Indigenous community was different to other people and that this reflected different standards in their dealings with the Indigenous community eg. asking additional questions of members of the Indigenous community about the reasons they require particular medicines which are not asked of other customers.

6.6.3.8 Privacy

As with other focus groups participants noted the lack of privacy and consequent concerns about confidentiality in community pharmacy. As cited earlier it was felt that pharmacists asked unnecessary questions about the reasons for taking particular drugs and members of the Indigenous community generally do not want explanations or information provided unless they specifically request it.

6.6.3.9 Generic medicines

Consistent with the issues raised about generic medicines in the broader focus groups the participants raised similar concerns. In particular, the participants felt that pharmacists influenced them to purchase generic brands because they were generally cheaper and an assumption was being made by the pharmacist that because they appeared to be “poor” the person could not afford other products. It was also reported that people’s experience with generic brands was not positive and that they do not work as effectively as the prescribed medicine. Indeed, one participant commented that “generics make me sick”.

6.6.3.10 Consumer engagement and quality improvement

We asked the participants whether they had ever been asked for feedback by their community pharmacy either verbally, or in writing such as a survey. No participant reported ever being asked for feedback, either verbally or in writing on the overall service or on products.

The Health Centre staff stated that the organisation has not been formally requested to provide views on customer service, quality improvement or even specific programs like QUM.

However, the centre indicated they would very much like to be involved in consultation at the local level but it would need to be on basis of asking the broader Indigenous community members for their views as users of the service and not just the staff of the health centre. This is a very important principle for local pharmacies and the Pharmacy Guild to note in conducting future consultation with the Indigenous community.

It was suggested by participants that it would be useful for pharmacies to have a simple anonymous service questionnaire and return box as a means to providing useful feedback.

6.6.3.11 Identification issues

It was reported that possession of appropriate identification was an issue for the Indigenous community. It was reported that if people do not possess a Medicare card they do not receive medicine. It was also reported that possession of appropriate identification was required to prove you are the person for whom the prescription is made out. One participant noted that for those people who use a regular pharmacist and have their member number registered, identification is not an issue.

6.7 Stakeholder Organisation Interviews

The issues identified by peak organisations reflect those expressed in the focus groups with additional focus on specific groups of consumers and clarification of strategies addressing quality improvement in community pharmacy.

6.7.1 Medicines supply and availability

All peak organisations identified medicines supply as a key need for consumers. Pharmacy organisations noted that this can be dependent of the size of the pharmacy and their stock holding capacity. The QCPP (QCPP) is seen as a key driver of the scope of products and services provided, with recognition that particular pharmacies may adopt some degree of specialisation related to local demographics and health needs. It was also noted that a good deal of the work of pharmacists in areas such as records maintenance is not necessarily visible to consumers. Similarly, it was noted that an underlying expectation of consumers is of consistently high standards of product quality.

Specialised consumer organisations expressed concerns about the extent to which product availability is consistent across the community pharmacy sector. For people with HIV/AIDS in NSW, supply of antiretroviral medication is principally through hospital pharmacy. This is despite a successful trial of supply by community pharmacy in Sydney two years ago and community pharmacy supply in South Australia. The effect of this mechanism is twofold – it limits ready access by consumers to the hours and terms of operation of the hospital pharmacies, and it has the effect of maintaining the experience of HIV/AIDS as a condition requiring hospital treatment rather than the more normalising setting of community based treatment for what is increasingly a condition more akin to chronic disease.

People who are placed on a methadone treatment program have access to this medicine through community pharmacy in all states and territories, however not all pharmacies participate in the program and requirements vary between jurisdictions.

People from non-English speaking backgrounds may seek medicines with which they were familiar in their country of origin; and difference in Australian products may cause some confusion or concern about equivalence and effectiveness. This is particularly the case for traditional and complementary medicines.

Peak consumer organisations reported similar issues of the availability of common medicines as described in the focus groups, especially for generic medicines for arthritis and mental illness.

6.7.2 Geographic and physical access

The major concerns identified by peak organisations about access centred on areas where there are a limited number of choices, such as country towns; and opening hours. In the case of opening hours a particular concern is that these may not coincide with those of GPs and specialists, thereby limiting consumer opportunities to get prescriptions filled.

Access to the pharmacist may also be restricted in ways which were also described in the focus groups, such as the placement of pharmacists at the rear and raised section of the pharmacy and the necessity to deal with pharmacy assistants in the first instance.

6.7.3 Information

All peak organisations nominated information for consumers as a high area of need and expectation. Both government and pharmacy organisations place considerable emphasis on this in policy, service, education and quality development strategies. It was noted by some organisations that consumers expect to be able to drop in to a pharmacy and have a conversation with the pharmacist, although these services are not necessarily remunerated under the supply based model of funding. Comparisons were drawn between the “open door” access to community pharmacy versus the “closed door” access to GPs and other medical practitioners. Recent years have seen an increasing recognition of this and strategies developed to ensure that this role is appropriately remunerated. The constraints on information provision can be related to the size of the pharmacy, where solo operators have more limited opportunity to provide these ad hoc counselling and information roles within the constraints of their workload. There is a recognition that information provision as well as community engagement is affected by both workforce and workload factors.

QCPP and the associated standards and educational strategies place a high emphasis on information provision to consumers. Supporting materials to assist this are generated from different and sometimes competing sources, including medicines manufacturers as well as organisations such as the PGoA, PSA (PSA), National Prescribing Service (NPS), Government and disease specific organisations. It was suggested that peak professional organisations may need to consider how such information strategies can be better organised and streamlined in cooperative, rather than competitive strategies.

Government and pharmacy participants recognised that the development of information and supportive relationships between consumers and their community pharmacists tends to vary according to demography and health status, with older consumers and multiple medicines users both expecting and more likely to establish ongoing and productive interactions. They noted that other consumers may be hesitant about asking for information and may leave a pharmacy without ever seeing the pharmacist; while some consumers, such as working people, may want fast, efficient service and be less likely to wait and talk. Consultations by the NPS suggest

that overall community expectations of community pharmacy may be lower than desirable, and principally centred around the right medicine at the right price with only basic information provided.

People from non-English speaking backgrounds are reported to apply their cultural paradigms to health care and may not understand, for example, the risks of mixing traditional remedies with other medicines; or the need to continue therapy when asymptomatic. Similarly, OTC medicines may be seen as “cure-alls” with advertising of their benefits misinterpreted in this light. Provision of information to these groups is seen as essential, but there may be additional barriers, such as not wishing to appear stupid if their English language skills are not good, or a reluctance to ask questions of authority figures. Sharing medicines may also be more common for these reasons among members of these groups.

Both consumer and carer peak organisations highlighted the priority need for consistent provision of written information, both about medicines and about the services that community pharmacy offers. They describe the provision of both written and verbal information as variable. Carers may be denied information on the basis of privacy concern. One peak consumers' organisation which has been promoting the uptake of CMI through peer education activities has received reports of consumers being denied this. The reasons pharmacists have given for denying CMI have been that the consumer does not need it, that it is too technical and that they would not understand it. In some instances pharmacists have sought to charge consumers for providing a CMI. All of these reasons are seen as unacceptable.

Like the focus group participants, consumer organisations expected that in ten years time, the debate about CMI provision should be resolved and it would be readily available and routinely provided without the consumer needing to request it.

6.7.4 Service

All peak professional and government participants identified the need and expectation of high standards of service in community pharmacy, provided by well trained staff who are familiar with the products they are supplying. While overall service quality is believed to be high, given the volume of transactions occurring in community pharmacy, participants recognised a lack of consistency at times. This may in part reflect both differences in pharmacist training and standards through State based systems of education and regulation. However, all participants noted there is considerable effort occurring through initiatives such as uniform national competency standards, QCPP and the Guild-Government agreements to raise the baseline levels of professional and service standards, although these initiatives may not be visible to consumers. Increasingly community pharmacy is being seen as an important primary care interface with consumers and strategies are moving to recognise and develop pharmacists and their staff in this role.

The tension between the “professional” and “retail” models of pharmacy was similarly recognised by professional and government participants with the view expressed that the retail focus is a strategy which was developed in the past to support business viability and that there is now a trend back towards the professional role as recognition and remuneration of these functions is improving. In the view of one peak professional organisation, mandatory professional development would be a useful step in driving this change. Home Medicines Reviews were cited as an example where a service places significant additional workload out of the pharmacy and remuneration is a key factor, together with workforce availability, for this service to be implemented more widely. The policy of making GPs the initiators of medicines reviews was seen as a significant barrier to uptake of reviews, even though pharmacists as a group were keen to perform this role.

Consumer organisations also report that service experiences in community pharmacy vary and that older people tend to maintain a relationship with one pharmacist building rapport over time. This is also true of consumers from non-English speaking backgrounds, who will often seek out a language speaking pharmacy where one is available. However in both these instances, there is a need to ensure that this close relationship does not result in a monopoly over pricing or products to the disadvantage of the consumer.

Younger people and those in small towns may more often find a less satisfying service experience, especially for example where the young consumer is seeking products such as condoms or emergency contraception. Barriers can be magnified where there is limited choice of community pharmacies and where the consumer is known to the pharmacist. A number of peak organisations pointed to the difficulties experienced by consumers in small towns where the pharmacist may be a prominent person in the local community and where concerns or complaints about service standards in the pharmacy can be both negatively received by the pharmacist and divisive among community members.

Opiate replacement consumers can experience quite intimidating service attitudes as illustrated by the following comment:

You are seen as ‘problem consumers’; there is limited access to the program – usually have to attend ‘out of peak periods’ and it’s not unusual for people to have to take a secondary place to other consumers in the pharmacy at that time. If you’re already restless and have to wait, you seem to be regarded as a potential troublemaker and thief; if you have to go and wait outside, you run the risk of being identified as a ‘loiterer’ and so there is a double whammy. Some people knock back work because of this inflexibility in access – so much for the ‘normalising’ process.

One consumer organisation reported that its research suggests that consumers seeking strong painkillers or pseudoephedrine compounds may be subjected to quite hostile questioning; people with mental illness may experience quite critical comments

about “all your ailments” and that consumers generally report being tired of a negative rhetoric about hoarding and doctor shopping.

Professional and government participants were clear about the expectations that consumers have of an effective working relationship with their pharmacist and that consumers do not like and will move away from pharmacists and staff who do not demonstrate empathy and a supportive manner with their customers.

It was noted by one peak professional organisation that Pharmacy Boards need to become more active and able to act when complaints are received. This requires attention to the registration of pharmacies with the Boards, sufficient resourcing, and consistency in approach between different jurisdictions.

6.7.5 Pharmacy assistants

Similar views on pharmacy assistants were expressed in peak organisation interviews as in the focus groups. While many were seen as helpful and appropriate in their dealings with consumers, there were notable exceptions cited where the assistant acts as a barrier to accessing the pharmacist, engages in intrusive questioning and in the case of opiate replacement consumers or those with mental illness may be very judgemental and inappropriate.

Peak pharmacy organisations noted that as yet there is no mandatory training or qualification for pharmacy assistants and there is a need for the development of career paths and different certification levels. Accordingly, QCPP is seen as one means of promoting development of the pharmacy assistant role.

6.7.6 Costs

Peak organisations identified significant concerns about costs to consumers. These includes the default mark-up previously contained in pharmacy software, the risk of increased costs where the consumer uses one pharmacist for supply rather than being able to source competitive pricing, and the costs of complementary medicines, devices and consumables, compared to alternative suppliers. There was a general view that the additional charges applied to medicines supplied through community pharmacy need to be more open and transparent to consumers.

For opiate replacement consumers, out of pocket costs per service can be significant, with reports of consumers in Victoria accumulating debts to the pharmacy of as much as \$1500.

6.7.7 Professional role

All organisations interviewed acknowledged the important professional role of pharmacists as experts in medicines. However, as with the focus groups, there were questions about the influences and imperatives on pharmacists as both health

professionals and retail business operators. The expectation is of impartial and professional advice free from commercial considerations.

It was noted by some professional organisation participants that consumers may not be sufficiently aware of the important contribution that pharmacists make as health care professionals as work such as prescription checking and quality assurance, and maintenance of records are not visible to them. Similarly the extent and frequency with which pharmacists act as first line advisors on primary health care is not necessarily recognised by the community.

Peak pharmacy and government participants noted the trends for professional development cited earlier, though a number felt that the pace of change has been slow. It was felt that there is a role for national leadership in this area and that pharmacists can be quite divided among themselves, with significant hostility and resistance experienced by change leaders from some within the profession.

A peak pharmacy organisation also noted that attitudes to consumers may be quite hostile and provided examples occurring in the AusPharm list of negative, derogatory and attributional comments based on the appearance and presentation of consumers. One consumer organisation also received numerous hostile personal messages to their spokesperson after media publicity criticising pharmacy costs and services, including one message saying “I hope your family gets sick”

A number of peak organisations cited the Pharmacy Guild as tending to be reactive to issues, rather than proactive in leading the case for development. There was a clear emphasis by participants on recognising emerging professional roles in areas such as chronic disease management and medication monitoring in areas such as residential aged care and home medicines reviews, however a number of participants felt the focus of the Guild was still too much on retail outcomes rather than professional services. This is seen as particularly important given the significant taxpayer funding of pharmacy services, a component which is seen as likely to increase rather than diminish in the future.

6.7.8 Privacy

Privacy of interactions between consumers and pharmacists is a major issue raised in consultations with consumers by consumer organisations. This is particularly the case where the pharmacy may also have non health related business functions such as a newsagency.

It was noted by several organisations that pharmacists may take an increasing role in health screening and disease management and the expectation is that these activities will also necessitate private screening and counselling areas.

Peak professional and government participants also noted this as a major issue and one that attracts the highest number of reported concerns from consumers. It was noted that privacy can be difficult to achieve in the retail environment, needs to take

account of other staff being present, as well as other customers, and consider the “noise and clutter” of products and services in the environment.. With the trend to development of additional professional service roles, privacy within the pharmacy was seen as a high priority to be addressed in future development.

Technology was seen as one strategy that may address some privacy issues in the future. Developments such as smart cards and electronic transfer of information between doctors and pharmacists may reduce the amount of verbal questioning and history taking in an open retail space. However it was noted that such developments will also bring additional requirements for confidentiality.

6.7.9 Generic medicines

Several peak consumer organisations identified limited access to generic medicines as a significant need for consumers and one that is not always met especially for people with asthma and those with mental illness.

Organisations report that consumers are frequently confused by the various terms applied to generics such as “home brand” or “chain” brand. There is a degree of suspicion about the motives for generic dispensing and whether this is driven more by profitability than therapeutic considerations. It was widely reported that there is a need for much more information about generic medicines, beyond issues of cost.

Professional organisation representative noted there are quality use of medicines issues with generics in aspects such as identification and consistency of supply, and these may not yet be sufficiently addressed.

6.7.10 Linkages

Most peak organisations identified the importance of effective working relationships between doctors and pharmacists. It was noted by one peak professional organisation that linkages within the health system generally are poorly developed and a significant barrier to continuity of care, and that pharmacy is reflective of this general problem. A number of opportunities for better links were identified including those between pharmacy and residential aged care, community nurses and with GPs, through strategies such as medication review processes and chronic disease management. One organisational participant put the challenge as the “need to work smarter with others”.

The role of pharmacists was felt by a number of organisation participants to not be well identified or accepted by other health system stakeholders, especially by GPs and their representative organisations. Public hostility expressed towards pharmacist professional roles by groups such as the AMA was seen as unhelpful and a more considered and cooperative dialogue was thought necessary. The use of GPs as a gatekeeper for pharmacist engagement in strategies such as Home Medicines Reviews was seen as a barrier to widespread implementation of this strategy. One peak consumer organisation noted that consumers may often feel they are in the

middle between pharmacists and doctors especially where there is a disagreement about therapy; it was suggested more mature and respectful collaboration was required.

6.7.11 Consumer engagement and quality improvement

All organisations interviewed saw considerable opportunities for increased engagement between community pharmacy and consumers. These can occur at the local, regional and national levels. A number of organisations felt that it was important to raise community expectations of pharmacy standards and services as a driver for change and ongoing quality and professional development. This included a focus on what consumers have a right to expect and request from community pharmacy. One participant noted this current project was a sign that attitudes were changing in the profession and it would not have occurred ten years ago.

Local engagement could include community pharmacists contributing to consumer awareness and education about medicines through community meetings, through information displays in local shopping areas, participation in awareness days and weeks, in partnership with other local health providers and in the placement and promotion of information about the services community pharmacy can offer both consumers and their carers. For migrant communities, engagement with language speaking media and health professions was seen as necessary and important.

Professional peak organisations noted the workforce and workload constraints that some pharmacies may experience, particularly smaller ones, which can prevent them from more active community engagement. Peak organisations engaged in strategies such as the Community Quality Use of Medicines program report varying responses from pharmacists to requests for engagement which range from positive to negative, suggesting that attitudinal factors may also be relevant.

Similar engagement opportunities were identified at regional, state and territory level through engagement with consumer and other health service organisations. One organisation suggested placement of pharmacy students within consumer organisations would assist mutual insights and learning.

The peak ethnic communities organisation noted some of the potential benefits of globalisation in gaining overseas trained pharmacists to work in Australia; and the potential for consumer information which is produced by global companies operating in overseas markets to be adapted for Australian consumers in those language groups. It was considered that there needs to be more consideration of such strategies by professional organisations and regulators to support appropriate workforce and information strategies for the diverse cultural demands in Australian communities. Similarly there would be benefits in ensuring more cross-cultural training for Australian pharmacists and their staff.

At national level a need for closer engagement with consumer organisations on the development of services, standards and training was identified. It was suggested that

the Guild consider establishing a consumer reference group with terms and support equitable with that of other stakeholder participants, a strategy supported by consumer, professional and government participants.

A further suggestion was that the Guild needs to provide leadership in establishing a more mature and respectful debate on consumer issues and concerns when they are raised publicly and with the profession.

7. DISCUSSION

The research into consumer experiences, needs and expectations of community pharmacy has canvassed a wide variety of views from everyday users of community pharmacy and representative consumer and pharmacy organisations. The research team used a variety of qualitative and quantitative methods, backed by a comprehensive review of the literature, to gain reliable information about those experiences, needs and expectations. The research has delivered some consistent messages about what consumers need, experience and expect of community pharmacy. These consistent messages provide the basis for clear directions for the Pharmacy Guild of Australia and other key pharmacy, government and consumer stakeholders to improve how community pharmacy meets needs, raises expectations and delivers high quality services to the community, especially those consumers with high needs. However there are also some divergent findings that point to further work that could be undertaken to contribute to a better understanding of the issues and the potential solutions to the issues raised through the research.

The research team has developed a broad interpretive framework to explore the results and discuss their implications.

7.1 General interpretation framework

The results of this research may be interpreted using a general framework for representing consumer experiences, needs and expectations in relation to the quality of pharmacy services (see Figure 93).

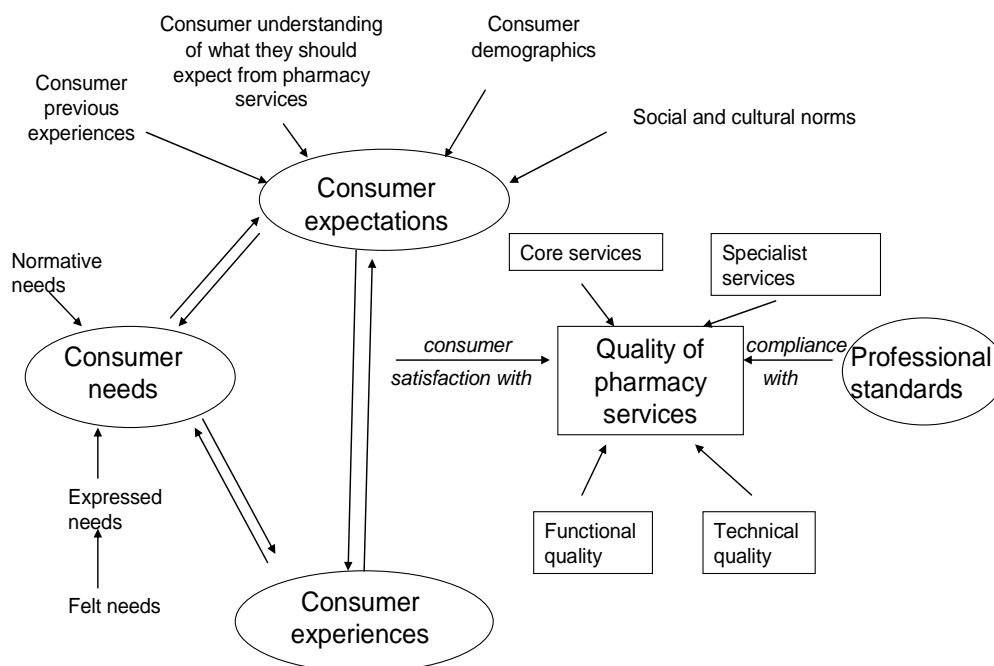


Fig 93. Framework for representing consumer experiences, needs and expectations in relation to the quality of pharmacy services

7.1.1 Pharmacy services

The concept of cognitive pharmacy services has been used extensively in the last 10 years with a number of definitions. According to Gastelurrutia (2005), cognitive services could be defined as “services that help to ensure that the patient’s therapy is suitable, safe, effective and convenient “ and could be divided into process-oriented services (e.g. counselling, dose administration aids, methadone program) and outcome cognitive services (e.g. disease state management) [1]. A range of cognitive services are currently being offered by community pharmacies in Australia. The Change Management and Community Pharmacy project distinguished the core services from the specialty health services [2]. Core services would be health services that every pharmacy should provide to the Australian community including dispensing prescriptions, providing verbal and written information such as CMI, advice on pharmacist only and pharmacy medicines, and home medication reviews which would be targeted towards specific categories. Specialty health services would be services that are available to patients with specific disease states such as asthma or diabetes. However, the profession is not yet in agreement as to which are the core services to be provided in all community pharmacies.

7.1.2 Consumer experiences, needs and expectations

Consumer needs can be classified into needs that are defined by experts and determined by investigation (normative needs), needs that are 'felt' by consumers and expressed needs (demands). In expressing their needs, consumers may base their thinking only on the services that they are aware of and not on the services that could be on offer.

Consumer expectations are influenced by a number of factors including consumer demographics, health needs, extent of choice available, social and cultural norms, consumer attitudes, and the extent to which the consumer has knowledge of what he or she should expect (e.g. knows about the availability of CMI and previous experiences (e.g. is used to receiving CMI) [3]. Previous experiences may cause expectations to shift, either directly as a result of information provided during the process of care, or indirectly because occurrences may alter consumer perceptions. Conversely, expectations may directly modify occurrences (e.g. when patients are requesting CMI) or alter consumer's perceptions of his experiences (e.g. a consumer may be disappointed if he or she does not receive CMI).

7.1.3 Quality of pharmacy services and consumer satisfaction

The evaluation of the QCPP distinguished the functional quality and the technical quality of pharmacy services [4]. The functional quality referred to how the service was perceived by the consumer (e.g. politeness of the staff). The technical quality referred to the 'correctness' or 'accuracy' of the service or product provided (e.g. the consumer has received the correct medication at the right dosage) [5]. These two dimensions sit under the broad concept of professional services.

The quality of pharmacy services can be measured at the professional and the consumer level. At the professional level, quality may be assessed by measuring the degree of compliance of pharmacy services with agreed standards of practice. It has been done, for example, in conducting pharmacy audits or through mystery shoppers visits. At the consumer level, the quality of pharmacy services can be assessed by measuring the gap between consumer expectations and consumer experiences [21]. However, it is not clear which aspects of pharmacy services may have the greatest impact on consumer experiences. Consumers can judge whether pharmacy staff are friendly, but may not be in a position to assess the relevance of, or need for, medicines and health advice. Furthermore, consumer expectations are influenced by their prior knowledge of pharmacy services. Consumers may not realise what the pharmacy can offer them and may not be aware of the recent developments in the area of cognitive pharmacy services.

The implications of considering the project's results within this framework are fourfold:

1. consumer satisfaction with services may not always reflect the quality of pharmacy services as measured by professional standards and guidelines; satisfaction of consumers is affected by their level of expectations and consumers may be unaware of what pharmacists have to offer;
2. satisfaction expressed by general consumers may provide a different picture of the quality of pharmacy services than the satisfaction expressed by consumer and professional organisations. Consumers belonging to or representing consumer organisations are likely to be more informed of the range and quality of pharmacy services than consumers in the general public. Hence, their expectations may be higher and they may be more critical of services than less informed consumers;
3. needs and expectations of consumers are influenced by specific health needs. Consumers representing specific groups such as people with mental illness will have needs, expectations and experiences which differ to those of the general population;
4. needs stated by consumers are expressed needs. They may not include normative needs as assessed by health professionals and needs related to the provision of new cognitive pharmacy services that they are not aware of.

7.2 Methodological issues

The research used both qualitative and quantitative methods to gather the views of consumers nationally. There were five methods of data gathering: a national telephone survey of users of community pharmacy, a face to face exit survey of community pharmacy customers in NSW, VIC, SA, QLD, WA and NT, a telephone survey of pharmacists, 13 stakeholder interviews and 12 consumer focus groups. These different methods have each their strengths and weaknesses. Quantitative methods such as surveys aim to measure behaviours or opinions, and to provide an accurate and reliable picture of a situation. The two consumer surveys carried out in this project were carefully planned to represent the general population of Australia with respect to the geographical, age and gender distribution. The main strength of well-administered surveys is their representativeness. Their main limitation is that they cannot give a good representation of the concerns of small segments of the population, unless they are specifically designed for this purpose. The general public survey in this project was designed to provide a good representation of health consumers. The results cannot segment the experiences and needs of specific groups of health consumers, such as people with mental illness or on opiate replacement therapy because the survey did not explore individuals' specific health issues. Furthermore, opinions expressed in surveys are limited to the questions which were asked.

Qualitative methods such as interviews and focus groups aim to explore the breadth of people's experience and to make sense of experiences in terms of the meanings

people bring to them. They also allow for specific groups' needs, experiences and expectations to be explored in depth. The use of both quantitative and qualitative methods of data collection in this project improves the validity of the results and its comprehensiveness. It allows comparisons to be made between survey results and interview and focus groups findings. The identification of patterns of convergence and divergence encourages a reflective analysis of the data.

A limitation of the methodology employed in this project is that the quantitative questionnaires could not be constructed on the knowledge of issues identified in the qualitative research. The timeframe allowed by the funding body precluded the development of a more standard research process of collecting and analysing the qualitative data and using the analysis of that data to construct the quantitative instruments. The time frame also did not allow rigorous reliability and validity testing of the survey instruments. A second consequence is that, rather than reporting and building on the themes which emerged from the qualitative work and surveying large numbers of consumers to explore the representativeness of the themes, all information from each source in this study is given equal weight; thus the compilation of 2005 consumer responses from the two surveys carries the same weight as opinions expressed by the 85 participants in focus groups and interviews. Some issues raised in the focus groups or interviews were not covered in the survey questions.

7.3 Interpretation of Results

7.3.1 Overall satisfaction

The results from the general public and exit surveys showed a high level of satisfaction of consumers with services provided by community pharmacies. Consumers, and health consumers in particular, rated the performance of pharmacists and their assistants very highly. The service was quick (80% waited less than 10 minutes for their prescription), the privacy was well or very well maintained (94%). Almost 80% of respondents could not think of anything to improve the services.

These findings are generally consistent with the Australian literature in which consumers expressed generally a high level of satisfaction with the quality of pharmacy services provided [6], [7], [8], [9], [10], [11], [4], [2], [12], [13].

The findings of the focus groups and organisation interviews provide a different perspective on consumer experiences. In contrast to the views of consumers expressed in the surveys, concerns about availability of medicines, privacy, poor or variable service provision by pharmacy assistants, lack of approachability of pharmacists and lack of provision of information on medicines featured much more strongly. Similar concerns have been raised in the relevant Australian focus group literature [9], [10], [2].

The differences between the qualitative and quantitative results could seem puzzling at first glance, but should be interpreted using the general framework for representing consumer experiences, needs and expectations described above. The first element to consider relates to the different characteristics of consumers involved in each separate research module in terms of needs and expectations. Consumers in the focus groups were more likely to have specific needs e.g. people living with HIV/AIDS or people on opiate replacement therapy. By contrast, only 2% of respondents in the general public survey had used needle exchange services. Second, consumers in the focus groups were also more likely to be better informed consumers as they belonged to or represented a consumer organisation. As such, they were more likely to have more clearly defined expectations of community pharmacies and so were more likely to be critical of pharmacy services than general consumers who had no such expectations.

7.3.2 Availability of medicines

In the exit survey 87% of respondents said that their prescription medicines were available or could be obtained quickly. Conversely, 13% of respondents said that their prescription medicines could not be obtained quickly. These data should be interpreted cautiously. The definition of “quickly” was not explicit in the questionnaire. Additionally, it cannot be determined from these data whether the lack of availability was related to particular brands only and if other generic products would have been available. The reported lower rate of availability in NSW (51%) needs to be further investigated. The NSW result is based on interviews with 25 consumers who were lodging or collecting a prescription, in Sydney (CBD and suburbs), Wagga Wagga and Goulburn (seven pharmacies in total). Due to the small sub-sample and limited geography, we cannot rule out that these results are due to chance only. However, strong concerns about disruption of supply of medicines were also raised in the focus groups. These problems with availability of medicines were related to particular situations (remote areas), particular health conditions (such as asthma and diabetes) or particular medication needs (availability of antiretroviral medications restricted to hospitals).

7.3.3 Provision of information

The results from the general public and exit surveys were less positive when the quality of specific services was assessed. In the general public survey, 56% of respondents declared they ‘never or rarely receive written information on how to use the medicine’ when they get prescriptions or OTC medicines. In the exit survey, of the consumers who lodged or collected a prescription, only 7% received written instructions and only 19% spoke with the pharmacist about the medicine or related issue. The frequency of provision of information on medicines to consumers in our surveys is lower than that reported in the exit consumer survey in the QCCP (QCCP) in 2003-2004 [4]. That survey indicated that approximately 50% of consumers with prescription for continuing medicines reported receiving counselling; 22% of consumers reported being given written information (34% if a new medicine was

dispensed). The differences in results may be related to the type of questions asked and to the fact that the QCCP survey was done at a time when pharmacies were becoming accredited and so were more likely to provide good service. In the Medicines Information for Consumers (MIC) program evaluation, 16% to 21% of consumers being prescribed a medication for the first time reported receiving a CMI, which is similar to our findings.

Provision of medicines information is an important consumer need which has been recognised by the pharmacy profession and is considered to be part of the core pharmacy services that could be expected by consumers. Patient counselling, including the provision of CMI, is included in the PSA Professional Practice Standards. Advice on OTC medicines is included in the PSA standards for the provision of pharmacist only and pharmacy medicines. PSA encourages pharmacists to regularly conduct self-assessments of their practices against these standards. In July 2000, these two sets of standards were included in the QCCP. The patient counselling standard is a mandatory standard i.e. there must be 100% compliance with this standard for the pharmacy to be accredited. However, it must be noted that the current standard reflects only partially the PSA guidelines on 'Consumer Medicine Information and the Pharmacist'. It states that 'patients are offered CMI for all new medications' and 'patients are provided with CMI for repeat medications on request'. However, it does not include other specific circumstances listed in the guidelines where CMI should be provided, for example 'when a significant change to the CMI has been notified by a sponsor'.

Another important issue to consider is how to measure the compliance with Professional Practices Standards. There is currently no recording system for the provision of CMI. The PSA self-assessment tool measures the compliance with the Professional Practice Standards as met, unmet or not applicable, but there is no gradation of the compliance level. In the QCCP survey, 67% of the pharmacists interviewed agreed with the statement that 'the approaches that this pharmacy uses for delivering CMI would be regarded as 'best practice' despite the low level of CMI delivery which was observed. There may be a mismatch between what both professional organisations and pharmacists at the grassroots' level consider as 'best practice' in terms of provision of medicines information.

All sets of standards, QCCP standards, PSA Professional Practice Standards and PSA standards for the provision of pharmacist only and pharmacy medicines are currently under review. It is not known yet how partial compliance with PSA professional practice standards will influence the accreditation process in the future and if any PSA Professional Practice Standard will be a specific mandatory component of the QCCP.

Provision of CMI is a service which is specifically remunerated under the Third Community Pharmacy Agreement: pharmacies enrolled in the Medicines Information to Consumers (MIC) program receive an ongoing participation allowance of 10 cents per claimable PBS/RPBS prescription for delivering CMIs. Our research confirms

previous findings that provision of CMI by community pharmacists remains low despite financial incentives.

Several barriers to CMI delivery were identified in the evaluation of the MIC program. They included lack of pharmacist awareness of the professional standards on provision of CMIs, time constraints, access constraints (when CMIs had to be obtained from other sources than dispensing software) and perceptual constraints. In the QCCP survey, while 93% of the 1101 pharmacists interviewed felt that 'people value the information that pharmacists provide in the form of CMI', 61% indicated that they may have not delivered a CMI in the last 6 months because 'the side effects listed in the CMI would have caused anxiety or alarm and perhaps led to non-compliance', 45% because 'the consumer was someone who in their view may not have been able to understand the information', 38% because 'the consumer did not speak or read English', 35% 'because the consumer was obviously in a rush' and 29% because 'the consumer had a diagnosed mental illness'. According to PSA guidelines, the appropriateness of CMI delivery is a matter for professional judgment. With this consideration in mind, it is important to ensure that pharmacists are well aware of patients' needs and expectations including needs of specific groups.

7.3.4 Consumer satisfaction and quality of services

The high level of satisfaction expressed in the general public and exit surveys contrasts with the low level of cognitive services provided in terms of verbal or written counselling for both prescription and OTC medicines. Similar results have been found in the Australian and international literature. It has been pointed out that consumer satisfaction relates mainly to what people require of pharmacies i.e. 'that they be accessible, have the medicines in stock, have a pleasant environment and not make them wait long to be served' [1]. Satisfaction of consumers is conditioned by their expectations. Consumers in the general public may be unaware of the cognitive services that pharmacists can offer them and so have low expectations. The difference between the high levels of satisfaction expressed by consumers and the average or low quality of some professional services may also be explained by the fact that consumer satisfaction is more influenced by the functional quality of the service than by the technical quality.

7.3.5 Health consumers versus non health consumers

In the general public survey and exit survey, 41% and 43% of respondents respectively were health consumers according to our definition. Not surprisingly, health consumers tended to be older, were more likely to be female, to be retired or on a pension, and less likely to be employed full-time. In the general public survey, health consumers were more likely to ask advice from the pharmacist than non health consumers but were less likely to speak with the pharmacist about how to use a medicine. This may be explained by the fact that health consumers were less likely to get a prescription for the first time, and so were less in need of information than non health consumers but were more likely to ask advice if needed than non health

consumers. This behaviour was confirmed in the exit survey which showed that health consumers were less likely to speak with the pharmacist or the pharmacy assistant when getting prescription medicines. In both surveys, health consumers consistently rated the performances of the pharmacists and pharmacy assistants higher than non health consumers. This may indicate that health consumers were more likely to develop an ongoing positive relationship with pharmacists because of their frequent visits and their higher loyalty to one pharmacy.

7.3.6 Privacy

The research gave conflicting results on the privacy issue. The consumer surveys and more particularly the exit survey demonstrate a high degree of satisfaction by consumers with the level of attention to privacy they have experienced in their pharmacy. By contrast in the focus groups there were many examples of consumers having experienced a lack of privacy. This divergence of findings may be explained by the differences in needs. Some groups of consumers (e.g. with mental illness or on opiate replacement therapy) may have higher needs for privacy and also different expectations. Conversely, if consumers expect to have a transaction with the pharmacist which is limited to delivery and payment of medicines, they are less likely to be concerned by the lack of privacy. The PSA Professional Practice Standards include the following privacy provision: 'the patient's rights to privacy and confidentiality are observed at all times', for most services provided. The QCCP standards require that 'the pharmacy has an appropriate patient area for private counselling of patients' so that the conversation is not overheard.

7.3.7 Aboriginal people

The focus group with Aboriginal people showed similar concerns to other groups (methadone users group), in particular in terms of privacy and lack of engagement of pharmacists with consumers. Additionally, issues of racism and impoliteness of staff, costs (co-payment and non-PBS medicines) and administrative barriers (identification required) were also raised. A key study in 1997 showed that there were numerous barriers which prevented Aboriginal people accessing PBS medications [14]. The implementation of the Section 100 program since 1999 has improved access to medicines in remote areas. A new study of Aboriginal people access to medicines is currently planned by the Department of Health and Ageing and may provide further information on how specific needs of Aboriginal people are best met.

7.3.8 Generic medicines

In the focus groups, several participants expressed concerns about the quality of generics and confusion over frequent changes in appearance and brand names over short time periods. There is clearly a need for more information of consumers on the value and the purpose of generics and the need to purchase medicines at the same pharmacy or same chain to get the same brand over time.

7.3.9 Consumer needs

All data collection methods in this research provided consistent expressions of consumer needs from community pharmacy. The expressed need for more information about medicines to be provided confirms previous findings in the Australian literature [8], [9], [13], [15], [2], [16].

Interviews with government and pharmacy organisations showed that they were well aware of these needs and placed a high emphasis on information provision to consumers, in particular through PSA and associated standards.

The need for other services from pharmacies, over and above core services such as dispensing and provision of OTC medicines, appears to be clearly driven by the special needs of specific consumer categories. For example health screening services and medication review services are likely to be the expressed needs of those who see value in these services based on their health circumstances [7], [17], [18], [19].

Consumers also want more prominent signage encouraging consumers to ask for information on medicines and health treatments. They want also more information on services such as home medicines review or medicines records assistance.

Continuity of care and shared information between doctors, pharmacists and consumers was identified as a need in this project. This confirms the findings of a number of recent Australian studies [9], [12], [13], [20].

A number of organisations reported that it was important to raise community expectations of pharmacy standards and services as a driver for change and ongoing quality and professional development.

7.4 Developing a Sustainable Model of Consumer Engagement in Community Pharmacy Policies and Practices

The research commissioned by the Pharmacy Guild of Australia in May 2005 stipulated that they wished to gain a comprehensive picture from health consumers and the general community of their past and current experiences of community pharmacy, their pharmacy related needs and their expectations of community pharmacists and pharmacy staff. From those findings, the Pharmacy Guild and the Expert Advisory Group wished to understand how consumer and community input could be obtained in an ongoing manner about the policies and practices of community pharmacy.

7.4.1 Attitudes to and current practice in consumer engagement by community pharmacy

A total of 507 pharmacists were interviewed in the pharmacist survey. Overall, 69% of respondents indicated that they currently invited customers to give feedback or evaluation of the facilities or services provided. The most common form of consumer feedback was obtained from informal discussions with regular customers (69%), followed by feedback forms (31%) and regular surveys (17%), including telephone, face to face and self completion surveys. A total of 40% of the respondents indicated that they involved their customers in decision making regarding the facilities and services that could be provided within the pharmacy. The vast majority of pharmacists (90%) perceived feedback from customers to be very or quite useful in shaping the services or facilities provided at the pharmacy. The best means of obtaining customer feedback was considered to be through informal discussions (81%), suggestion boxes (74%), feedback forms (71%) and occasional surveys (70%).

7.4.2 Consumer experience of consumer engagement in community pharmacy

The focus groups highlighted the limited opportunities for consumers to engage with their community pharmacy around quality issues. This was most starkly illustrated by the very small number of consumers in the focus groups who had ever been asked for feedback by their community pharmacy either verbally or in a survey (4). Lack of knowledge of complaints processes within community pharmacy and the need for Pharmacy Boards to become more active and able to act when complaints are received also emerged through the focus groups and the stakeholder interviews.

The focus groups and interviews with consumer stakeholder groups also suggested that work may be needed to be done on attitudes of some pharmacy staff to certain groups of consumers. This ranged from cross-cultural training for Australian pharmacists and their staff to ensuring pharmacists spent time with consumer organisations to discuss the issues for particular needs groups such as IV drug users and Indigenous groups.

7.4.3 Support for increasing consumer engagement in community pharmacy

More engagement with consumers was seen by most of the focus groups and interview participants as being highly desirable, especially in identifying and working to meet the needs of particular groups of consumers. Bringing pharmacists and consumers together to discuss common issues was seen as being mutually beneficial. Community pharmacists could inform consumers about the range and quality of services offered and could in turn receive useful information about the needs of their local community. All organisations interviewed saw considerable opportunities for increased engagement between community pharmacy and consumers at the local, regional and national levels.

At national level a need for closer engagement with consumer organisations on the development of services, standards and training was identified. There was broad support for a formal national consumer advisory structure. This structure could be the forum for “mature and respectful debate”¹ on consumer issues and concerns. Pharmacy profession stakeholders identified workforce and workload constraints as the most common barriers to active consumer engagement.

Support from pharmacists for consumer involvement at the national level (35%) was considerably less than that at the local level (61%). Involvement by consumers at the State level attracted support from just one quarter of pharmacists interviewed. Close to a fifth of the pharmacists interviewed did not support consumer involvement at any level. National stakeholders however supported consumer involvement at all levels. Consumers in the focus groups were also positive about consumer involvement in determining community pharmacy policy and practice at all levels. The varying support can be illustrated thus:

	Pharmacy level	National level	State level
Pharmacists			
National stakeholders			
Consumer focus groups			

Table 19: Levels of support for consumer involvement in community pharmacy

Dark shading – high levels of support; Light shading – low levels of support

Given these results, the research team has developed an approach that it believes will work in Australian Community Pharmacy.

7.5 A Framework for Consumer Participation in Community Pharmacy

The research team has designed a broad framework for consumer and community participation for community pharmacy in Australia. Within the framework, there are options for strategies that are known to be effective for gaining consumer input at each level of the health system : national, state, regional and locally (pharmacy).

There is also a process suggested for the detailed development and implementation of the model over the next 3 years. The research team wishes to acknowledge that the implementation of a new model or framework will take time and involve a careful process of engaging both consumers and pharmacists and their respective organisations in discussion and debate on the model and strategies for participation. The end result in the medium to long term should be a partnership between pharmacists’ and those who use their services and advice, to ensure quality community pharmacy continues to meet consumer needs and expectations.

¹ Quote from a consumer organisation representative

The model has been developed with due regard to the results of the research. In particular the relevant results from the consumer interviews (telephone and exit), pharmacist interviews, consumer focus groups, stakeholder interviews and the literature review that dealt with the issue of consumer participation in community pharmacy policy and practice. The model has been derived from a range of other models for consumer participation in the broader health care system.

The research team suggests that the overarching framework should be one that focuses on quality improvement in community pharmacy over time. Consumers would contribute their experiences, needs and expectations of community pharmacy at the national, state and local pharmacy levels in order to influence the development of new professional services to meet existing and future needs and to refine and improve existing professional service delivery. In turn pharmacists should provide support and practical encouragement to health consumers to contribute their views.

Some fundamental underpinnings of the model are:

1. Participation in health care policy and practice improvement is an extension of Australians' democratic rights to express their views and to be heard.
2. Practical support for participation will be built in to all strategies for consumer participation.
3. Participation will be timely, so that consumer views can influence both final and ongoing decisions.
4. Efforts will be made to engage with consumers who have barriers to their participation².
5. Consumer participation can make a positive difference to the effectiveness, efficiency and value of community pharmacy in Australia.

Principles within the broad framework are proposed to be:

1. Participation means partnership, where mutual respect for each others' views is important and tokenism is not tolerated
2. Consumer participation will require organisational and cultural change within community pharmacy organisations
3. Consumer participation plans and strategies will need to align with capacity of community pharmacies and the profession to implement them
4. Consumer participation in community pharmacy must be supported by the peak professional bodies
5. Consumer participation in community pharmacy must be built up from community pharmacies, not imposed from the pharmacy professional bodies [24].

² Note: In conducting consultations with the Indigenous community it is important to consult with the relevant Indigenous community members for their views as users of the service(s) and not only the staff of peak organisations or Aboriginal Medical Services.

7.5.1 Theoretical constructs informing change in community pharmacy and consumers

Introducing change requires people to learn and implement new behaviours. In the context of this study, both pharmacists and their staff and consumers will need to learn new roles and develop new understandings of what quality community pharmacy services mean, if the objectives of consumer input into ensuring quality pharmacy services are to be achieved.

Underpinning any model for consumer engagement with community pharmacy is the need to drive consumer expectations of pharmacy beyond the relatively low level of expectation currently exhibited through the general population surveys conducted through this research. The results of this research show that there is a clear disjuncture between the experiences and expectations of ordinary health consumers and those who have been exposed to consumer organisations that promote consumer rights and raise awareness of quality service delivery.

Exposure of all health consumers to the existing pharmacy professional standards would be a foundation activity to raise awareness about quality in community pharmacy. Once consumers have a better understanding of the concept of quality professional pharmacy care and services, they then need to develop skills and confidence in how to express these new expectations. The goal is to nurture more discerning, inquiring Australian health care consumers when it comes to community pharmacy services.

Any model that emerges from this current research needs to both change perceptions and expectations in the majority of health consumers, and to change attitudes and behaviour of all pharmacists and pharmacy staff. Both these outcomes pose challenges for the pharmacy profession and consumers and for their representative organisations.

The conceptual framework used in developing the strategy on the Quality Use of Medicines provides an approach that could be utilised to address the limitations of relying on individual learning theories described above. This conceptual framework uses the “Integrated Approach” approach advocated by Winett et al [22]. It is a multi-strategic, multi-system approach with all key partners engaged at each step of the process, and provides opportunities for implementing sustainable programs. Winett [23] further argued that in approaching a problem there are likely to be individual, interpersonal, organisational, environmental and institutional factors, all of which need to be addressed. To implement a program successfully, aspects from the various theories and principles both behavioural and non-behavioural should be utilised rather than concentrating solely on one. Further, evaluation will need to encompass multiple outcomes at multiple levels that may mean that the program may have greater practical significance.

The Integrated Approach framework provides a systematic pathway to instituting change consisting of the following four steps;

1. Collecting data on a problem (undertaking an environmental analysis)
2. Looking for successful interventions (what works)
3. Examining implementation issues including an analysis of existing and potential resources as well as what is needed for sustainability
4. Ongoing evaluation (has the intervention achieved desired outcomes)

To some extent this research has completed steps 1 through 3. However, the research team is suggesting further work on step 3 to occur following the research report publication.

Some early work that should be done by the pharmacy profession is to undertake some planning and self assessment regarding consumer participation in community pharmacy. In particular:

1. the capacity and readiness of the community pharmacy sector to engage with consumers
2. what resources and commitments are required from the pharmacy profession and its representative bodies
3. how to monitor and review the effects of consumer engagement

7.5.2 Key Questions

The key questions that then drive the articulation of a sustainable model of consumer engagement in community pharmacy are:

1. How to engage health consumers in a dialogue which will raise their expectations of the services they require from community pharmacy?
2. How do consumers become aware of the knowledge and skills required to use medicines safely and effectively?
3. How to expose community pharmacy staff to effective strategies of consumer engagement that assist them in their quality improvement activities?

7.6 Models of consumer participation

The Australian health care system has embraced consumer participation to varying degrees, with a number of models emerging in the mental health, disability and women's health sectors. More recently models have emerged in general practice and acute care. Common features of the models are:

1. *Strong support from Government and peak stakeholder groups*
2. *National and/or State advisory structures*
3. *Practical support and resources to support participation strategies at the local level*

These features are described below and lead in to recommendations for a sustainable model in community pharmacy.

7.6.1 Strong support from Government and peak stakeholder groups

Policy statements of support and allocation of resources have been features of the models. In some cases this has extended to legislative support for participation. The enshrining of consumer participation in Standards and Accreditation processes is also a key emerging theme.

7.6.2 National advisory structures

Consumer advisory structures at the national level generally advise a peak professional body or sections of a government department. The consumer advisory groups are generally constructed through invitations to representative consumer organisations for them to nominate individuals for a fixed term. The Terms of Reference (ToRs) are determined by the organisation that seeks their advice, although the ToRs are often refined by the group once it is formed.

7.6.3 State advisory structures

In some cases, models have included another layer of advisory structures at the State level. It would differ from the national group in terms of focus. Pharmacy organisations at the State level tend to have a strong continuing education focus and the State consumer advisory structures would also mirror this focus.

7.6.4 Practical support and resources to support participation strategies at the local level

Effective implementation of consumer participation has often been contingent on the provision of practical support and advice on the development of strategies and the conduct of activities to gain consumer involvement in and feedback on services and planning. The support can range from project officers who can work closely with local

pharmacies to determine what would best suit their needs, through to funds to run focus groups or conduct surveys or interviews in pharmacies. This strategy supports those who are “early adopters” in the profession.

Once a cohort of “model” pharmacies is established in each State/Territory, then the process of “diffusion of innovation” can be encouraged by other pharmacies visiting or speaking to the “model” pharmacy staff to hear first hand how they implemented strategies.

7.7 Sustainability through strengthening relationships

Any consumer participation model developed will have a strong emphasis on strengthening the relationship between consumers and providers. The development of structures that bring consumers and policy makers together at the national level are important foundations for dialogue on issues of mutual concern. In relation to community pharmacy, there are existing strong relationships in place that need to be built upon in a sustainable model of consumer engagement.

These strong relationships are essentially between consumers and community pharmacy staff around the more functional aspects of community pharmacy such as friendliness and promptness. The other relationships that are currently strong are those between community pharmacies and the representative pharmacy organisations and between individual consumers and organised consumer groups (see Figure 94).

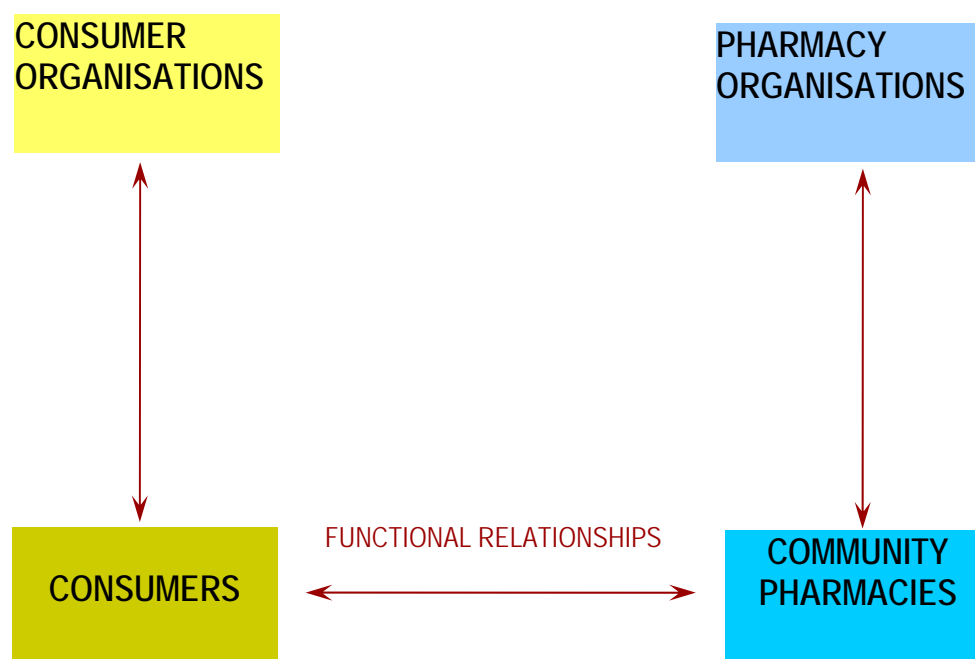


Fig 94. Current strong relationships in community pharmacy

There are also a set of weaker relationships. These are between consumer organisations and community pharmacies and consumer organisations and pharmacy organisations. The relationship of consumer to community pharmacy in terms of quality improvement activities is also in existence, but, as demonstrated through the research, currently quite weak (see Figure 95).

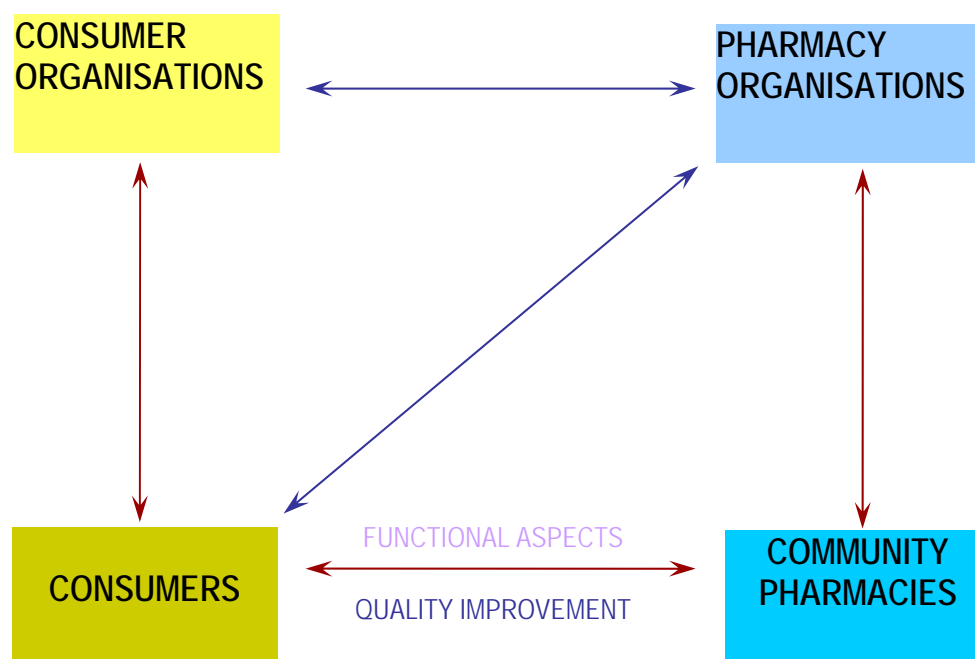
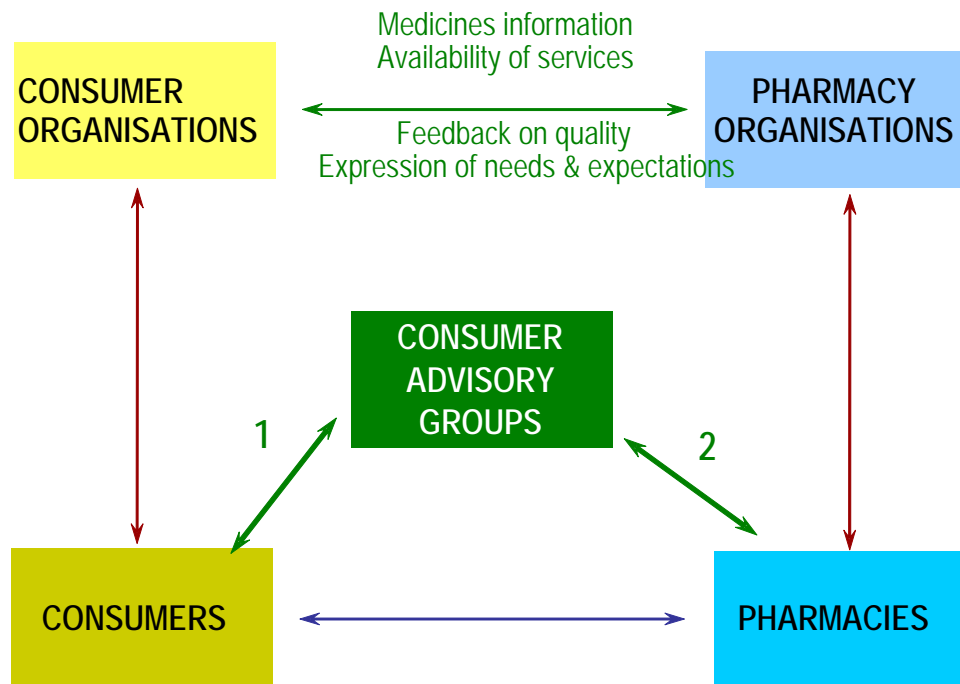


Fig 95. Current weaker relationships in community pharmacy
Red lines = current strong relationships; Blue lines = current weaker relationships

The model being proposed for community pharmacy will strengthen the existing weaker relationships and reinforce and further strengthen the existing strong relationships (see Figure 96).



1 - nomination source

2 – input to policy & standards

Fig 96. Strengthening relationships through sustainable model of consumer engagement in community pharmacy

8. RECOMMENDATIONS

8.1 Recommendations

The following recommendations have been formulated after thorough assessment of data from all data collection methods, by the research team.

8.1.1 Medicines information

The provision of medicines information in both written and verbal form to individuals who use community pharmacy for filling prescriptions or purchasing non-prescription items remains at unacceptably low levels. The research indicates that it is not being routinely provided to consumers who use ongoing medication to manage their chronic conditions. The research also shows that there is limited understanding by consumers of the availability of written medicines and health related information in pharmacies; therefore, consumers expectations are low. To effectively address this situation, the provision of information about the safe and effective use of medicines must be proactively provided by pharmacists and pharmacy assistants, and demanded by consumers.

In examining the various professional standards, accreditation requirements under QCPP, and guidelines produced by various professional organisations and the Pharmacy Boards, the research team believes there is a need, in the current reviews being undertaken of these documents, for greater clarity and consistency on the requirements of pharmacy staff to provide medicines information to consumers.

Recommendation One

It is recommended that:

The PGoA works with the Pharmaceutical Society of Australia (PSA), other pharmacy professional bodies and the Pharmacy Boards as part of an integrated strategy to improve the provision of information on medicines to consumers to:

- a) Emphasise, promote and monitor the routine proactive provision of both verbal and written medicines information to all community pharmacy customers.
- b) Review of the Professional Practice Standards on patient counselling to ensure the inclusion of the recommendations regarding the provision of Consumer Medicines Information (CMI) contained in the PSA guidelines on 'Consumer Medicine Information and the Pharmacist'.
- c) Ensure that pharmacists and their staff are fully aware of the professional standards relating to patient counselling and provision of information to consumers.

- | | |
|----|--|
| d) | Ensure compliance of pharmacists and their staff with the PSA Professional Practice Standards and standards for the provision of pharmacist only and pharmacy medicines through proactive monitoring of these standards |
| e) | Ensure that compliance with these standards is a mandatory requirement of the QCPP. |
| f) | Develop in collaboration with the Consumers' Health Forum of Australia (CHF) a campaign through consumer organisations to encourage health consumers to request the provision of information and CMI when they are provided with medicines through pharmacies. |
| g) | Require all pharmacists to clearly advertise the availability of medicines information within their pharmacies. |

8.1.2 Raising expectations of community pharmacy professional services

The research demonstrated that there is limited consumer awareness of the professional standards required of pharmacists and the full range of professional services available through community pharmacy. There are a number of matters that fall within this broader issue:

- apparent poor consumer understanding of pharmacy assistant training and assumptions that it is biased toward the non-medicines products;
- limited awareness of the range of services available through pharmacies;
- limited awareness of complaints processes including the role of the Pharmacy Boards;
- limited experience by consumers of being asked formally for feedback.

Recommendation Two

It is recommended that the PGoA:

- Encourages all pharmacies to clearly advertise the availability of specific professional services such as home delivery, dose administration aids, return of unwanted medicines, home medicines review, medication list printouts.
- Works with the PSA, other pharmacy organisations, the Pharmacy Boards and CHF to develop a consumer version of the PSA Professional Practice Standards and Standards for the provision of pharmacist only and pharmacy medicines which could be distributed to consumers.
- Consults with CHF about the development of consumer materials about training of pharmacists and pharmacy assistants. The dissemination of those materials could be coordinated through CHF to a wide range of consumer organisations. The materials should also be displayed in community pharmacies.
- Develops resources for all community pharmacies that promote and foster consumer feedback on the services in the pharmacy,
- Develops resources for all community pharmacies to clearly explain the pharmacy's complaints process and the role of the State Pharmacy Boards.

8.1.3 Privacy

The research highlighted marked differences in the responses of consumers in the surveys (general population and exit) and those in the focus groups and consumer stakeholder interviews in relation to privacy. This requires further investigation to determine whether privacy is an issue that is in need of attention in community pharmacy. Both the PSA professional practice standards and the QCPP standards include recommendations on privacy. Pharmacists have also been advised of the implementation of the National Privacy Principles.

Recommendation Three

It is recommended that the PGoA:

- Undertakes further research with consumers and consumer organisations regarding privacy issues in community pharmacy. The research should explore consumers' views, especially those from disadvantaged or marginalised groups, on how privacy is dealt with in the community pharmacy context and propose recommendations to ensure patient privacy in specific situations.
- Pharmacy professional organisations and Pharmacy Boards ensure that adequate guidance is provided to pharmacies participating in methadone programs to protect patient privacy during the dispensing process.

8.1.4 Medicines supply

The research highlighted the high priority consumers placed on medicines (prescription and non-prescription) being readily available at their chosen pharmacy when they needed them. While community pharmacy generally performed well in the functional area of waiting times and availability of medicines, our research appeared to indicate some concerning variability of supply of medicines in different States. This was particularly prominent for people with ongoing chronic health conditions who are seeking to effectively self-manage their medicines. The research team is concerned about the findings related to supply of medicines in NSW but we acknowledge that the small sample size means that we cannot rule out that these results are due to chance only. Further exit surveys can contribute to the monitoring of supply issues in community pharmacy.

Recommendation Four

It is recommended that the PGoA further investigates matters affecting the timely availability of medicines to consumers through community pharmacies, particularly in NSW.

Recommendation Five

It is recommended that the exit survey method using an expanded sample of pharmacies across Australia should be routinely used as part of the re-accreditation processes of the Quality Care Pharmacy Program (QCPP). The results of the exit surveys should be presented in the annual reports of the QCPP.

8.2 A way forward

The results of the general and exit surveys demonstrated a high level of satisfaction with pharmacy services by consumers and a very high rating of pharmacists and their staff in terms of delivery of those services in a professional and personal manner. There is, however, substantial room for improvement in the delivery of core professional services, such as the provision of medicines information to consumers of these medicines, and for promoting greater awareness of the full range of professional services available from community pharmacies. In addition the comments from groups such as those in methadone programs, people from non-English speaking backgrounds and Aboriginal people and from broader consumer advocacy groups indicate a strong focus is needed to improve routine provision of information and professional services to groups with specific and high needs. Of particular note also was the need to consider carefully the issues of privacy and culture. Many of these issues could be addressed through a greater level of consumer engagement in the development, implementation and reviewing of community pharmacy services.

There are issues that require immediate attention and action; however for there to be sustainability in the efforts to improve quality in community pharmacy, and to better meet the needs and expectations of consumers, there needs to be an ongoing set of

structures and processes at the local, State and national levels. The model suggested for implementation by the research team will be an important factor in sustainable development of a quality community pharmacy sector in Australia.

The Sustainable Model of Consumer Engagement in Community Pharmacy Policies and Practices offers an integrated strategy. Implementation of the Model will require commitment by all pharmacy professional organisations at the national and state levels together with a commitment from the peak consumer organisations to working with community pharmacy. The success of the Model will be contingent on the provision of resources for a range of pharmacy and consumer organisations to ensure the effective implementation of all the strategies identified. The recommendations below pertain to the development of a sustainable model of consumer engagement in community pharmacy. The recommendations are based on evidence of effective models of consumer participation.

The Model recommended has components at the national, State and local (pharmacy) levels. The national components are to align with the strategic role of the Commonwealth Government and the Pharmacy Guild of Australia and other national stakeholder bodies in relation to policy and standard setting for community pharmacy. The State components are to enable better access to consumer advice by community pharmacies and to allow for more regional factors to be taken into account. There are a number of State and Territory differences in relation to access of pharmacies and medicines, processes and systems of delivering specialised medicines and the operation of regulatory bodies which are State based. State consumer structures would replicate the current model of the main pharmacy groups such as the Pharmacy Guild of Australia and the Pharmaceutical Society of Australia of State/Territory Branches. The consumer advice and support at the State level could specifically be used to develop the important continuing education and support role played by State Branches of the PGoA, PSA and the monitoring role of the State Registration Authorities. The components at the local community pharmacy level are to ensure relevance and accessibility of consumer advice on specific issues to the pharmacy and the local community.

Recommendation Six

It is recommended that:

- the Sustainable Model of Consumer Engagement in Community Pharmacy Policies and Practices as outlined in section 7 be accepted by the PGoA and that a Community Pharmacy Consumer Advisory Council be established as a matter of urgency to oversee the implementation of the full model by December 2006. It would be an advisory group to the profession, hosted by the PGoA and supported by the CHF.
- the recommendations of this report be priority items on the agenda of the Advisory Council. Terms of Reference would include:
 - Oversight of a national campaign to raise awareness of professional community pharmacy services amongst both consumers and pharmacy staff
 - Oversight of the framework and model of consumer participation in community pharmacy
 - Developing a mechanism for consumer input to:
 - the Pharmacy/Government Agreement negotiations
 - the PSA Professional Practice Standards and the QCPP accreditation development and review processes
 - the training of pharmacists and pharmacy staff
 - Monitoring and advice on key consumer issues:
 - CMI
 - Counselling
 - Consumers with special needs
- The PGoA negotiates through the Guild/Government Agreement appropriate resources for the implementation of the Sustainable Model of Consumer Engagement in Community Pharmacy Policies and Practices.
- The CHF be funded for the equivalent of a FTE Project Officer and travel budget to support the National and State Advisory Structures that are part of the Model.
- The PGoA should draft a strong statement of support for consumer involvement in community pharmacy at all levels and seek the support of the PSA, the Australian College of Pharmacy Practice and Management (ACPPM), the Department of Health and Ageing, the Association of Professional Engineers, Scientists and Managers (APESMA) and the CHF. The statement would be posted on all relevant pharmacy profession related websites and published in all relevant pharmacy publications.
- The PGoA actively supports regular monitoring of consumer involvement and feedback at the local pharmacy level during the QCPP accreditation process.

Recommendation Seven

It is recommended that all States and Territories have their own community pharmacy consumer advisory structure.

The Terms of Reference would include:

- Consumer input to continuing professional development activities for pharmacists in relation to consumer engagement strategies, medicines information provision, and other key consumer issues
- Act as a resource for local pharmacies to test ideas and discuss issues with consumers
- Encourage and support local pharmacies to undertake consumer engagement activities by assisting in the implementation of the recommended strategy from this research.

Membership would be comprised of nominees of relevant State and local consumer organisations (the diversity of community pharmacy consumers would be reflected in the membership).

State coordinators should be appointed to support the State consumer advisory structure and resource the implementation of the consumer engagement strategy in the State.

8.2.1 Monitoring Research on Consumer Experiences of Community Pharmacy

The research conducted by UniSA and its partners has provided the pharmacy profession and the PGoA in particular with a benchmark regarding consumer experiences of community pharmacy. Repeating the research during the next Guild-Government Agreement cycle would allow for monitoring of change over time in the meeting of consumer needs by community pharmacy. All aspects of the research, except the literature review, would be included:

- General population/health consumer telephone survey
- Exit surveys with pharmacy customers
- Focus groups
- Stakeholder interviews
- Pharmacists interviews

Recommendation Eight

It is recommended that research on consumer experiences, needs and expectations of community pharmacy be undertaken to monitor changes in consumer experiences improvements in consumer engagement in community pharmacy in line with the Guild/Government Agreement cycle, commencing the next research in July 2007 to ensure it is complete in early 2008 in time for negotiations on the next Agreement.

8.2.2 Implementation Timeframe

The following timeframe is recommended for the full implementation of the sustainable model of consumer engagement in community pharmacy.

Activity	Timeframe
Disseminate the research report and recommended model for consumer participation in community pharmacy	End 2005
Conduct workshops in each State/Territory with local stakeholders to flesh out local strategies	Feb/Mar 2006
Establish national and State consumer advisory groups	Apr to Jun 2006
Establish central fund for support	June 2006
Employ State/Territory Project Officers	June 2006
Recruit model pharmacies	Jul to Dec 2006
Commence local implementation in model pharmacies	Jan 2007
Conduct monitoring research on consumer experiences	Jul to Dec 2007
Conduct monitoring research on consumer experiences	Jul to Dec 2010

Table 20: Implementation timeframe for sustainable model of consumer engagement in community pharmacy

8.3 Conclusions

The research into consumer experiences, needs and expectations has provided the pharmacy profession with a rich source of information about the consumer perspective of community pharmacy.

The results of this study indicate that, at a functional level, consumers are very satisfied with their experiences when they use community pharmacy services. At a professional level however, consumer and professional organisations are less satisfied with the delivery of core services such as provision of medicines information. Information was identified as both a major need and an expectation of community pharmacy.

Consumer needs most frequently identified through the research were:

- Ready access to needed medicines including shorter waiting times for prescriptions to be dispensed
- the need for consistent provision of written information, both about medicines (prescription and non-prescription) and about the services that community pharmacy offers
- to speak with the pharmacist about how to use the medicine and to receive written instructions on how to use the medicine

Pharmacists were seen by most participants as experts in medicines, more so than doctors. All participants reported that personalised service from their community pharmacist was highly valued and a key need and expectation.

All peak professional and government stakeholders identified the need for high standards of service in community pharmacy, provided by well trained staff who are familiar with the products they are supplying.

ATTACHMENT 1: PROJECT INFORMATION SHEET

CONSUMER EXPERIENCES, NEEDS AND EXPECTATIONS OF COMMUNITY PHARMACY PROJECT

A Research Project of the Pharmacy Guild of Australia

Research Contractors: *University of South Australia,
Harrison Health Research, Tony Lawson Consulting
and Australia's Health*

Background

The Pharmacy Guild of Australia has commissioned research into consumer expectations of community pharmacy to assist with improving relationships between consumers, pharmacy staff and government, and to contribute to the development of policy and services. The research commences in May and will be complete in June 2005.

Context

The development of novel pharmacy services, the national implementation of standards of pharmacy practice and the move from a limited dispensing-counselling approach to an integrated patient-centred approach, have dramatically changed community pharmacy practices in the last 10 years. However, the public may be unaware of these changes.

Community Pharmacy involves consumers in a number of strategies and initiatives such as the Implementation Steering Group for Home Medicines Review. However, there is no organised, systematised framework to involve consumers in the enhancement of the quality of pharmacy services, either at the "grassroots" level in community pharmacies or at the federal and state level in peak professional bodies. Last year the publication of the survey of community pharmacists in the Choice magazine illustrated the insufficiency of on-going communication and fruitful collaboration between pharmacy and consumer organisations (Choice magazine survey, 2004).

The development potential of community pharmacy in the health care system is immense. It may include strengthening of the core function of pharmacists in dispensing and counselling to support the quality use of medicines. Pharmacists may also represent the first point of call for patients engaged in self-management of chronic illnesses and are ideally placed to provide advice on healthy lifestyle and disease prevention.

Pharmacy services designed and delivered with an understanding of the views and needs of those who use them are more likely to effectively target those needs. Collaboration with consumers as stakeholders will lead to sustainable improvements and maintain public confidence in community pharmacy.

Aim of Project

In view of the above, the following research questions will be addressed:

- What are consumer experiences in relation to community pharmacists and pharmacy assistants?
- What are consumer expectations and needs in relation to community pharmacists and pharmacy assistants? Are these expectations and needs met?
- What gaps and deficiencies may exist in the services provided by community pharmacists? How can any shortfalls be addressed?
- How are consumers currently involved in the improvement and development of pharmacy services?
- How can consumer participation be encouraged at the different levels (community pharmacy, professional organisations, development of common projects)?

Proposed Methodology

The consulting team under the leadership of the University of South Australia is proposing a methodology encompassing five distinct modules of data collection, employing a variety of processes including telephone surveys, face to face exit surveys, interviews and focus groups. These modules will ensure that the perceptions and expectations of the general public and health consumers are comprehensively measured and contrasted against the views of pharmacists. Informing this process will be consultation with key stakeholders to the project, particularly in relation to their needs and expectations, and a literature search to review current research and best practice in community pharmacy and related fields. The information gathered will be summarized and analysed, and will play an integral part in the synthesis of the report and, most importantly, in the generation of recommendations that are likely to influence the future direction of community pharmacy.

Quantitative and Qualitative methods

The research will use both qualitative and quantitative methods to gather the views of consumers nationally. There are five methods for data gathering:

1. National telephone survey of both occasional and frequent users of community pharmacy (n=2000)
2. Face to face exit surveys of community pharmacy customers in NSW, VIC, SA, QLD, WA and NT (n=520)
3. Telephone survey of pharmacists (n=500)
4. Stakeholder interviews (n=13)
5. Consumer focus groups in ACT, NSW, VIC, WA and SA (n=12)

Literature Review

In addition, a literature review of international and Australian studies and reports on consumer needs, experiences and expectations of community pharmacy will be undertaken.

All data gathering and the literature review will be carried out concurrently to meet the deadline for a Draft Final Report.

Intended Outcomes

The intended outcome of this project is the development of best practice framework(s)/model(s) which will identify and provide a better understanding of the general population and health consumers' experience, needs and expectations of pharmacist, pharmacy assistants and community pharmacy in order to improve the relationship between these stakeholders and assist in the development of better policy and services.

The Project Team

Project Co-Directors: Ms Kathy Mott, Senior Consultant Health Sciences, UniSA
Ms Frances Eltridge, General Manager, Harrison Health Research

Project Advisor: Professor Andrew Gilbert, Director, Quality Use of Medicines and Pharmacy Research Centre (QUMPRC), UniSA

Project Manager: Mr Tony Lawson, Tony Lawson Consulting

Research Consultants Dr Agnes Vitry and Dr Deepa Rau, QUMPRC, UniSA
Dr Derek Weir and Mr Tony Wade, Australia's Health

For further information about the research, please contact:

Ms Kathy Mott, Project Director, UniSA
Mr Tony Lawson, Project Manager

Ph 08 8302 1106 or 0416 258 889
Ph 0417 895 180

ATTACHMENT 2: COMMUNICATION PLAN

1. Introduction

- 1.1 The Communications Plan is the University of South Australia's (UniSA) definition of the organisational elements and process that will be applied to the management of all internal and external communications for the contract period of the Consumer Experiences, Needs and Expectations of Community Pharmacy Project.
- 1.2 The purpose of the Communications Plan is to describe the communications that are to take place between the UniSA and its subcontractors (the consultants), between the consultants and the Pharmacy Guild and stakeholders. In specific terms the Communication Plan outlines the responsibilities of those required to ensure timely and appropriate generation, collection, dissemination, storage and ultimate disposition of all information about the operation of the Project:
- (1) Among UniSA and its subcontractors.
 - (2) Between UniSA and the Pharmacy Guild.
 - (3) Between UniSA and external parties.

It also provides a framework for collecting and disseminating information including status, progress and final reports.

See **Attachment A** for contact details of relevant UniSA staff, Consultants to the project and Pharmacy Guild officers.

- 1.3 This Plan is underpinned by the following communications principles:
- UniSA and its subcontractors believe that all Project communication should be as open as possible, whilst ensuring commercial and confidential information is protected.
 - The sponsorship of the Pharmacy Guild will be acknowledged in all external communications as prescribed by the Guild.
 - Information about the Project which may be released to media outlets by the Project will only be done so with the approval of the Pharmacy Guild and after consultation with stakeholders where appropriate.
 - In any communications to external parties, the intellectual property rights of all parties will be respected and protected.
 - All formal communication will be in writing and conveyed by fax or post and no party will rely solely on the use of email for conveyance of critical information, unless agreed otherwise by both parties.
 - Compliance with National Privacy principles and legislation.

2. Communication Management

2.1 Communication Tools

- 2.1.1 Transmission of information will be by electronic means except for formal/contractual information. Contractual information is to be provided in writing. Email, fax and telephone will be used as common communication tools.

- 2.1.2 For formal reports the Consultants shall submit five hard copies and one electronic copy of the draft and final report.
- 2.1.3 The provision of progress reports may be provided by email to the Pharmacy Guild.

2.2 Types of Communication

- 2.2.1 A number of regular meetings are to occur. The attendance, frequency and timing are described below.
- 2.2.2 Consultant Project Team Meetings – regular weekly teleconference meetings will be held. Face to face planning meetings to workshop findings and prepare reports will be held on a needs be basis at a date and time to be determined.
- 2.2.3 Consultant meetings with Pharmacy Guild – regular progress reports will be forwarded to the Pharmacy Guild and the consultants and Pharmacy Guild may request meetings with them and the Expert Advisory Group at times to be negotiated. Meetings will be held on receipt of the draft and final reports. These meetings may also include other stakeholders.
- 2.2.4 A range of informal communication methods will be utilised to discuss issues, identify common concerns and to explore solutions. The methods will include phone, fax, email and opportunistic face to face encounters.

2.3 Communication Responsibilities

The Co - Project Directors have responsibility for communication and liaison with the Guild and key external parties but on day-to-day matters the Project Manager will be responsible for liaison with the Guild.

3. Information Management

3.1 Types of Documents

The following categories of documents will be generated by the Project:

- Management documents: include Project plans, Project procedures, progress and status reports and other similar deliverable documents,
- Commercial documents: include contract documents, purchase orders, payment claims, accounting records, change request documents, subcontract payment documents and other similar documents.

3.2 Document and Data Management

- 3.2.1 Data is able to be stored locally on the responsible consultant's password-protected server. Each project staff member will ensure data backup processes are in place to protect against and recover from data loss. UniSA's current procedures include server backup at the end of each week. Copies will be stored on a central UniSA server. UniSA servers have Windows and Unix operating systems.
- 3.2.2 Tracking and identification of developmental versions is mandatory. Each mark-up of a document is to be treated as a new version. During internal reviews of developmental documents, this will be controlled by the modified document's file name being modified to capture the person and the date (e.g. filename-TL-051104.doc).
- 3.2.3 Submittal/transmittal of contract-related documents will require written

transmittals to confirm dates of issue and receipt for contract monitoring purposes. The Project Manager will maintain a register of deliverable documents and their status.

3.3 Document numbering system

3.3.1 UniSA will operate the Project with a document numbering and identification system that provides a unique identifier to each project document.

3.3.2 Unique identifiers will be used for contractual correspondence and for major meetings where decisions, instructions, actions or special conditions are documented.

4. Performance Reporting

4.1 Progress Reporting

4.1.1 Progress reporting on the Consumer Experiences, Needs and Expectations of Community Pharmacy Project will be provided on a weekly basis by email and a formal interim Report is to be provided on 10th June 2005.

4.1.2 Regular weekly teleconferences of the consulting project team will be held. The Project Manager will provide an Agenda prior to each meeting and will prepare notes documenting all key discussions, decisions and information which the Project may rely upon. An action list describing all outcomes, responsibilities and due dates will accompany the notes. The notes will be circulated by email to members.

4.2 Formal Reporting

4.2.1 Formal reporting is required on following dates;

Draft Report – 30th June 2005

Final Report – 29th July 2005

The Consultant shall submit five hard copies and one electronic copy (in MS Word or Excel as appropriate) of the Draft reports and Final reports to the Pharmacy Guild in accordance with the timeframe outlined above.

4.2.2 Under the terms of the contract formal reporting is to be conducted between the following parties;

Pharmacy Guild

Dr Simone Jones

Research Manager

The Pharmacy Guild Of Australia

National Secretariat

Level 2, 15 National Circuit Barton Act 2600

Po Box 7036, Canberra Business Centre Act 2610 Australia

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University of South Australia

Ms Kathy Mott
Project Director
AHPMC Trials Evaluation
Senior Consultant
Business and Consultancy Unit
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University of South Australia
GPO PO Box 2471
ADELAIDE SA 5001
Phone: (08) 83021106
Fax: (08) 8302 0669
Email: kathy.mott@unisa.edu.au

5. Communication Plan Review

This plan will be monitored on a regular basis and will be discussed as an agenda item at every consulting team meeting. Any changes made will be highlighted and communicated to all key stakeholders.

Appendix A - Contact Details Community Pharmacy Project

NAME	ADDRESS/PHONE	EMAIL
Ms Kathy Mott Co - Project Director	Senior Consultant Business and Consultancy Unit Division of Health Sciences University of South Australia GPO Box 2471 ADELAIDE SA 5001 Phone: (08) 8302 1106 Fax: (08) 8302 1472 Mobile: 0416 258 889	Kathy.mott@unisa.edu.au
Ms Frances Eltridge Co – Project Director	General Manager Harrison Market Research Pty Ltd Suite 1, 198 Greenhill Road, Eastwood SA 5063 Phone: 08 84904215 Fax: 08 84904299 Mobile: 0419 864 160	frances@harrisonresearch.com.au
Professor Andrew Gilbert Key Advisor	Director, Quality Use of Medicines and Pharmacy Research Centre Division of Health Sciences University of South Australia Phone: 08 8302 2373 Fax: 08 8302 1209	andrew.gilbert@unisa.edu.au
Mr Geoff March Key Adviser	Research Fellow School of Pharmacy and Medical Sciences University of South Australia Phone: 8302 2635 Fax: 08 8302 2389	Geoff.March@unisa.edu.au
Mr Tony Lawson Project Manager	Director - Tony Lawson Consulting 29 Elizabeth Street NORWOOD SA 5067 Phone: 08 8361 2165 Mobile: 0417895180	tlawcons@bigpond.net.au
Mr Glen Kelly Senior Consultant	Managing Director Harrison Market Research Pty Ltd Suite 1, 198 Greenhill Road, Eastwood SA 5063 Phone: 08 8490 4205 Fax: 08 8490 4299 Mobile: 0439 668 099	glen@harrisonresearch.com.au
Mr Tony Wade and Dr Derek Weir Senior Consultants	Directors - Australia's Health Pty Ltd PO Box 5084 LYNEHAM ACT 2602 Telephone 02 6257 0260 Facsimile 02 6257 0268 Tony W Mob: 0413 883 740	wade@australiahealth.com weir@australiahealth.com

NAME	ADDRESS/PHONE	EMAIL
Dr Agnes Vitry Senior Researcher	Senior Lecturer School of Pharmacy and Medical Sciences University of South Australia Phone: 8302 2392 Fax: 8302 1087	Agnes.Vitry@unisa.edu.au
Dr Deepa Rao Senior Researcher	Research Fellow School of Pharmacy and Medical Sciences University of South Australia Phone: 8302 2377 Fax: 08 8302 1087	Deepa.Rao@unisa.edu.au
Dr Barbara Anderson Project Officer	Senior Research Fellow School of Pharmacy and Medical Sciences University of South Australia Phone: 8302 1639 Fax: 08 8302 1087	Barbara.Anderson@unisa.edu.au
Ms Jo Harrison Admin Officer	Business and Consultancy Unit, Division of Health Sciences University of South Australia (City East Campus) GPO Box 2471 ADELAIDE SA 5000 Phone: (08) 8302 1099 Fax: (08) 8302 1472	Joanne.harrison@unisa.edu.au
Ms Vanessa Eley Admin Officer	Business and Consultancy Unit, Division of Health Sciences University of South Australia (City East Campus) GPO Box 2471 ADELAIDE SA 5000 Phone: (08) 8302 1095 Fax: (08) 8302 1472	Vanessa.eley@unisa.edu.au
Dr Simone Jones Research Manager	The Pharmacy Guild Of Australia National Secretariat PO Box 7036, Canberra Business Centre Act 2610 Australia Telephone +61 2 6270 1888 • Facsimile +61 2 6270 1800	simone.jones@guild.org.au
Ms Erica Vowles Assistant Project Officer	The Pharmacy Guild Of Australia National Secretariat PO Box 7036, Canberra Business Centre Act 2610 Australia Telephone +61 2 6270 1888 • Facsimile +61 2 6270 1800	erica.vowles@guild.org.au

ATTACHMENT 3: DOCUMENT MANAGEMENT SYSTEM

CONSUMER EXPERIENCES, NEEDS AND EXPECTATIONS OF COMMUNITY PHARMACY PROJECT

PHARMACY GUILD OF AUSTRALIA

DOCUMENT MANAGEMENT SYSTEM INFORMATION

1. The University of South Australia will maintain a Document Management System in relation to the consumer experiences, needs and expectations of community pharmacy project on the following basis.
2. All documents will be allocated document numbers and registered in accordance with the following protocols:-

AAA-XXXXX-000-(A) (VERA/X)

Where:

- (a) The first set (3) = alpha

CON	=	Contract
COR	=	Correspondence (In and Out)
DAT	=	Data (Tools and Results)
FIN	=	Financial
MIN	=	Minutes (Minutes, agenda, teleconference notes etc)
PLA	=	Plans (Project Related Plans)
REP	=	Reports

- (b) The second set (5) = numeric
= UniSA's unique project identifier;

- (c) The third set (3) = numeric
= the sequential numbering of documents;

- (d) The fourth set (4) = alphanumeric where –
Ver = Version
A = Draft
0-100 = Submitted

Example: CON-69822-001-P-Ver0

= Contract - UniSA identifier- first contract - Project Management –version submitted to Client.

3. Please ensure when requesting amendments to documents or generating a new document to CC Joanne Harrison at joanne.harrison@unisa.edu.au
4. When naming documents, please ensure that you include the following details in order to facilitate registration and filing:-

Region_Category_Group_Date

e.g. H_Int_GP_121204 where

Categories will be:-

Int	=	Interview
Fin	=	Financial
Ser	=	Service Usage
Con	=	Consumer Focus Groups
Sta	=	Stakeholder Workshops

5. All consultants/team members may generate and circulate documents.
6. Only the Project Director and Project Manager may amend Master documents.

ATTACHMENT 4: MATRIX – ASSESSING COMPONENTS AGAINST ALL SURVEY TOOLS

TOOLS	NEEDS	EXPECTATIONS	EXPERIENCES
General Population Telephone Survey	1 key question on what they would like to see improved to meet needs	General expectations now Future expectations	Explore what services and products they have experienced and the quality of those services and products
Face to face Exit Survey of customers	What they would want to be different	Not addressed	Rate experience this time re quality, access, availability, respect/privacy and timeliness
Pharmacist telephone interviews	What they perceive are consumer needs currently and in the future? What needs community pharmacy best meets? Barriers and enablers to meeting needs How often do they talk to GPs?	When they introduce new services do they engage consumers in early discussion re service design and delivery? What response have consumers given to new services? How have they evaluated effectiveness of new service?	To what extent do they use consumer feedback generally? What impact has QCPP had on the ability to meet consumer expectations and needs?
Stakeholder face to face interviews	Explore needs of specific groups and general consumer needs. Future needs	Expectations of community pharmacy To what extent community pharmacy meets the members' expectations Expectations Involvement in quality improvement or new services design in community pharmacy	To what extent needs are met now Experiences of giving feedback on quality
Consumer focus Groups	Explore needs of specific groups and general consumer needs.	Expectations of community pharmacy Expectations Involvement in quality improvement	Positive and negative experiences, gaps, improvements Involvement in Quality Improvement
Literature review	What the literature says about consumer needs	What the literature says about consumer expectations	What the literature says about consumer experiences

ATTACHMENT 5: MODULE 1 GENERAL PUBLIC SURVEY INSTRUMENT - CATI SCRIPT

Good morning/afternoon/evening, my name is ... from Harrison Research. We are conducting research around Australia about pharmacies in the community and the services they provide. _IF NECESSARY, CONFIRM THIS MEANS CHEMIST SHOPS_. We need to speak to a representative sample of Australia's population; may I please speak with the person in the household, aged 15 or over, who was the last to have a birthday?

REINTRODUCE OR CALL BACK AS NECESSARY

IF THEY WANT TO KNOW WHO IT'S FOR, YOU CAN TELL THEM - THE PHARMACY GUILD OF AUSTRALIA

IF CONCERNED ABOUT PRIVACY I can assure you that any information you give will remain confidential. Any identifying information, such as this phone number, is removed before we analyse the results. No one's individual answers can be passed on to our clients or anyone else."
PAUSE

"_SCREEN 1_ Does anyone in this household work in market research or in a pharmacy? _IF YES, THANK & TERMINATE. IF NO, CONTINUE_

The survey will take about 15 minutes to go through. _IF THEY'RE HESITATING BECAUSE OF TIME_ We do need to get opinions from as wide a cross-section as possible; I could call back later if it would be more convenient. _ARRANGE CALLBACK IF REQUIRED OR CONTINUE_

Thank you"

pause

"May we commence the interview?"

start

"Q1 Do you personally, or does someone for whom you are a carer, have an ongoing condition requiring treatment, medication or monitoring?"

MULTI

1. Yes, me personally
2. Yes, someone I care for

3. No

"Q2 How often, if ever, do you visit a pharmacy, either to buy something, get advice or browse?"

1. Daily/most days
2. 2-3 times/week
3. About once a week
4. 2-3 times a month
5. About once a month
6. Every few months
7. Once or twice a year
8. Less often
9. Never

"Q3 How often, if ever, do you use a healthcare professional or seek advice on a health issue?"

SEE Q2

"Q4A How often, if ever, do you go to a pharmacy for prescription medicines?"

SEE Q2

"Q4B How often, if ever, do you go to a pharmacy for non-prescription, or over-the-counter, medicines such as painkillers, cold & flu remedies, antihistamines, etc?"

SEE Q2

"Q4C How often, if ever, do you shop at a pharmacy for vitamins or herbal remedies?"

SEE Q2

"Q4D How often, if ever, do you access other health care products at pharmacies, such as wound dressings, foot care, dental care, equipment hire, etc?"

SEE Q2

"Q4E How often, if ever, do you get personal care products such as cosmetics, perfume, hair care, etc at a pharmacy?"

SEE Q2

"Q4F Gifts, cards, etc.?"

SEE Q2

"Q4G Are there any other products or services you access at pharmacies which I haven't mentioned?"

1. Yes
2. No

IF NOT 1 IN Q4G GO Q5

"Q4H What is that?"

1. Other item 1 (specify)
2. Other item 2 (specify)

"Q4I And how often do you shop at a pharmacy for these items?"

SEE Q2

"Q5 How often, if at all, do you visit a pharmacy for advice from the pharmacist?"

SEE Q2

"Q5A How often, if at all, do you visit a pharmacy to ask advice from the pharmacy assistants?"

SEE Q2

"Q6 _READ OUT 1-4_ Which of the following best describes you:"

1. Although I have a choice, I generally use one particular pharmacy
2. I generally use a particular pharmacy group or chain, but the branch varies
3. I shop at whichever pharmacy is most convenient at the time, regardless of group
4. There is only one pharmacy in my area, so I always go there
5. Other (specify)

IF NOT 1 IN Q6 GO Q7

"Q6A _UNPROMPTED_ Why do you generally use this one particular pharmacy?"

MULTI

1. They speak my language
2. The staff are friendly
3. The pharmacist is always available
4. Pharmacist gives good advice
5. I don't have to wait too long for scripts
6. The staff and pharmacist know me
7. Co-located with my GP
8. Co-located with other health practitioners (specify)
9. Close/convenient to my GP
10. Close/convenient to other health practitioners (specify)
11. Close/convenient to my home
12. Close/convenient to my work
13. It's in the shopping centre I use
14. It's in the shopping strip I use
15. Close/convenient to shopping in some other way (specify)
16. Close/convenient to somewhere else (specify)
17. More convenient than going into shopping centre
18. Parking outside/close by is easy
19. Other (specify)

20. Don't know, never thought about it

"Q7 _READ OUT 1-4_ When you need to have a prescription filled, do you usually:"

1. Sit and wait while it is filled
2. Browse around the shop while waiting
3. Leave and come back when they say it will be ready
4. Leave and come back when it's convenient to you
5. It varies- depending on waiting time
6. It varies- depending on how busy I am
7. It varies- depending on whether children are with me
8. It varies- other (specify)
9. Other (specify)

IF 1-8 IN Q4A GO Q8G

IF NOT 1-8 IN Q4A GO Q8JP

"Q8G _IF EVER GET PRESCRIPTIONS IN Q4_ I'd like to get some idea of how often some things happen when you visit a pharmacy for prescriptions. Using a scale of always, usually, sometimes, rarely or never, could you tell me whether:"

1. You wait less than 10 minutes to get your medicine
2. You wait less than 20 minutes to get your medicine
3. You wait less than 30 minutes to get your medicine

FOR EACH

Q8 PRESCRIPTIONS

"Q8 Using a scale of always, usually, sometimes, rarely or never, could you tell me whether
[Q8G]"

1. Always
2. Usually
3. Sometimes
4. Rarely
5. Never
6. Don't know

Q8JP

=0

IF 1-8 IN Q4A GO Q9G

IF 1-8 IN Q4B GO Q9G

IF NOT 1-8 IN Q4A GO Q9JP

IF NOT 1-8 IN Q4B GO Q9JP

"Q9G _IF EVER GET PRESCRIPTIONS OR OTC MEDICINES IN Q4_ I'd like to get some idea of how often some things happen when you visit a pharmacy for prescriptions or over-the-counter medicines. Using a scale of always, usually, sometimes, rarely or never, could you tell me whether:"

RND

1. The pharmacy has the medicine in stock or can get it in quickly
4. You speak with the pharmacist about how to use the medicine
5. You receive written information on how to use the medicine, apart from what is on the bottle or packaging
6. The pharmacist checks with you later that you had no side effects from the medication

FOR EACH

"Q9 Using a scale of always, usually, sometimes, rarely or never, could you tell me whether
[Q9G]"

1. Always
2. Usually
3. Sometimes
4. Rarely
5. Never
6. Don't know

Q9JP

=0

IF 1-8 IN Q4C GO Q10G

IF 1-8 IN Q4D GO Q10G

IF NOT 1-8 IN Q4C GO Q10JP

IF NOT 1-8 IN Q4D GO Q10JP

"Q10G _IF EVER GET VITAMINS/HERBAL REMEDIES IN Q4_ I'd like to get some idea of how often some things happen when you visit a pharmacy for other health-related products, such as vitamins, skin treatments, wound care, eye drops etc"

RND

1. You receive advice that the product is right for you or the person you are buying it for
2. The assistants are knowledgeable about the health-related products they are selling
3. You receive prompt attention when you enter the pharmacy
4. You receive printed information about the health issue relating to the product
5. The assistant refers you to the pharmacist for advice as often as you would like

FOR EACH

"Q10 Again using a scale of always, usually, sometimes, rarely or never, could you tell me whether _[Q10G]_"

1. Always
2. Usually
3. Sometimes
4. Rarely
5. Never
6. Don't know

Q10JP

=0

"Q12 Is English your first language?"

1. Yes]Q14G
2. No

IF NOT 1 IN Q6 GO Q13

"Q12A Do you choose your regular pharmacy because a staff member speaks your language?"

1. Yes
2. No

"Q13 How often, when you visit, does the pharmacy have someone who can speak to you in your own language?"

1. Always
2. Usually
3. Sometimes
4. Rarely
5. Never

"Q14G _[IF USE MORE THAN ONE PHARMACY_ Thinking about the pharmacy you use most often]

On a scale of 0-10, where 0 means performs extremely poorly and 10 means performs extremely well, how would you rate the pharmacists, rather than other staff, for:"

RND

1. Giving clear information or advice
2. Being polite and courteous
3. Maintaining your privacy
4. Being available when you need to speak with a pharmacist
5. Listening to what you have to say
6. Inviting questions

FOR EACH

"Q14 How would you rate the pharmacist for _[Q14G]_ _0 MEANS PERFORMS EXTREMELY POORLY, 10 MEANS PERFORMS EXTREMELY WELL, D FOR DON'T KNOW_"

WIDTH=2

NUM 0-10, D

"Q15G [_IF USE MORE THAN ONE PHARMACY_ Again thinking about the pharmacy you use most often and...] Now thinking about the pharmacy assistants rather than the pharmacist, on a scale of 0-10, where 0 means performs extremely poorly and 10 means performs extremely well, how would you rate the pharmacy assistant staff for:"

RND

1. Making you feel welcome
2. Calling you by name when you are leaving or collecting a script
3. Being polite and courteous
4. Being able to offer advice on products or services
5. Listening to what you have to say
6. Maintaining your privacy

FOR EACH

"Q15 How would you rate the pharmacy assistant staff for _[Q15G]_ _0 MEANS PERFORMS EXTREMELY POORLY, 10 MEANS PERFORMS EXTREMELY WELL, D FOR DON'T KNOW_"

WIDTH=2

NUM 0-10, D

"Q16 And what is it about using pharmacies that most needs to be improved?"

MULTI

1. Lower prices on medicines
2. Lower prices on other products
3. Shorter waiting times for prescriptions
4. Assistants spend more time serving customers
5. Private area for discussion
6. The pharmacist being more available
7. Other (specify)

8. Can't think of anything

"Q17 I'm going to read out a list of services and I'd like you to tell me, for each one, whether you have a real NEED for the item to be provided, not just that you think it would be nice to have available."

MULTI

1. The pharmacy carries the medicine you need in stock or can get it quickly
2. You wait less than 10 minutes to get your medicine
3. You wait less than 20 minutes for your medicine
4. The pharmacist speaks with you about how to use the medicine
5. You receive written instructions on how to use the medicine, apart from what is on the bottle or packaging
6. The pharmacist checks with you later that you had no side effects from the medication
7. You receive advice that the non-prescription health products are right for you or the person you are buying them for
8. You receive printed information about the health issue relating to the product
9. The person you speak with about a non-prescription item is a pharmacist
10. Don't NEED any of these services

"Q18 I'm now going to read out the remaining services and I'd like you to tell me which, if any, you expect to be provided."

MULTI

NOT Q17

1. The pharmacy carries the medicine you need in stock or can get it quickly
2. You wait less than 10 minutes to get your medicine
3. You wait less than 20 minutes for your medicine
4. The pharmacist speaks with you about how to use the medicine
5. You receive written instructions on how to use the medicine, apart from what is on the bottle or packaging
6. The pharmacist checks with you later that you had no side effects from the medication
7. You receive advice that the non-prescription health products are right for you or the person you are buying them for
8. You receive printed information about the health issue relating to the product
9. The person you speak with about a non-prescription item is a pharmacist
10. Don't expect any of these services

"Q19_READ OUT 1-9_ Have you ever used a pharmacy, for any of the following services?"

MULTI

RND

1. Health screening or monitoring (eg blood pressure, bone density, blood sugar etc)
2. Help to stop smoking
3. Needle exchange
4. Medicine review, where a pharmacist discusses all your medicines with you, at home
5. Medicine review, where a pharmacist discusses all your medicines with you, at the pharmacy
6. Medicines or prescriptions delivered to your home
7. Special packs to help you take the right medicine at the right time (CLARIFY IF REQ'D-DOSETTE OR WEBSTER PACKS)
8. Testing, calibration, or maintenance of your medical equipment, such as asthma machines, blood glucose meters, etc
9. To decide whether to see a doctor
-
10. No, have not used a pharmacy for any of these

"Q20 If these services were regularly available from your local pharmacy, at no charge, how often, if at all, would you use _Health screening or monitoring (eg blood pressure, bone density, blood sugar, etc_?"

SEE Q2

"Q21 How often, if at all, would you use a pharmacy for _Help to stop smoking_?"

SEE Q2

"Q22 How often, if at all, would you use a pharmacy for _Needle exchange_?"

SEE Q2

"Q23 How often, if at all, would you use a pharmacy for _Medicine review, where a pharmacist discusses all your medicines with you, at home_?"

SEE Q2

"Q24 How often, if at all, would you use a pharmacy for _Medicine review, where a pharmacist discusses all your medicines with you, at the pharmacy_?"

SEE Q2

"Q25 How often, if at all, would you use _Medicines or prescriptions delivered to your home_"
SEE Q2

"Q26 How often, if at all, would you use _Special packs to help you take the right medicine at the right time (CLARIFY IF REQ'D- DOSETTE OR WEBSTER PACKS)_, _CLARIFY IF REQ'D- DOSETTE OR WEBSTER PACKS_"
SEE Q2

"Q27 How often, if at all, would you use a pharmacy for _Testing, calibration, or maintenance of your medical equipment, such as asthma machines, blood glucose meters, etc_"
SEE Q2

IF 9 IN Q20 GO Q28JP

"Q28 If there were a charge for blood pressure checks at the pharmacy, would you be willing to pay... _READ DOWN UNTIL RESPONDENT SAYS YES_"

1. \$15 per visit
2. \$10 per visit
3. \$5 per visit
4. \$2 per visit
5. \$1 per visit
6. Would not be willing to pay anything

Q28JP

=0

IF 9 IN Q26 GO Q29JP

"Q29 If there were a charge for special packs to help you take the right medicine at the right time, would you be willing to pay... _READ DOWN UNTIL RESPONDENT SAYS YES_"

1. \$15 per pack
2. \$10 per pack
3. \$5 per pack
4. \$2 per pack
5. \$1 per pack
6. Would not be willing to pay anything

Q29JP

=0

IF 9 IN Q20 GO Q31

"Q30 If there were a charge for time spent with the pharmacist, for monitoring and support to help you stabilise your blood sugar level, would you be willing to pay... _READ DOWN UNTIL RESPONDENT SAYS YES_"

1. \$25 per visit
2. \$20 per visit
3. \$15 per visit
4. \$10 per visit
5. \$5 per visit
6. \$2 per visit
7. \$1 per visit
8. Would not be willing to pay anything

"Q31 Are there any other comments or suggestions you would like to make about pharmacists, pharmacy assistants or community pharmacy in general?"

1. Yes (specify)
2. No

"Q32 Thank you, that concludes the main part of the survey. I just need to ask a few questions about you to help us analyse our results. What year were you born? _RECORD AS NUMBER, D IF REFUSED_"
WIDTH=4
NUM 1900-1990

"Q33_CODE GENDER, DO NOT ASK UNLESS UNSURE_"

1. Male
2. Female

"Q34_READ OUT 1-9 AS REQUIRED_ Which of the following best describes your household?"

1. Lone person household
2. Group household of unrelated adults
3. Group household of related adults
4. Young couple, no children
5. Older couple, no children at home
6. Couple or single parent with mainly pre-school children
7. Couple or single parent with mainly primary-school children
8. Couple or single parent with mainly teenage children
9. Couple or single parent with mainly adult children still living at home

IF 1 IN Q34 GO Q36

"Q35G Including yourself, how many people in total usually live in this household aged...? _TYPE 0 WHERE NO ONE OF THAT AGE_"

1. 0-4
2. 5-12
3. 13-17
4. 18-24
5. 25-34
6. 35-44
7. 45-54
8. 55-64
9. 65-75
10. 75 or over

FOR EACH

"Q35 Including yourself, how many people in total usually live in this household aged...? _[Q35G]_ _TYPE 0 WHERE NO ONE OF THAT AGE_"

EACH

"[Q35G.....] [Q35..]"

BLANK

WIDTH=2

1. NUM 0-99
2. NUM 0-99
3. NUM 0-99
4. NUM 0-99
5. NUM 0-99
6. NUM 0-99

- 7. NUM 0-99
- 8. NUM 0-99
- 9. NUM 0-99

"Q36 And what is your current employment status?"

- 1. Student
- 2. Part-time employment
- 3. Full-time employment
- 4. Unemployed
- 5. Home duties
- 6. Retired / age pensioner
- 7. Pensioner (not aged pension)
- 8. Refused

"Q37 _(READ OUT 1-7)_ Which of the following ranges best describes your household's gross income?"

- 1. Less than \$25,000 a year
- 2. \$25,000 to less than \$50,000
- 3. \$50,000 to less than \$75,000
- 4. \$75,000 to less than \$100,000
- 5. \$100,000 to less than \$150,000
- 6. \$150,000 to less than \$200,000
- 7. \$200,000 or more
- 8. Don't know
- 9. Refused

"Q38 That concludes the survey, thank you for your time.

ATTACHMENT 6: MODULE 2 EXIT SURVEY

PROJECT 6611 - COMMUNITY EXPERIENCES, NEEDS & EXPECTATIONS - JUNE 2005

MODULE 2: EXIT SURVEY

N.B. ONLY BOLD TEXT IS READ OUT

Good morning/afternoon/evening, my name is ... from Harrison Health Research. We are conducting research around Australia about pharmacies and the services they provide, to help understand the public's actual experiences and what they would like to be different. In the process, we are speaking with people using a community pharmacy about their experiences during the visit.

Screen 1: **Does anyone in your household work in market research or in a pharmacy?**

IF YES, THANK & TERMINATE. IF NO: CONTINUE.

The survey will take about 5 minutes. IF THEY'RE HESITATING BECAUSE OF TIME: We do need to get opinions from as wide a cross-section as possible and it would really help if we could speak with you.

IF CONCERNED ABOUT PRIVACY: I can assure you that any information you give will remain confidential. Any identifying information is removed before we analyse the results. No one's individual answers can be passed on to our clients or anyone else.

IF THEY WANT TO KNOW WHO THE CLIENT IS, YOU MAY TELL THEM IT'S THE PHARMACY GUILD OF AUSTRALIA.

Thank you.

Q1. **What is the main reason you are here today?** UNPROMPTED BUT PROBED - MULTI RESPONSE

- 01 Have prescription filled (leave & collect in same visit)
- 02 Collect a prescription
- 03 Drop off a prescription
- 04 Buy non-prescription or OTC medicine - specific product
- 05 Buy non-prescription or OTC medicine - seeking remedy, not specific product
- 06 Buy vitamins or herbal remedies
- 07 Buy a health-related product (specify)
- 08 Buy a personal care product (specify)
- 09 Buy gift, card, etc.
- 10 Buy other (specify)
- 11 Health-promotion event (e.g. blood pressure, cholesterol, blood sugar check, etc.)
- 12 Other health check/monitoring - not promoted event
- 13 Get advice from pharmacist - prescription-related
- 14 Get advice from pharmacist - to decide whether to see a doctor
- 15 Get advice from pharmacist - other health advice
- 16 Get advice from pharmacy assistants - prescription-related
- 17 Get advice from pharmacy assistants - to decide whether to see a doctor
- 18 Get advice from pharmacy assistants - other health advice
- 19 Get advice from pharmacy assistants - non-health related
- 20 Browse for ...(specify)
- 21 Other (specify)
- 22 Nothing else (Q2 ONLY)

Q2. **What else, if anything, did you do while you were here?** UNPROMPTED BUT PROBED - MULTI
SEE Q1 FOR CODES

- Q3. IF LODGED OR COLLECTED SCRIPT (CODE 01-03 IN Q1 OR Q2):
Please tell me which, if any, of these things happened, specifically in relation to your prescription, during your visit today. SHOW CARD 1
- 1..... The pharmacy had the prescription medicine in stock or could get it quickly
 - 2..... You received written instructions on how to use the medicine, apart from what is on the bottle or packaging
 - 3..... You spoke with the pharmacist about the medicine or related health issue - initiated by you
 - 4..... You spoke with the pharmacist about the medicine or related health issue - initiated by them
 - 5..... You spoke with a pharmacy assistant about the medicine or related health issue - initiated by you
 - 6..... You spoke with a pharmacy assistant about the medicine or related health issue - initiated by them
 - 7..... Don't know whether I spoke with pharmacist or pharmacy assistant
 - 8..... None of them
- Q4. IF OTC MEDICINES (CODES 04-05) IN Q1 OR Q2:
Please tell me which, if any, of these next things happened during your visit today in relation to the over-the-counter medicines you were after. SHOW CARD 2
- 1..... The pharmacy had the non-prescription medicine in stock or could get it quickly
 - 2..... You spoke with the pharmacist about the medicine or related health issue - initiated by you
 - 3..... You spoke with the pharmacist about the medicine or related health issue - initiated by them
 - 4..... You spoke with a pharmacy assistant about the medicine or related health issue - initiated by you
 - 5..... You spoke with a pharmacy assistant about the medicine or related health issue - initiated by them
 - 6..... Don't know whether I spoke with pharmacist or pharmacy assistant
 - 7..... None of them
- Q5. IF SPOKE WITH SOMEONE IN Q3 OR Q4: How well or poorly was your privacy maintained during the conversation(s)?
- | | | |
|-------------------|--------------------------------|---------------------|
| 1 Very well | 3..... Neither well nor poorly | 4..... Quite poorly |
| 2..... Quite well | | 5..... Very poorly |
- Q6. IF LODGED OR COLLECTED SCRIPT (CODE 01-03 IN Q1 OR Q2):
How long was the advertised or stated waiting time when you lodged the script?
- | | | |
|--------------------|--------------------|----------------------------|
| 01 < 10 mins | 04 20-24 mins | 07 40-49 mins |
| 02 10-14 mins | 05 25-29 mins | 08 50-59 mins |
| 03 15-19 mins | 06 30-39 mins | 09 60+ mins (specify) |
| | | 10 Can't recall |
- Q7. IF COLLECTED SCRIPT (CODE 01-02 IN Q1 OR Q2) Was this the first time, or the first time in the last 12 months, that medication has been dispensed to you [OR TO THE PERSON NAMED ON THE SCRIPT IF THEY ARE COLLECTING IT ON SOMEONE'S BEHALF]?
- | | |
|---|-----------------------------------|
| 1 Yes - first time | 4..... Don't know - not my script |
| 2..... Yes - first time in last 12 mths | 5..... Don't know |
| 3..... No - have had it before | |
- Q8. IF COLLECTED SCRIPT (CODE 1-2 IN Q1 OR Q2) While you were waiting for your script to be filled, did you: READ OUT 1-4
- 1 Sit and wait while it was filled
 - 2..... Browse around the shop while waiting
 - 3..... Leave and come back closer to when they said it would be ready
 - 4..... Leave and come back at a later time, when it was convenient to you GO Q10
 - 5..... Other (specify)

- Q9. IF 1-3 IN Q8: **How long did you actually wait for your script?**
- | | | |
|-------------------|-------------------|---------------------------|
| 01 < 10 mins | 04.... 20-24 mins | 07.....40-49 mins |
| 02.... 10-14 mins | 05.... 25-29 mins | 08.....50-59 mins |
| 03.... 15-19 mins | 06.... 30-39 mins | 09.....60+ mins (specify) |
| | | 10.....Can't recall |
- Q10. IF 1-4 IN Q8: **On a scale of 0-10, where 10 means extremely reasonable and 0 means not at all reasonable, how reasonable or otherwise did you find this waiting time?**
INSERT NUMBER, D FOR DON'T KNOW
- Q11. IF 1-4 IN Q8: **If you had known in advance that it can take close to 10 minutes to complete the paperwork and safety checks for many prescriptions, how reasonable or otherwise would you have found the waiting time, using the same 0-10 scale?**
INSERT NUMBER, D FOR DON'T KNOW
- Q12. IF CLEAR FROM QUESTIONS 3 OR 4, YOU MAY JUST CODE THIS - OTHERWISE ASK:
During this visit, did you have any contact with ...? READ OUT 1-2
MULTI
- | | |
|--------------------------------|----------------------------|
| 1 The pharmacist | 3..... Neither - GO Q14 |
| 2..... The pharmacy assistants | 4..... Don't know - GO Q14 |
- Q13. IF HAD CONTACT WITH ASSISTANTS (CODE 2 IN Q12): **Thinking about the pharmacy assistants, rather than the pharmacist, on a 0-10 scale, where 0 means performed extremely poorly and 10 means performed extremely well, how would you rate the pharmacy assistant staff today for...**
INSERT NUMBER, D FOR DON'T KNOW
- ...Making you feel welcome
 - ...Calling you by name when you are leaving or collecting a script
 - ...Being polite and courteous
 - ...Being able to offer advice on other products or services
 - ...Listening to what you have to say
 - ...Maintaining your privacy
- Q14. IF HAD CONTACT WITH PHARMACIST (CODE 1 IN Q12): **Thinking about your visit here today and using a scale of 0-10, how would you rate the pharmacist(s), rather than other staff, for:**
INSERT NUMBER, D FOR DON'T KNOW
- ...Giving clear information or advice
 - ...Being polite and courteous
 - ...Maintaining your privacy
 - ...Being available when you need to speak with a pharmacist
 - ...Listening to what you have to say
 - ...Inviting questions
- Q15. **What could have been done differently to improve your visit to this pharmacy today?**
- 1..... Something (specify)
 - 2..... Can't think of anything
 - 3..... Nothing - all was good
- Q16. **Thank you, that concludes the main part of the survey. I just need to ask a few questions about you to help us analyse our results. Do you personally, or does someone for whom you are a carer, have an ongoing condition requiring treatment, medication or monitoring?** MULTI
- 1..... Yes, me personally
 - 2..... Yes, someone I care for
 - 3..... No

Q17. Which of the following best describes you _READ OUT 1-4_:

- 1..... Although I have a choice, I generally use one particular pharmacy
- 2..... I generally use a particular pharmacy group, but the branch varies
- 3..... I use whichever pharmacy is most convenient at the time, regardless of group
- 4..... There is only one pharmacy in my area, so I always go there
- 5..... Other (specify)

Q18. How often, if ever, do you... SHOW CARD 3

- ...visit a pharmacy, either to buy something, get advice or browse?
- ...go to a pharmacy for prescription medicine
- ...go to a pharmacy for non-prescription, or over-the-counter, medicines such as painkillers, cold & flu remedies, antihistamines, etc
- ...buy vitamins, herbal remedies or other health care products at pharmacies, such as wound dressings, foot care, dental care, equipment hire, etc?
- ...buy other, non-health-related products at a pharmacy
- ...visit a pharmacy for advice from the pharmacist
- ...visit a pharmacy to ask advice from the pharmacy assistants

Q18 FREQUENCY GRID:

- | | |
|----------------------|-------------------------|
| 1. Daily / most days | 5. About once a month |
| 2. 2-3 times a week | 6. Every few months |
| 3. About once a week | 7. Once or twice a year |
| 4. 2-3 times a month | 8. Less often |
| | 9. Never |

Q19. Is English your first language?

- 1 Yes - GO Q21 2..... No

Q20. IF NO: Was there someone here today who can speak to you in your own language?

- 1..... Yes 2..... No 3..... Don't know

Q21. What year were you born?

Q22. Code gender:

- 1..... Male 2..... Female

Q23. And what is your current employment status?

- | | | |
|-----------------------------|------------------------------|------------------------|
| 1..... Student | 4..... Unemployed | 7..... Other pensioner |
| 2..... Part-time employment | 5..... Home duties | 8..... Refused |
| 3..... Full-time employment | 6..... Retired / aged pensnr | |

Thank and terminate.

Q24. Record day.

- | | | | |
|----------------|------------------|-----------------|---------------|
| 1 Monday | 3..... Wednesday | 5..... Friday | 7..... Sunday |
| 2..... Tuesday | 4..... Thursday | 6..... Saturday | |

Q25. Record time.

- | | | |
|----------------------|----------------------|----------------------|
| 1 07:30 - 8:59 | 3..... 12:00 - 13:59 | 5..... 16:00 - 18:59 |
| 2..... 09:00 - 11:59 | 4..... 14:00 - 15:59 | 6..... 19:00 - 21:30 |

Q26. Code location:

- | | | |
|------------------------|-------------------------|--------------------------|
| 01 NSW - Sydney metro | 05 QLD - Brisbane metro | 10 VIC - Melbourne metro |
| 02 NSW - regional | 06 QLD - Townsville | 11 VIC - regional |
| 03 NT - Darwin metro | 07 QLD - Cairns | 12 WA - Perth metro |
| 04 NT - regional urban | 08 SA - Adelaide metro | 13 WA - regional |
| | 09 SA - regional | |

ATTACHMENT 7: MODULE 3 PHARMACISTS SURVEY - CATI SCRIPT

"Good morning/afternoon, my name is [Q0IV] from Harrison Health Research. We are conducting a study on behalf of the Pharmacy Guild. Please may I speak with the pharmacist on duty? _IF MORE THAN ONE ON DUTY, ASK FOR THE SENIOR ONE. REINTRODUCE OR ARRANGE CALLBACK AS REQUIRED._

The study is about community experiences, needs and expectations and, in this module of the study, we are speaking with pharmacists around Australia about how consumers are or could be involved in shaping how community pharmacy services are delivered. The survey will take 5-8 minutes. _IF THEY'RE HESITATING:_ This project has an A1 Guild Approval Rating. We do need to get opinions from as wide a cross-section as possible and it would really help if we could speak with you. _ARRANGE CALLBACK AS REQUIRED._

IF CONCERNED ABOUT PRIVACY: I can assure you that any information you give will remain confidential. Any identifying information is removed before we analyse the results. No one's individual answers can be passed on to the Guild or anyone else.'

IF THEY WANT TO VERIFY IT'S A GUILD PROJECT, TELL THEM IT WAS IN THIS MONTH'S GUILD NEWSLETTER, OR THEY CAN VIEW THE PROJECT SUMMARY AT (REFER TO ADDRESS ON DESK OR SCREEN) "www.guild.org.au/public/researchdocs/2005-01_execsum.pdf

PAUSE

"Thank you."

START

Q1 INDEPENDENT OR GROUP

"Q1 Before we start the main questions, could you tell me - is this pharmacy an independent or part of a group or chain of pharmacies?"

1. Independent
2. Part of group/chain _INCLUDES SMALL, CO-OWNED GROUP OF 2 OR 3 PHARMACIES_
3. Don't know

Q2 IN PRINCIPLE INVOLVEMENT

"Q2 In your opinion, to what extent should pharmacy customers be involved in determining policy and practices for community pharmacy? Please use a scale of 0-10, where 10 means they should be heavily involved and 0 means they should not be involved at all. "

WIDTH=2

NUM 0-10,D

Q3 FEEDBACK CURRENTLY ON SERVICES

"Q3 Are customers at this pharmacy ever invited to give feedback or evaluation of the facilities or services you currently provide? "

1. Yes
2. No]Q8
3. Don't know]Q8

Q4 HOW GET FEEDBACK ON SERVICES

"Q4 In what ways are they asked for their opinions on your current facilities or services?"

UNPROMPTED - MULTI RESPONSE"

MR

1. Suggestion boxes
2. Feedback forms provided
3. Signs up encouraging feedback to staff
4. Periodic/regular telephone survey - done by this pharmacy
5. Periodic/regular telephone survey - done by group/chain
6. Periodic/regular face-to-face survey - done by this pharmacy
7. Periodic/regular face-to-face survey - done by group/chain
8. Occasional surveys on specific issues or services - specify issues/services
9. Focus/discussion groups
10. Annual open meeting (general invitation)
11. Consumer/community advisory group - for this pharmacy
12. Consumer/community advisory group - for group/chain
13. Informal discussions with regular customers
14. Other (specify)

15. Don't know

USE 1-4, 6, 8-11,13-15 IF 1 IN Q1

USE 1-15 IF 2 OR 3 IN Q1

IF NOT 4-7 IN Q4 GO Q5JP

Q5 CURRENT SERVICES SURVEY FREQUENCY

"Q5 How often do you conduct customer surveys evaluating current facilities or services?"

1. At least once a month
2. Every few months
3. About twice a year
4. Once a year / annually
5. Less often (specify)
6. Don't know

Q5JP

=0

IF NOT 9 IN Q4 GO Q6JP

Q6 CURRENT SERVICES FOCUS GROUPS FREQUENCY

"Q6 How often do you hold focus or discussion groups to evaluate current facilities or services?"

SEE Q5

Q6JP

=0

IF NOT 11-12 IN Q4 GO Q7JP

Q7 CURRENT SERVICES ADVISORY GROUP FREQUENCY

"Q7 How often does your advisory group meet?"

SEE Q5

Q7JP

=0

Q8 CUSTOMER EVER INVOLVED IN FACILITIES & SERVICES

"Q8 Are customers ever involved in reviewing or determining what facilities or services you should be providing at this pharmacy?"

1. Yes
2. No]Q13
3. Don't know]Q13

Q9 HOW INVOLVED RE SERVICES

"Q9 In what ways are they involved in this process? _UNPROMPTED - MULTI RESPONSE_"

MR

SEE Q4

USE 1-4, 6, 8-11,13-15 IF 1 IN Q1

USE 1-15 IF 2 OR 3 IN Q1

IF NOT 4-7 IN Q9 GO Q10JP

Q10 PREFERRED SERVICES FREQUENCY

"Q10 How often do you conduct customer surveys which explore what facilities or services they would prefer to have?"

SEE Q5

Q10JP

=0

IF NOT 9 IN Q9 GO Q11JP

Q11 PREFERRED FOCUS GROUPS FREQUENCY

"Q11 IF PERIODIC REVIEW FOCUS/DISCUSSION GROUPS (CODE 09 IN Q9): How often do you hold customer focus or discussion groups exploring what facilities or services they would prefer to have?"

SEE Q5

Q11JP

=0

IF NOT 11-12 IN Q9 GO Q12JP

IF 11-12 IN Q4 GO Q12JP

Q12 PREFERRED ADVISORY GROUPS FREQUENCY

"Q12 How often does your advisory group meet?"

SEE Q5

Q12JP

=0

Q13 PERCEIVED USEFULNESS OF CUST FEEDBACK

"Q13 Overall, how useful or otherwise is customer feedback in helping this pharmacy shape the services or facilities you provide, or the way you provide them?"

1. Very useful
2. Quite useful
3. Not particularly useful
4. Not at all useful
5. Can't say]Q15

Q14 WHY USEFUL/NOT USEFUL

"Q14 Why do you say that? _UNPROMPTED - MULTI_"

MR

1. Customers know best what they need
2. Helps us determine demand for services/facilities
3. Helps us know what we need to tell customers
4. They don't understand our requirements
5. They don't know what they need
6. Tried it in past, got nothing useful out of it _PROBE WHY NOT_ (specify)
7. Other (specify)

8. Can't say

Q15 INVOLVE AT NATIONAL, LOCAL ETC

"Q15 In your opinion, should consumers be involved in determining pharmacy policy and practices..."

READ OUT 1-3 - MULTI"

MR

1. ...at national level
2. ...at state level
3. ...at the individual pharmacy level

4. None of them

Q16 PROMPTED STRATEGIES

"Q16 Which of the following strategies for involving customers could you see working for this pharmacy in particular? _READ OUT 1-13 - MULTI_"

MR

1. ...Suggestion boxes
2. ...Anonymous feedback forms provided around the store
3. ...Signs up encouraging customers to give feedback to staff
4. ...Regular telephone surveys - done by this pharmacy
5. ...Regular telephone surveys - done by your group/chain
6. ...Regular face-to-face surveys - done by this pharmacy
7. ...Regular face-to-face surveys - done by group/chain
8. ...Occasional surveys on specific issues or services - specify issues/services
9. ...Periodic focus or discussion groups
10. ...Annual open meeting by general invitation
11. ...Customer advisory group - for this pharmacy
12. ...Customer advisory group - for group/chain
13. ...Informal discussions with regular customers

14. None of them

USE 1-4, 6, 8-11,13, 14 IF 1 IN Q1
USE 1-14 IF 2 OR 3 IN Q1

Q17 OTHER UNPROMPTED STRATEGIES

"Q17 Are there any other strategies for involving customers that you think would be useful or would like to see happen at this pharmacy? "

1. Yes (specify)
2. Can't think of any

Q18G AGREEMENT RE STATEMENTS GRID

"Q18G I'm going to read a number of statements and I'd like you to say how much you agree or disagree with each of them, using a scale of 0-10 where 10 means you strongly agree and 0 means you strongly disagree. Do you agree or disagree that _READ OUT_"

RND

1. Consumers have a valuable role to play in shaping pharmacy policy and pharmacy practice at all levels of the health care system, both public and private
2. Community pharmacies would really benefit if they had ongoing processes to involve their customers in service improvement and development
3. The QCPP should have further requirements for consumer participation, to include at least one more strategy or activity each year _INTERVIEWER NOTE: QCPP IS THE QUALITY CARE PHARMACY PROJECT RUN BY THE PHARMACY GUILD_
4. The Guild, Pharmaceutical Society and other pharmacy groups should establish a national Consumer Advisory Group to provide input on key policy and practice issues
5. Each State PGoA and PSA should have Consumer Advisory Groups for pharmacies to use for advice on quality and new services development
6. The larger pharmacies should be required to have an ongoing consumer advisory group
7. Individual pharmacies should be able to access a State fund to support consumer participation
8. Pharmacies should have access to a State fund for developing innovative participation or consumer research strategies
9. The PGoA, PSA and other pharmacy groups should provide pharmacies with advice and support for consumer participation, such as a Project Officer to assist with designing surveys or conducting focus groups

FOR EACH

Q18 AGREEMENT RE STATEMENTS

"Q18 Do you agree or disagree that _[Q18G]_"

0=STRONGLY DISAGREE, 10=STRONGLY AGREE - RECORD NUMBER, D IF DON'T KNOW"

WIDTH=2

NUM 0-10,D

Q19 OTHER COMMENTS

"Q19 Are there any other comments you would like to make about involving the community?"

1. Yes (specify)
2. Can't think of any

Q20 POSITION

"Q20 Now just a few questions to help us analyse our results. Are you... _READ OUT 1-4_"

1. ...Owner
2. ...Manager
3. ...Regular staff
4. ...Relieving staff
5. Other (specify)

Q21 YEAR QUALIFIED

"Q21 What year did you qualify as a pharmacist? _R IF REFUSED_"

WIDTH=4

NUM 1900-1990,R

Q22 HOW LONG IN COMM PHARMACY

"Q22 How long have you worked in community pharmacy? "

1. Less than 1 year
2. 1-2 years
3. 3-5 years
4. 6-10 years
5. 11-20 years
6. More than 20 years

IF 4 IN Q20 GO Q24

Q23 HOW LONG IN THIS PHARMACY

"Q23 How long have you worked at this particular pharmacy? "

SEE Q22

Q24 MANAGEMENT TRAINING

"Q24 Have you had any formal management training?"

1. Yes
2. No]Q26

Q25 TRAINING TYPE

"Q25 What sort of training was this?"

1. MBA
2. Diploma
3. Uni/college/TAFE Certificate
4. Group/chain internal training
5. Other (specify)

Q26 # PHARMACISTS

"Q26 Including yourself, how many pharmacists are employed in this pharmacy? _RECORD

NUMBER, R FOR REFUSED_"

WIDTH=2

NUM 1-20,R

Q27 # SCRIPTS PER DAY

"Q27 On average, how many scripts does this pharmacy fill per day? _RECORD NUMBER, R FOR REFUSED_"

WIDTH=2

NUM 0-1000,R

Q28 # CUSTOMERS SPOKEN TO PER DAY

"Q28 On average, how many customers do you personally speak with per day? _RECORD
NUMBER, R FOR REFUSED_"

WIDTH=2

NUM 0-500,R

Q29 STATE/TERRITORY

"Q29 What State or Territory are you located in? "

1. ACT
2. NSW
3. NT
4. QLD
5. SA
6. TAS
7. VIC
8. WA

Q30 LOCATION

"Q30 Are you located in... _READ OUT 1-3_"

1. ...A capital city
2. ...A regional city
3. ...A regional or rural town
4. Other (specify)

Q31 ESL

"Q31 Is English your first language?"

1. Yes]Q33
2. No

Q32 NE FIRST LANGUAGE

"Q32 What is your first language?"

1. Arabic
2. Chinese - Cantonese
3. Chinese - Mandarin
4. Chinese - other language (specify)
5. Greek
6. Indonesian
7. Italian
8. Spanish
9. Vietnamese
10. Other (specify)

Q33 YEAR OF BIRTH

"Q33 What year were you born? _R FOR REFUSED_"

WIDTH=4

NUM 1900-1990, R

Q34 GENDER

"Q34 _RECORD GENDER - DO NOT ASK UNLESS UNSURE_"

1. Male
2. Female

Q35 CLOSE

"Q35 On behalf of The Pharmacy Guild and Harrison Research, thank you for your time and comments. _PRESS ENTER TO END INTERVIEW_"

ATTACHMENT 8: OUTLINE OF INTERVIEW SCHEDULE

Peak organisation interviews about consumer views of community pharmacy

The Pharmacy Guild of Australia has commissioned research into consumer expectations of community pharmacy to assist with improving relationships between consumers, pharmacy staff and government, and to contribute to the development of consumer focused policy and pharmacy services. The research is being conducted by a team led by the University of South Australia.

As part of the project a series of interviews are being conducted with peak organisations. Mr Tony Wade and Dr Derek Weir will be conducting these interviews which will take up to one hour.

Interview topics:

From your organisation's perspective:

- What do consumers need from community pharmacy? How does this differ by type of consumer, need or circumstance (for example by age, health condition, location)?
- What do people expect from community pharmacy services and staff (for example range, type and quality of services; costs, information and privacy)? What underlies these expectations?
- What are people's reported experiences of community pharmacy services and staff (eg in services, practice environment, integration with other health care providers)?
- What might community pharmacy and its service look like 10 years from now?
- Who needs to make these changes? How can consumers be engaged in these changes?

Discussion from the interviews will be recorded through written notes. Results will be collated and reported in the project without personal identifying information.

You can read more about the project in a .pdf document on the Pharmacy Guild website at http://www.guild.org.au/public/researchdocs/2005-01_execsum.pdf and about Tony Wade and Derek Weir on their website www.australiahealth.com (follow the links: "about this site" and "about us")

ATTACHMENT 9: INTRODUCTORY LETTER FOR FOCUS GROUPS

Invitation to attend a focus group about consumer views of community pharmacy

The Pharmacy Guild of Australia has commissioned research into consumer expectations of community pharmacy to assist with improving relationships between consumers, pharmacy staff and government, and to contribute to the development of consumer focused policy and pharmacy services. The research is being conducted by a team led by the University of South Australia.

As part of the project a series of focus groups with consumers and carers are being held around Australia. Mr Tony Wade and Dr Derek Weir will be conducting these sessions.

The groups will meet for 2 hours and discuss the following topics:

- What are consumer experiences in relation to community pharmacy?
- What are consumer expectations and needs in relation to community pharmacy? Are these expectations and needs met? What gaps and deficiencies may exist in the services provided by community pharmacy? How can any shortfalls be addressed?
- How are consumers currently involved in the improvement and development of pharmacy services? How can consumer participation be encouraged at the different levels (community pharmacy, professional organisations, national policy)?

Discussion from the groups will be recorded through written notes. Results will be collated and reported in the project without personal identifying information.

Should you have any questions prior to the group meeting, please contact the organisation issuing this invitation.

You can read more about the project in a .pdf document on the Pharmacy Guild website at http://www.guild.org.au/public/researchdocs/2005-01_execsum.pdf and about Tony Wade and Derek Weir on their website www.australiahealth.com (follow the links: “about this site” and “about us”)

ATTACHMENT 10: DEMOGRAPHIC AND HEALTH SERVICE USE INFORMATION FORM

<i>Your age range (please tick one)</i>	
Between 15 and 25 years	
Between 26 and 40 years	
Between 41 and 55 years	
Over 55 years	

<i>Your gender (please circle one)</i>	Male	Female
--	------	--------

*Do you personally, or does someone for whom you are a carer, have an ongoing condition requiring treatment, medication or monitoring?
Please describe which conditions:*

--

How often, if ever, do you visit a pharmacy, either to buy something, get advice or browse?"

--

How often, if ever, do you use a healthcare professional or seek advice on a health issue?"

--

ATTACHMENT 11: FOCUS GROUP CONSENT FORM

Focus group about consumer views of community pharmacy

The Pharmacy Guild of Australia has commissioned research into consumer expectations of community pharmacy to assist with improving relationships between consumers, pharmacy staff and government, and to contribute to the development of consumer focused policy and pharmacy services. The research is being conducted by a team led by the University of South Australia.

For further information about the research, please contact:

Ms Kathy Mott, Project Director, UniSA
Mr Tony Lawson, Project Manager

Ph 08 8302 1106

As part of the project a series of focus groups with consumers and carers are being held around Australia. Mr Tony Wade and Dr Derek Weir from Australia's Health P/L are conducting these sessions.

The groups will meet for 2 hours and discuss the following topics:

- What are consumer experiences in relation to community pharmacy?
- What are consumer expectations and needs in relation to community pharmacy? Are these expectations and needs met? What gaps and deficiencies may exist in the services provided by community pharmacy? How can any shortfalls be addressed?
- How are consumers currently involved in the improvement and development of pharmacy services? How can consumer participation be encouraged at the different levels (community pharmacy, professional organisations, national policy)?

Discussion from the groups will be recorded through written notes. Results will be collated and reported in the project without personal identifying information.

You can read more about the project in a .pdf document on the Pharmacy Guild website at http://www.guild.org.au/public/researchdocs/2005-01_execsum.pdf and about Tony Wade and Derek Weir on their website www.australiahealth.com (follow the links: "about this site" and "about us")

<i>I understand the purpose and conditions of this focus group and agree to participate:</i>	
<i>Name</i>	
<i>Signed</i>	
<i>Date</i>	

ATTACHMENT 12: FOCUS GROUP INFORMATION SHEET

What is this focus group about?

The research project is addressing consumer needs, expectations and experiences of community pharmacy and identifying:

- Are they met?
- Gaps and deficiencies in services.
- How consumers are involved in quality improvement and development.
- How consumer participation can be encouraged.

A full description of the project can be found on the Pharmacy Guild of Australia website at: http://www.guild.org.au/public/researchdocs/2005-01_execsum.pdf

Intended outcomes of this research

- Better understanding of consumer needs, expectations and experiences
- Improve relationships between stakeholders
- Assist in the development of better policy and services

Where to find the results of the research

Pharmacy Guild commissioned research projects are published on their website at <http://www.guild.org.au/public/r&d.asp#commissioned>

Definitions used in this research

Needs

Health care needs, treatments and products, information and advice, and reassurance. For acute and ongoing conditions and prevention of illness.

Expectations

Service quality, timeliness, availability, accessibility, confidentiality and privacy and respectfulness. Product quality, quantity, price, availability, timeliness.

Experiences

Past and present experiences of services, products and outcomes.

ATTACHMENT 13: STAKEHOLDER ORGANISATIONS AND FOCUS GROUP PARTICIPANTS

INTERVIEWS			
Location	Stakeholder organisation	Date	Participants
Canberra	Pharmacy Guild of Australia	28 June	1
Canberra	PSA	29 June	1
Canberra	Australian College of Pharmacy Practice and Management	23 June	1
Canberra	Department of Health and Aging	29 June	1
Canberra	CHF of Australia of Australia	20 June	2
Canberra	National Aboriginal Community Controlled Health Organisations	Declined	0
Canberra	Carers Australia	7 June	1
Canberra	Federation of Ethnic Communities Councils of Australia	28 June	2
Melbourne	Federation of Ethnic Communities Councils of Australia	5 July	1
Canberra	Council on the Aging/National Seniors	7 July	1
Canberra	Australian Injecting & Illicit Drug Users League	9 June	2
Sydney	People Living with HIV/AIDS	15 June	1
Sydney	Australian Consumers Association	17 June	1
Sydney	National Prescribing Service	29 June	1
Total Interviews/participants		13	16

FOCUS GROUPS			
Location	Stakeholder organisation	Date	Participants
National t/c	Health Care Consumers of Rural and Remote Australia	28 June	5
Canberra	Carers ACT	6 July	8
Sydney	Combined Pensioners and Superannuants Association	16 June	8
Sydney	Arthritis Australia	16 June	7
Melbourne	Health Issues Centre/Chronic Illness Alliance	24 June	8
Melbourne	Ethnic Communities Council Victoria	8 July	0
Melbourne	Diabetes Australia (Victoria)	24 June	8
Melbourne	Victorian Mental Illness Awareness Council	8 July	10
Melbourne	Asthma Foundation of Victoria	8 July	6
Adelaide	Council on the Aging/National Seniors	21 June	9
Perth	Health Consumers Council of WA	4 July	17
Adelaide	Muna Paiendi Community Health Centre (Elizabeth)	14 July	6
Total focus groups/participants		12	92

ATTACHMENT 14: LITERATURE REVIEW RESULTS

Table 1: Studies on consumer experiences in Australia

Reference/ Country	Objectives	Methods	Participants	Main Results
Gilbert and Vawser 1996 [23]	To optimise the health impact of rural and remote pharmacists on the communities they serve.	Consumer survey at local area meetings of the Country Women's Association.	No numbers given.	Consumers commented that pharmacists in rural areas perform very valuable and valued services. Rural consumers understood the reasons for sending pharmaceuticals via a third person where distance was a difficulty, but there was wide acknowledgement that face-to-face counselling from a pharmacist was the most desirable interaction. Privacy for personal health problems; lack of confidentiality and anonymity was a barrier to using community pharmacies.
CHF of Australia 1995 [7]	To investigate the impact on consumers of recent changes in pharmaceuticals policy.	Consultations with consumers with chronic conditions, low income, non-English speaking backgrounds and living in non-metropolitan areas.	15 consultations with over 130 participants.	Participants were concerned that they were not receiving the information on pharmaceuticals which they wanted. Only some participants reported that there were opportunities to talk to the chemist when getting a new prescription filled. Often, they only dealt with a shop assistant and this was not satisfactory in terms of getting information about medications. It was thought that speaking to the chemist was more likely if it was a first-time prescription, if the consumer had a disability, if the layout of the shop allowed it and if the dispensing area was separate from the rest of the shop.
Whitehead P et al 1999 [8]	To investigate if there is an association between the level of drug information provided in community pharmacies and business performance as measured by consumer satisfaction and consumer loyalty.	Questionnaire survey administered to consumers in community pharmacies in Sydney metropolitan and Newcastle areas of NSW.	253 consumers in 10 high (sit down consultation style) and low (traditional) information provision pharmacies.	No significant difference in the summed consumer scores of behavioural intention or consumer satisfaction between the two pharmacy types. However, 41% of consumers currently patronising low provider pharmacies indicated a preference for high information provider pharmacies.
Gilbert and Beilby 2000 [1]	To evaluate consumer experiences and satisfaction with medication management services.	Questionnaire surveys of patients pre and post the medication management service in South Australia.	93 respondents in the pre-survey (50% return rate) ; 37 respondents in the post-survey (42.9%).	56.7% of the respondents indicated that the medication management program had made some difference to their health care and/or management of their illness. More than 45% stated that there had been improvements in the understanding of their conditions and nearly 50% in the understanding of medications.

Reference/ Country	Objectives	Methods	Participants	Main Results
Plunkett et al 2001 [5]	To evaluate satisfaction of consumers with advice about skin conditions from community pharmacists involved in an educational programme.	Telephone interviews with pharmacy consumers recruited through 126 pharmacies in Victoria.	181 consumers: 15% males and 85% females. Ages ranged from 20-49.	96% of consumers reported being satisfied (score of 4 to 7 on a 7-point scale) with the treatment and advice given in the pharmacy.
Benrimoj and Gilbert 2002 [10]	To assess the implementation of standards of practice for the provision of <i>Pharmacist Only</i> and <i>Pharmacy Medicines</i> . Standards assessed covered resource management, customer care and advice, pharmacy design and environment and the rights and needs of customers.	45 pseudo patients recruited and participated in 2370 pharmacy visits in all states and territories (approximately 50% of community pharmacies). Six scenarios were used to simulate patient requests, either a direct product request or symptom based request. The level of pharmacy interaction was measured by allocating a score of 0, 0.05 or 1 for each interaction element (e.g. "who is it for?", "symptoms how long"?).	2370 pseudo patient visits (1464 direct product requests and 906 symptom based requests).	Direct product requests: some clinical interaction occurred in 80% of pharmacies. 65% of pseudo patient visits resulted in patients receiving verbal information. In contrast, pharmacies assessed whether another treatment had been tried in only 23% of visits and in the duration of the symptoms was ascertained in only 24% of cases. Symptom-based requests: 99% of pharmacies exchanged information with the pseudo patient. 93% of pseudo patient visits resulted in patients receiving verbal information. In contrast, in 29% of visits pharmacies assessed other medications and in 31% of cases other symptoms.
Chen and Larkin 2002 [2]	To evaluate consumer attitudes toward and experiences of domiciliary visits by community pharmacists.	Interviews using a semi-structured questionnaire with consumers who had had a domiciliary visit 6 months ago in their homes.	17 respondents, 10 male and 7 female respondents aged 60-96 years.	Respondents reported the domiciliary visits by the community pharmacist as a positive experience. Respondents reported learning more about their medications during the home visit and enjoyed the opportunity to ask questions or express concerns.
Koo, Krass and Aslani 2002 [9]	To investigate consumers' awareness, perceptions and modes of Consumer Medicine Information (CMI) use, impact of CMI on consumers, and factors affecting CMI use.	Focus groups in metropolitan Sydney, NSW.	6 focus groups with 57 consumers.	Most participants were aware of written information about prescription medications but were unfamiliar with the term "CMI". Few had experienced a health care professional including a pharmacist providing or discussing CMI but most had read it and found it useful. There was limited interaction when written information was provided.
Allanson and Gilbert 2003 [3]	To evaluate consumer satisfaction with home medication reviews in the "Providing Sustainable Pharmacy Services to the Southern Coastal Region of South Australia" project.	Telephone interviews of consumers who had a home medication review.	54 of 136 patients (response rate 39.7%).	Over 94% of those surveyed indicated that they had an increased understanding of their medicines as a result of the home medication review.

Reference/ Country	Objectives	Methods	Participants	Main Results
Australian Consumers' Association, 2004 [14]	To investigate the quality of advice given on OTC medicines in pharmacies.	Mystery shoppers who acted out three scenarios and recorded information on questions that were asked, who assisted them, the advice they were given and what medications if any were sold.	87 pharmacies both chains and independents in Sydney, Wollongong and Adelaide areas.	Advice given in 58 out of the 87 pharmacies was rated 'poor', 10 were rated 'OK', and 19 were rated as 'good'. 80% of visits where researchers dealt solely with an assistant were classed as 'poor'. Of the 11 visits where contacts were solely with the pharmacist, 6 were rated 'poor', one as 'OK' and 4 as 'good'.
Bajramovic, Emmerton and Tett 2004 [24]	To explore beliefs and expectations of GPs, consumers and pharmacists in relation to concordance defined as an agreement between the patient and the health professional about the best use of treatment.	Two focus groups with consumers and pharmacists; in-depth semi-structured interviews with GPs in Brisbane.	7 consumers (6 females and one male) aged 65 and older and having one or more chronic conditions. 9 pharmacists (6 males, 3 females). 2 of the 9 pharmacists were hospital pharmacists and 7 community pharmacists.	Consumers were happy with the easy accessibility of pharmacists and the amount of treatment information they could access in a pharmacy and expressed the positive view that pharmacists are spending more time with them than previously.
Benton, Snow and Parr 2004 [13]	To assess the extent to which community pharmacies are providing Consumer Medicine Information (CMI).	Telephone surveys of nationally representative samples in July 2003 and April 2004.	1000 consumers interviewed in each survey.	Of consumers who had had a prescription filled in the past six months 41 to 47% were aware of the availability of CMIs in 2003 and 2004 respectively, and 24 to 29% had at some point in the past received a CMI. Of the consumers being prescribed a medication for the first time, 16 to 21% received a CMI. The provision of a CMI increased consumer satisfaction with the pharmacy services.

Reference/ Country	Objectives	Methods	Participants	Main Results
Chapman, Roberts and Stokes 2004 [11] (a)	To assess the impact of the Quality Care Pharmacy Project (QCPP) on quality of services offered by community pharmacy. The QCPP aims to maintain the standards and quality of care through re-accreditation processes.	Questionnaire survey of pharmacy consumers as they exited sampled pharmacies (84); 22-item survey tool (pharmacy SERVPERF); the survey tool addressed both technical quality (what the consumer experiences eg timely service provision, feeling that the pharmacist understands their specific needs, how the pharmacy looks or interactions with staff) and technical quality (eg the right drug dispensed to the right person, providing a non-prescription item that is appropriate, etc.).	1902 questionnaires were returned with a response rate of 69.6%. Two thirds of the respondents were female and 67% were 45 years or older.	60% of the respondents rated the service received at the pharmacy as excellent. This included waiting time, level of service and quality of service. 93% of consumers presenting a new prescription reported receiving at least some counselling; approximately 50% of consumers with prescription for continuing medicines and 75% of consumers seeking non-prescription medicines reported receiving counselling. 22% of consumers reported being given written information (34% if a new medicine was dispensed). Generally, basic professional services such as advising on how to take a medicine or choosing a non-prescription medicine were performed relatively frequently but that more advanced or high-level services were performed much less frequently. The median score for pharmaceutical care oriented directive guidance was 40% compared with basic counselling (median score 75%). Less than half of the consumers who had experienced an ADE reported that the pharmacy knew of this experience. The technical and functional quality of services provided by accredited pharmacies was superior to non-accredited pharmacies in terms of counselling given, consumer perceptions of quality and satisfaction and intention to return. Providing written medication information (Consumer Medicines Information) and maintaining patient profiles include ADE history are the subject of two of the QCPP standards yet there was no difference between accredited and non-accredited pharmacies in these areas of technical quality.

Reference/ Country	Objectives	Methods	Participants	Main Results
Chapman, Roberts and Stokes 2004 [11] (b)	To assess the impact of the Quality Care Pharmacy Project (QCPP) on quality of services offered by community pharmacy. The QCPP aims to maintain the standards and quality of care through re-accreditation processes.	Questionnaire surveys of consumers with diabetes or asthma. Questionnaires distributed through pharmacies.	246 respondents for the diabetes survey and 103 respondents for the asthma survey.	Consumers expressed high levels of satisfaction with their diabetes and asthma related services. This high level of satisfaction was expressed in the face of low technical quality: despite the majority of respondents being regular consumers, a low level of disease management services was reported: 32% and 35% of respondents reported receiving none of the more traditional pharmacy services for diabetes and asthma respectively (e.g. written information on medicines, advice on use of a spacer); 38% and 34% of respondents reported receiving none of the more advanced disease management services (eg checking asthma plan and explaining how to use inhaler and checking technique). There was no difference between accredited and non-accredited pharmacies.
Chapman, Roberts and Stokes 2004 [11] (c)	To assess the impact of the Quality Care Pharmacy Project (QCPP) on quality of services offered by community pharmacy. The QCPP aims to maintain the standards and quality of care through re-accreditation processes.	Mystery shoppers visited pharmacies using a symptom-based or direct-based request scenario. Scores were categorised as unsatisfactory (scores 0-3), satisfactory (4-6) and excellent (scores 7-10).	362 visits made to 293 pharmacies (repeat visits for 69 sites). 61 visits with symptom-based scenarios.	Overall, the median score was 4 with an interquartile (IQR) of 2-6, 5 for symptom-based scenarios (IQR 4-7) and 4 (IQR 2-6) for direct product request scenarios. Accredited pharmacies performed significantly better than non-accredited pharmacies for direct product requests with a median score of 4 (satisfactory) versus 3 (unsatisfactory) respectively.
Gilbert and Edwards 2004 [6]	To explore experiences and perceptions of smoking cessation services delivered by community pharmacy teams.	Telephone interviews with smokers in the general community.	151 smokers	Less than 10% of respondents who had been to a pharmacy in the last 12 months had been asked whether they smoked or advised on different methods to help quit smoking.
Dunphy et al 2005 [12]	To analyse the current and potential provision of services within community pharmacies (Change Management and Community Pharmacy Project).	Stakeholder interviews and consumer forums.	51 stakeholder groups; 68 consumers in consumer forums.	Pharmacies are more accessible than GPs and their 'shopfront' nature provides a 'place to talk'. A lack of privacy and, at times, a lack of sensitivity shown to consumers by pharmacy staff, are seen as the main drawbacks. Pharmacists are not seen as using their clinical knowledge to assist in a range of areas, particularly in the area of complementary therapies. Patient support organisations generally see pharmacies as an efficient and relative cost-effective delivery point. There is some scepticism over various tests used by pharmacists for screening because of limited or no accreditation standards.

Reference/ Country	Objectives	Methods	Participants	Main Results
March 2005 [39]	To develop, implement and evaluate a model of pharmacy practice utilizing pharmaceutical care where pharmacists work individually with consumers to assist them to better manage their medications.	Questionnaires, interviews and focus groups. Measures: acceptance of pharmacist's service protocol, usefulness of service, change in perceptions of pharmacist's role, change in level of understanding and knowledge of medicines, and acceptance of novel practice innovations.	258 questionnaires, 68 interviews and 3 focus groups.	Respondents were very positive about new services. Most accepted new service protocol (history taking, assessment, planning and monitoring): highly rated (97% good/very good). Consumers' medicines-related knowledge and understanding improved (31% to 96%). Consumers reported increased confidence in managing their health conditions. Consumers noted changes in pharmacist's role: pharmacists more willing to provide information, give time to patient, monitor outcomes and greater perceived level of caring. Consumers noted service was individualized and based on consumer needs.
Peterson et al 2005 [4]	To assess the public's perceptions of pharmacists' involvement and role in cardio vascular disease prevention and management.	A telephone interview survey of 505 households was conducted across Australia. Households were randomly selected from the Electronic White Pages.	505 metropolitan, rural and remote residents (>29 years).	96.6% of those surveyed said they were satisfied or extremely satisfied with the quality of services provided at their pharmacy. 52.5% said they visited the pharmacy because of the convenient location, 35% because of the friendly staff; 21.4% because of the quality of the service provided.

Table 2: Needs, experiences, expectations of Aboriginal and Torres Strait Islander people

Reference/ Country	Objectives	Methods	Participants	Main Results
Young 1997[15]	To provide information regarding Aboriginal and Torres Strait Islander people's access to Medicare and the PBS across Australia.	Three components: 1) Regional case studies involving face to face semi-structured interviews with a broad range of key respondents in remote, rural and urban areas. 2) Semi-structured telephone interviews 3) Postal surveys of medical practitioners, pharmacists and HIC staff with frequent contact with Aboriginal and Torres Strait Islander peoples.	1) Eight selected locations including the Torres Strait and Northern Peninsula Area, QLD; Halls Creek, WA; Nhulunbuy, NT; Lake Tyers, VIC; Moree, NSW; Port Augusta, SA; Perth, WA; Western Sydney, NSW. Within individual regions 30-60 interviews were conducted with Aboriginal and Torres Strait Islander people, Aboriginal Community Controlled Health Services (ACCHS) staff and other health service providers. 2) 36 in-depth telephone interviews with ACCHS staff and other health service providers. 3) Postal surveys sent to 115 medical practitioners, 60 pharmacists and 36 Medicare Customer Service Centre Managers (about 30% response rate for health professionals and 75% for Medicare managers).	Barriers to accessing medications included: - lack of Medicare card/number, concession entitlement cards due to difficulties in providing proofs of identity/entitlement required, changing of names and family structures, beliefs regarding usefulness or need for cards/numbers, lack of awareness of eligibility, inability of service providers such as ACCHS staff or pharmacists to provide proof on behalf of the patient because of privacy provisions; - inability to afford co-payment because of low incomes of many Aboriginal and Torres Strait Islander people; - lack of physical access to pharmaceuticals in remote areas; - low compliance due to health beliefs, low value placed on Western medicines, poor labelling systems, lack of support and infrastructure to use medication properly and the removal or omission of medication from the PBS list such as antifungals or topical antibiotics which are used for conditions common among Aboriginal and Torres Strait Islander communities. While a number of dedicated pharmacists demonstrated a high level of understanding, there was also a significant number who showed racist attitudes and behaviours. Immediate access to medications by many Aboriginal and Torres Strait Islander people when they present at a clinic/ACCHS was generally felt to be necessary by health services personnel. The current range of HIC information materials were not appropriate to many Aboriginal and Torres Strait Islander communities and there was a need to develop culturally appropriate materials on a range of topics for both consumers and service providers (e.g. Aboriginal Health Workers).

Reference/ Country	Objectives	Methods	Participants	Main Results
Gilbert et al 1998 [40]	To gather information about quality of use of prescribed medications in the remote North and Far West of South Australia.	Four project groups in Ceduna, Whyalla, Pt Augusta, Pt Lincoln, including the local community pharmacist, other health professionals and representatives of organisations.	The community pharmacist and representatives of organisations such as: - Ceduna District Hospital - Ceduna Koonibba Aboriginal Health Services - Centrelink - Department of Family and Community Services - Tjutjunaku Worka Tjuta (Aboriginal Community Organisation) - Yalata Aboriginal Health Services	Findings of the Ceduna project are reported here. Participants identified the need to ensure access to medication by Aboriginal people given geographical and cost factors. Issues include supply and storage of medications, long term medication checks and medication review, compliance, safe storage of medicines at home including access to refrigeration for medicine storage, high staff turnover. Participants also identified the need for education and information on medication in a form which is accessible to Aboriginal people for e.g. culturally appropriate CMI sheets, access to updated information and easy to read leaflets for patients. Legal requirements and guidelines for after hours dispensing and dosette filling by the nursing staff were also identified as a significant issue.

Reference/ Country	Objectives	Methods	Participants	Main Results
Emerson et al 2001 [17]	<p>To pilot pharmacist assistance to 11 Aboriginal Health Services (AHSs) across Australia in urban, rural and remote areas including:</p> <ul style="list-style-type: none"> - assistance with the establishment, enhancement, and/or ongoing management of the AHS dispensary; - provision of continuing education on pharmaceutical issues to AHS staff and Aboriginal Health Workers (AHW's); - assistance with filling of dose administration aids; - assistance with general inquiries on medication issues; and - provision of medication reviews and/or concordance assessments for patients of the AHS. 	<p>Initial site visits, initial surveys by participating pharmacists of medication management practices at the AHSs and opportunities for enhancement, process data collected throughout the live phase including completion of survey questionnaires by AHS staff and documentation by pharmacists, and final evaluation interviews with pharmacists and AHS staff.</p>	<p>Participating pharmacists and AHS workers in 11 sites from across Australia.</p>	<p>The services delivered under the project were assessed by participants as being extremely valuable in improving quality use of medicines. The services were particularly valued by those AHSs implementing Section 100. These AHSs generally rated the pharmacist assistance provided through the project as a key success factor in the implementation of Section 100. The availability of pharmacist time was a problem at most of the sites. Several sites involved sole-pharmacist pharmacies, sometimes in one-pharmacy towns, and the difficulty and expense of obtaining pharmacy locums made it hard for the pharmacist to offer the optimum level of services within normal working hours. Pharmacists also expressed a need for cross-cultural training as a prerequisite to understanding and working in Aboriginal health. For the Section 100 sites, the pharmacist's involvement led to significant enhancements in dispensary procedures. Several AHSs indicated a need for more pharmacist time to be provided to assist with their dispensary management. Nearly all of the AHSs where staff received continuing education on medication issues from the pharmacist found this service very valuable. There is clearly an unmet need in the AHS sector for such education, particularly in non-urban areas where there is often little or nothing of this nature available. Several AHSs utilised pharmacist assistance in filling dose administration aids. It was believed that the pharmacist was the best placed to deliver this service. With regard to answering of general medication queries, most participants reported a high level of inquiries from AHSs to pharmacists, and the AHSs almost universally found the pharmacist extremely approachable and the information provided extremely useful. At the two sites where medication reviews were trialed, they were well received.</p>

Reference/ Country	Objectives	Methods	Participants	Main Results
Loller 2003 [18]	To provide support to both AHSs and pharmacies involved in the Section 100 scheme (S100). To identify problems with the Section 100 scheme.	Site visits, regional meetings and phone interviews. Survey questionnaires designed to capture information regarding both the supply of medication and the provision of support services by the pharmacy. The questionnaires contained both quantitative and qualitative components.	A total of 26 AHSs and 13 pharmacies servicing 37 sites were surveyed. Another 4 pharmacies were contacted for input without completing the full survey. A total of 26 sites were visited in person, 17 were conducted through phone interviews.	Both AHSs and pharmacies indicated that S100 is achieving its goal of improving access to Pharmaceutical Benefits Scheme (PBS) medications to Aboriginal people in these remote settings. Non-remote AHSs have indicated a desire to have access to the S100 scheme, based on the success of the scheme in remote settings and the need to overcome the barriers of access to the PBS that Aboriginal people face in non-remote areas. Pharmacies and AHSs acknowledged the continued expenditure by AHSs for non-PBS items to treat diseases more common in Aboriginal people for example fungal infections. Pharmacies and AHSs supported moves to extend the current range of items available under the current S00 scheme to overcome the financial burdens faced by AHSs purchasing certain non-PBS medication. Pharmacists have been providing a good supply mechanism to AHSs with 92% of AHSs surveyed receiving their medication orders within a week of ordering the medications. Pharmacists are also providing support and advice on medication management issues, despite the low uptake of the support allowance (25% of services receiving support from a pharmacy under the allowance). The major barriers to accessing support allowance by pharmacists were inability to access locum pharmacists, lack of time to provide the support services and inadequate remuneration. The main QUM issues identified involved difficulties complying with legislative requirements, a desire for increased feedback on medication usage, the need for increased staff training availability, additional mechanisms to improve the dispensing process in AHSs, further information on who should have access to medication under the scheme, a desire for additional information on the S100 scheme for orienting staff of AHSs and exploration of further initiatives to involve pharmacists in dispensing functions for AHSs.

Reference/ Country	Objectives	Methods	Participants	Main Results
Barry L 2003 [19]	To estimate current costs involved in providing health care services to Aboriginal people in remote communities, costs associated with the implementation of “professional practice standards for pharmacy services to remote Aboriginal Health centres” and costs associated with training of staff to improve medicines practices.	Participant observation, key informant structured interviews using Critical Incident Techniques, review of documents.	Participant observation of the clinic; stake holder interviews.	Interviews indicated a need for air conditioning units in the clinic, reference books such as the AMH, pre-printed labels and cautionary labels, hygienic tablet counting tray and a surface cleanser. Participant observation also revealed the need to improve dosage administration aid system through proper training of staff or through pharmacist intervention. Potential pharmacist intervention (one day a week) could mean potential savings and could also provide a check for drug interactions which was found to be currently lacking. The training of Aboriginal Health Workers as pharmacy assistants was also considered to be highly desirable as it would ensure the presence of a staff member with pharmacy knowledge and practice skills and who is culturally aware and a part of a significant language group in the town where the pharmacy is located.

Reference/ Country	Objectives	Methods	Participants	Main Results
Filmer 2003 [41]	<p>To assess and pilot test the practicality of measurement and the acceptability to pharmacy staff of the draft '<i>Professional Practice Standards for Pharmacy Services to Remote Aboriginal Health Centres</i>'.</p> <p>To assess and pilot test '<i>Professional Practice Standards for Medication Management and Dispensing</i>' at the Ltyentye Apurte Health Service.</p>	The Critical Informant Technique (CIT) involving the use of key informant interviews and participant observation.	Participant observation of the health clinic at Santa Teresa, or Ltyentye Apurte (80km from Alice Springs) and interviews with stakeholders.	<p>The majority of the standards were determined to be suitable in terms of practicality of measurement and acceptability to staff in the community pharmacy in which they were pilot tested. For standards that were viewed as unsuitable, a revised wording was suggested.</p> <p>The audited Alice Springs pharmacy met 41 of the 84 standards in the 'Professional Practice Standards for Pharmacy Services to Remote Aboriginal Health Centres'. The pharmacy did not meet 35 standards and 7 of the standards were not applicable. Some of the standards that were not met include the pharmacy not supplying written procedures to the health service, no monitoring of usage of medications, no on-site professional support to visiting pharmacists, no provision for conducting HMRs, lack of communication regarding in-service training by pharmacists, no system in place to evaluate pharmacy services. Professional Practice Standards for Medication Management and Dispensing were developed. Ltyentye Apurte Health Service met 65 of the standards and did not meet 32 standards. 7 standards were not relevant to the health service. Standards that were not met included labeling, limited counselling due to communication barriers, lack of documentation, improper dosette filling, no written procedures, no monitoring of usage of medications, storage, no monitoring of stock and absence of procedure to identify adverse drug reactions. All the staff at the Ltyentye Apurte Health Service indicated that they would appreciate further involvement in the patient care process by pharmacy, especially if it freed up some of the RANs' time to deal with other patient matters. Participant observation and interviews also indicated the need to discuss issues with the pharmacist such as pre-printed medication labels, procedure to identify patients for HMRs, dosette filling training for staff, written procedures for labelling of dosettes.</p>

Reference/ Country	Objectives	Methods	Participants	Main Results
Kelaher et al 2004 [16]	To evaluate the performance of the S100 scheme in terms of access to PBS medicines by clients of remote Aboriginal and Torres Strait Islander Health Services (ATSIHSs) and compliance with existing statutory requirements.	Public submissions, interviews with key stakeholders, pharmacist survey, medicine utilisation and expenditure data, survey of ATSIHS, case studies.	Survey of 39 pharmacies (response rate 63%)	The evaluation showed increased PBS expenditure on Aboriginal and Torres Strait Islander people. The impact was somewhat greater for community-controlled services than State and Territory-operated services, particularly in Northern Territory. Problems getting required medicines were relatively common due to limitations to stock at pharmacies, limitations on imprest list and unanticipated demand. Removal of the co-payment and the streamlining of provision of medicine have in many cases increased the time ATSIHS staff can spend on clinical care. Town-based ATSIHSs reported that many of their Aboriginal clients did not access the pharmacies in the local town prior to S100 because they were not confident enough to go and get prescriptions supplied. There are still a number of barriers to access including operational barriers (e.g. when travelling), staffing levels, access to non-PBS medicines. A number of concerns were raised about compliance with statutory requirements including labelling of medicines, record keeping, and storage of medicines. Training in dispensary management and Quality Use of Medicines (QUM) needs to be provided to ATSIHS staff.

Table 3: Studies on general consumer experiences in other countries

Reference/ Country	Objectives	Methods	Participants	Main Results
Airaksinen, Ahonen and Enlund 1995 [42] Finland	To define how the nature and range of pharmacy services measure up to customer expectations.	Surveys mailed to people from the local population registers with sampling according to area of residence (big cities, small cities and rural municipalities), age and gender.	1222 participants aged 20-69; 56% female 44% males. Response rate of 73% with 848 returned questionnaires.	93% of respondents expressed highest satisfaction with competence and trustworthiness. 85% of respondents expressed highest satisfaction with pharmacists as over the counter prescribers. Around 40% were dissatisfied with the lack of time for pharmacist-customer interactions. 56% of respondents expressed highest dissatisfaction with queuing times and thought that they had to wait too long. 53% of respondents thought it was difficult to discuss intimate matters concerning medications due to the open nature of pharmacies.
Briesacher and Corey 1997 [43] USA	To measure patient satisfaction with chain and independent community pharmacies.	An exit survey was administered face to face to people in randomly selected chain or independent pharmacies in Philadelphia.	260 consecutive people immediately after their visits to chain (10) or independent (16) pharmacies.	An aggregate of responses across the two pharmacy types showed an excellent or very good rating given by 52% of the respondents for all items including pharmacy location, waiting time, pharmacist skills and accessibility by phone.
Bell, McElroy and Hughes 2000 [29] Northern Ireland	To assess societal perceptions of the role of community pharmacist and community based pharmacy services.	Structured interviews with members of the general public in five sites.	1000 members of the public; 41.9% males and 58.1% females. Age range not specified.	87.8% agreed that pharmacists' knowledge of medicines is extensive; 82.5% reported finding it easy to talk to their pharmacists. 76.7% considered pharmacists to be caring health care professionals. However 81% of respondents had never been asked by their pharmacists if they were satisfied with the service provided. 50% of respondents supported home visits by community pharmacists to both house-bound/ elderly patients and to those discharged from the hospital. 62.3% were reluctant to talk to a pharmacist about confidential issues due to the open nature of the pharmacies.
Kamei et al 2000 [44] Japan	To determine the relationship between pharmacy functions such as attitude of pharmacy/pharmacies; convenient hours, information management with patient satisfaction.	Questionnaire survey on evaluation of pharmacy services.	669 outpatients who used pharmacies to get their prescriptions filled at 32 pharmacies. 45.2% male and 54.4% female.	The attitude of the pharmacists such as general attitudes and specialized services such as providing information and explanation had a positive correlation with patient satisfaction. Other factors that rated low but influenced satisfaction include availability of OTC drugs and insufficient inventories of prescribed medications.

Reference/ Country	Objectives	Methods	Participants	Main Results
Norris and Rowsell 2003 [45] New Zealand	To investigate issues of manner and politeness in encounters between pharmacy staff and their consumers.	12 surrogate shoppers posing as customers visited community pharmacies throughout New Zealand.	180 community pharmacies.	Shoppers expressed concerns including wanting to feel at ease in the pharmacy, to feel confidence in the quality of service received, to feel included in the counselling and to gain a clear understanding. Shoppers expressed concerns including wanting to have their need for privacy acknowledged and respected.
Pronk et al 2003 [46] Netherlands	To explore patients' satisfaction with their community pharmacy services and to evaluate effects of an intervention programme including patient education activities.	Intervention at 0 (T0), 12 (T1) and 24 (T2) months. 500 questionnaires were distributed by each of the 28 pharmacies at each stage (14 intervention and 14 control).	The response rates were 54% (n=6341), 44% (n=5199) and 43% (n=2034) at T0, T1 and T2.	59.5% of the patients said they would ask the pharmacy staff if they were concerned about side effects. However 16.9% of all patients reported experiencing difficulties with asking questions due to lack of privacy, waiting time (8.8%) and busy pharmacy staff (6.7%).
Anderson, Blenkinsopp and Armstrong 2004 [20] UK	To systematically review feedback from pharmacy users on their perceptions and experiences of health related advice and services provided from community pharmacists.	Searches were conducted for peer-reviewed and non-peer reviewed research. Inclusion period was 1990-February 2001.	Seven peer reviewed and 13 non-peer reviewed reports in UK were identified for inclusion.	Several studies showed that some pharmacy users expressed concerns about the level of privacy in community pharmacies and that a pharmacy might be selected or deselected depending on facilities for private discussion. This issue was particularly important in research on consumer attitudes to pharmacy advice on contraception and sexual health.
Bawazir 2004 [47] Saudi Arabia	To measure consumers' current experience of pharmacy services and their opinion concerning future additional services.	Questionnaires completed by consumers in participating pharmacies.	911 Arabic-speaking consumers (69% male; 31% female) (79.6% response rate).	Of 409 respondents who had raised a personal/private matter: 58.5% indicated pharmacists spoke more quietly across the counter and 14.4% reported pharmacist used a private area within the pharmacy.
Levy, 2004 [33] USA	To determine consumer expectations, needs and experiences.	Questionnaire survey mailed to 1000 consumers nationwide.	596 usable replies with a 60% response rate. Consumers of independent, chain, supermarket and mass merchandising pharmacies.	78% of consumers describe pharmacists as friendly, 78% knowledgeable, 73% cooperative and 53% trustworthy. 86% said the pharmacists never offered contact for consultations or reminded them about refills.

Reference/ Country	Objectives	Methods	Participants	Main Results
Cox K 2004 [21] UK	To summarise research on communication between patients and health care professionals about medicines.	Systematic literature review of articles published between 1991 and 2000.	134 articles selected including 32 articles on communication between patients and pharmacists.	Pharmacists and patients made verbal contact in over two-thirds of prescription issues, although there was ambiguity concerning how long these discussions lasted. Patients and pharmacists were more likely to discuss a prescription if the pharmacist had a positive attitude towards communicating with patients and was less busy. In most cases pharmacists did not offer counselling about prescription or OTC medicines. Although the majority of patients accepted counselling about prescription medicines when it was offered, most patients said they would prefer to ask for advice about OTC medicines. According to observations of interactions and pharmacists' reports, a small minority of patients appeared to resent counselling about prescription and OTC medicines. The main reason patients gave for refusing counselling by pharmacists was they thought that their doctor had already given them sufficient information. Pharmacists only asked a minority of patients questions about their prescriptions. Most patients did not expect to be questioned when buying an OTC medicine. A minority of patients asked pharmacists questions about their medicines. The reasons patients gave for not asking pharmacists questions included fear or embarrassment, lack of awareness of which questions they should/could ask, the pharmacist being too busy, trust in or loyalty to their doctor, the patient being too busy and not wanting to bother the pharmacist.
Cavaco, Sousa Dias and Bates 2005 [48] Portugal	To explore the public's perceptions and attitudes towards community pharmacy.	Semi-structured interviews conducted with individuals recruited via snowball sampling and group interviews.	15 individuals recruited from an urban and a rural Health Care Centre aged between 25-65 years. 6 group interviews (total 25 group participants).	Pharmacy usage: positive comments included high trust, image of efficiency and modernisation, pleasant and helpful and effort in the patient's interest; negative comments included high costs, loss of time due to inefficiency, randomly present and minimal responsibility, little interest in user's benefit. Community pharmacy services: positive comments with community pharmacy usage included full up to date drug knowledge, familiarity with users, professional accountability with medication use; negative comments included reduced health care intervention, superficial knowledge of patients, minor drug intervention and therapeutic follow-up.

Table 4: Studies on consumer experiences with information provision in other countries

Reference/ Country	Objectives	Methods	Participants	Main Results
Taylor 1994 [49] Canada	To document reasons consumers do not ask for advice while considering the purchase of non-prescription medicines.	Questionnaire: to be taken home for completion, responses obtained during subsequent telephone call.	151 consumers who had purchased a non-prescription medicine, without seeking advice – response rate of 60.6%.	Main reasons self-selectors did not want advice: used the product before; already received advice elsewhere, generally a physician. 4 of 6 respondents who had wanted advice but did not ask for it indicated that the pharmacist looked too busy to be approached.
Krska, et al 1995 [50] UK	To estimate the extent of patient counselling.	Two methods: direct observation of consumer-pharmacist interactions and patient questionnaires administered pre and post receiving medicines.	14 pharmacists allowed counselling practices to be observed; 267 patients participated in survey of expectations and experiences.	Patient questionnaires: 41% reported receiving information mainly how often to use the medicines (only 2% were told about adverse effects). 81% felt that the time spent on counselling was adequate, even when this was no time at all; 62% felt information given was adequate.
Livingstone 1996 [51] UK	To study communication between elderly people and pharmacists to determine the frequency with which elderly people receive any verbal information/advice about prescription medicines, and to elucidate communication issues relevant to interactions between pharmacists and elderly people.	Tape recordings of verbal interactions between elderly patients and community pharmacists in each of 4 participating pharmacies.	43 elderly patients (women aged 60 or over and men aged 65 or over).	65% of patients receiving prescribed medications had not verbal interaction at all with the pharmacist, speaking only to other staff; pharmacists provided verbal information to 12.5% of patients about prescription medicines, which was limited to aspects of the dosage regimen, most common number of items of information given was 3.
Aslanpour and Smith 1997 [52] UK	To establish the rate of oral counselling on dispensed medications.	Non-participant observation. Collection of 1, 472 prescription items observed.	Random sample of 50 community pharmacists from the greater London area.	Counselling was provided for 39% of patients; counselling was given for approx. 70% of new prescription items and 20% of repeat items.
John & Evans 1997 [28] UK	To establish whether customers are being asked questions and provided with advice when purchasing medicines, and customers' attitudes to provision of advice and questioning associated with such sales.	Questionnaires hand delivered to all 2190 residences in a sample of streets in Cardiff, Wales.	810 questionnaires were returned with a response rate of 37%: 540 females, 260 males, 10 were not documented.	Of the respondents who had purchased a non-prescription medicine in the previous 6 months 44% said they were questioned; 47% given advice.

Reference/ Country	Objectives	Methods	Participants	Main Results
Anderson 1998 [27] UK	To evaluate if consumers came to pharmacies for advice on general health matters, read health promotion leaflets and to examine if consumers saw pharmacists as a reliable source of advice about staying healthy.	Interviews of consumers who entered one of 6 pharmacies.	592 consumers aged 16 or older. 74% female, 40% aged 60 or over.	When buying an OTC medicine 25% of respondents had to ask for advice and 23% were offered advice; when having a prescription dispensed, 42% were offered advice and 26% had to ask for advice.
Bell, McElroy and Hughes 2000 [29] Northern Ireland	To assess societal perceptions of the role of community pharmacist and community based pharmacy services.	Structured interviews with members of the general public in five sites.	1000 members of the public; 41.9% males and 58.1% females. Age range not specified.	54.3% of respondents reported that their pharmacist always or often gave them advice about their medicines.
Sleath and Wurst 2002 [53] UK	To examine patient receipt of, and preferences for receiving antidepressant information.	Face-to-face interviews in 8 pharmacies.	83 English-speaking patients, collecting antidepressant prescriptions	17% patients did not receive verbal information about how long medication would take to work; 50% told what to do if a major side effect occurred; approx. 11% had a reading level below the level of the written pharmacy antidepressant information leaflet; 36% preferred to receive only written antidepressant information.
Traulsen, Almarsdottir and Bjornsdottir 2002 [54] Iceland	To explore lay user perspectives on issues such as access to and quality of pharmaceuticals and pharmacy services.	Seven focus groups with a range of pharmacy consumers.	35 consumers aged 20 to 81 years of age: 40% male and 60% female.	There was a perceived lack of information about medicines among the consumers. Pharmacists did not provide information on their own initiative, consumers had to ask for information. CMI should be in an appropriate language.
John, Krska and Hansford 2003 [55] UK	To identify factors which may influence the provision of advice and referral from community pharmacists with regard to over the counter alginate and H2 receptor antagonist products	Questionnaire issued to customers provided with an alginate or H2 receptor antagonists from community pharmacies with one reminder sent to non-responders	Customers of 39 community pharmacies in Scotland and Wales. 608 completed questionnaires were returned: response rate of 79%.	Of the 523 customers who stated that they requested the product by name, 186 (36%) reported receiving advice on the product, 313 (60%) said they had not. Of the 85 customers who did not request a named product, 51 (60%) received advice while 28 (33%) did not.
Pronk et al 2003 [46] Netherlands	To explore patients' satisfaction with their community pharmacy services and to evaluate effects of an intervention programme including patient education activities.	Intervention at 0 (T0), 12 (T1) and 24 (T2) months. 500 questionnaires were distributed by each of the 28 pharmacies at each stage (14 intervention and 14 control).	The response rates were 54% (n=6341), 44% (n=5199) and 43% (n=2034) at T0, T1 and T2.	Almost two thirds of the respondents saw the pharmacy as a source of information. However 7.5% of the respondents reported being less satisfied with the answers to their questions due to receiving too little information.

Reference/ Country	Objectives	Methods	Participants	Main Results
Bawazir 2004 [47] Saudi Arabia	To measure consumers' current experience of pharmacy services and their opinion concerning future additional services.	Questionnaires completed by consumers in participating pharmacies.	911 Arabic-speaking consumers (69% male; 31% female) (79.6% response rate).	69% report that they received advice about their medications only when they asked for it; 45% consumers felt pharmacists allowed enough time to discuss their problem fully and they listened well; 30.7% said that they were given a short time and only partial attention by the pharmacist to discuss problems/concerns; 17.9% indicated pharmacists encouraged consumers to ask questions and to express any concerns on dispensing.
Levy, 2004 [33] USA	To determine consumer expectations, needs and experiences.	Questionnaire survey mailed to 1000 consumers nationwide.	596 usable replies with a 60% response rate. Consumers of independent, chain, supermarket and mass merchandising pharmacies.	62% of respondents using independent pharmacies, 48% who use chains, 47% who use supermarket, and 47% who use mass merchandising pharmacies said their pharmacist provided them information on when and how often to take their medication.

Table 5: Studies on consumer needs and expectations in Australia

Reference/ Country	Objectives	Methods	Participants	Main Results
CHF of Australia 1995 [7]	To investigate the impact on consumers of recent changes in pharmaceuticals policy.	Consultations with consumers with chronic conditions, low income, non-English speaking backgrounds and living in non-metropolitan areas.	15 consultations with over 130 participants.	Participants wanted information on pharmaceuticals presented verbally and in written form. They wanted clear instructions firstly from their doctors and then confirmed by their pharmacists on exactly how the medication was to be taken. Information about risks, side-effects and interactions with other drugs was also a high priority.
Gilbert and Vawser 1996 [23]	To optimise the health impact of rural and remote pharmacists on the communities they serve.	Consumer survey at local area meetings of the Country Women's Association.	No numbers given.	Better interaction between pharmacists and other health professionals to provide a more complete health service, especially upon discharge from hospital. There was wide acknowledgement that face-to-face counselling from a pharmacist was the most desirable interaction.
Plunkett et al 2001 [5]	To evaluate satisfaction of consumers with advice about skin conditions from community pharmacists in Victoria, Australia.	Short telephone interviews with pharmacy consumers recruited through pharmacies.	181 consumers were interviewed: 15% males and 85% females. Ages ranged from 20-49.	80% of respondents consulted a pharmacist as the only source of treatment and advice for common skin conditions.
Teh, Chen and Krass 2001 [56]	To evaluate consumer attitudes towards pharmacist-delivered health information and screening services over time and with personal experiences of these services.	A validated instrument was administered in 1994 (Cohort A) and 2000 (Cohort B) to consumers who had not experienced health information and screening programme and to consumers in 2000 (Cohort C) who had experienced such as service from community pharmacies in non metropolitan NSW.	98 consumers from Cohort A, 58 from Cohort B, 159 from Cohort C. Cohort C had participated in a CVD health promotion and screening programme. All consumers were 18 years or over.	Cohort C had more favourable attitudes towards the pharmacist providing these services as compared to Cohort B. Cohort B had more favourable attitudes towards pharmacist screening as compared to Cohort A. No differences in Cohort A and B with respect to promoting health and providing health information – consumer attitudes not changed with time.

Reference/ Country	Objectives	Methods	Participants	Main Results
Thompson and Stewart 2001 [22]	To explore older persons' opinions about their receipt of prescription drug information from general practitioners (GPs) and pharmacists; to determine information older persons wish to know about their prescription medication and the information sources they use.	Detailed in-home interviews between 1993-1995.	204 interviewees, identified through GPs.	The vast majority of respondents liked to receive verbal counselling about their prescription medications. Only a small minority had no real perception of a need for information. Respondents wanted to know when and how to use the medication (89%), the condition for which the medication was prescribed (76%) and side effects (72%). For 90% respondents, GPs were greatest prescription drug information source; 57% indicated pharmacists as secondary source; Item of information most desired was when and how to take medication (89%), followed by condition for which medication prescribed (76%) and side effects (72%). 92% thought that information on medication labels was adequate; 76% thought that when receiving new prescription medication, an information leaflet written for consumer about medication would be helpful. The 75 and over group were less enthusiastic about receiving such leaflets than the 65-74 age group.
Bajramovic, Emmerton and Tett 2004 [24]	To explore beliefs and expectations of GPs, consumers and pharmacists in relation to concordance defined as an agreement between the patient and the health professional about the best use of treatment.	Two focus groups with consumers and pharmacists; in-depth semi-structured interviews with GPs in Brisbane in 2003.	7 consumers (6 females and one male) aged 65 and older and having one or more chronic conditions. 9 pharmacists (6 males, 3 females). 2 of the 9 pharmacists were hospital pharmacists and 7 community pharmacists.	Consumers wanted to spend more time with health professionals and expressed the need for a system where harmonious relationships between health professionals could take place which could result in a more consumer friendly health care system. Consumers expressed the need for more information both verbal and written on their treatments and conditions, more CMI's, self care cards. The sharing of information between pharmacists and doctors was also seen as essential.
Dunphy et al 2005 [12]	To analyse the current and potential provision of services within community pharmacies (Change Management and Community Pharmacy Project).	Stakeholder interviews and consumer forums.	51 stakeholder groups; 68 consumers in consumer forums.	Interviewees saw the core functions of pharmacy as relating to medication dispensing and advice. Pharmacists were seen as the first port of call for people who could not afford doctors. They placed greater emphasis on the development and expansion of medication safety function than on the implementation of novel services. There was a low awareness of services currently offered by pharmacies. Consumers and consumer groups want to see pharmacists consistently offer core functions, such as CMI leaflets supplied every time medication is issued, Safety Net information.

Reference/ Country	Objectives	Methods	Participants	Main Results
Peterson et al 2005 [4]	To assess the public's perceptions of pharmacists' involvement and role in cardiovascular disease (CVD) prevention and management.	A telephone interview survey of 505 households was conducted across Australia. Households were randomly selected from the Electronic White Pages.	505 metropolitan, rural and remote residents (> 29 years).	<p>Preliminary results: 75.7% of respondents agreed or strongly agreed that pharmacists are capable of providing lifestyle changes advice (including weight loss, smoking cessation, alcohol intake etc); 70.5% that pharmacists are capable of providing OTC and herbal medicine advice in patients with CVD;</p> <p>64% that pharmacists are capable of providing information on CVD and their management; 95.5% that pharmacists are capable of providing advice on how to take medicines properly. 50% of respondents were likely or very likely to seek advice on lifestyle changes; 65% on OTC and herbal medicines in patients with CVD; 50% for information on CVD and their management; 89.5% for advice on how to take medicines properly; 52% to monitor the outcome of drug treatment. However 91-99% respondents said they were likely to go to a GP for information. Nurses, dieticians and naturopaths were other sources of information.</p> <p>52% of respondents agreed or strongly agreed that pharmacists are capable of providing blood pressure screenings, 51% for diabetes screening, 37.6% for cholesterol screening and 10% for diagnosing cardiovascular diseases. 59% of respondents said they were likely or very likely to use blood pressure testing or screening if provided; 60% for diabetes screening if provided; 52% for cholesterol screening if provided; 31% for CVD diagnoses if provided. Respondents were more likely to go to a GP (97-98%) or nurses (47- 73%) for these services.</p>

Table 6: Studies on consumers needs and expectations in other countries

Reference/ Country	Objectives	Methods	Participants	Main Results
McElnay, Nicholl and Grainger-Rousseau 1993 [25] Northern Ireland	To investigate consumer attitudes and opinions regarding use of current and proposed community pharmacy services.	Structured interview of members of the public using a short questionnaire. Interviews were carried out in public places like shopping centres and arcades. Participants were selected randomly.	906 members of the public aged above 16 years. 37% were male and 63% female.	GPs advice was preferred over that of a pharmacist for many conditions: 51.6% for backache, 61.2% depression, 37.7% for acne/spots/rash. 16.9% indicated that they would never ask a pharmacist for advice. 93.4% of those interviewed felt that pharmacist had a role to play in health education; 90.6% supported the provision of health screening services such as cholesterol and blood pressure screenings.
John & Evans 1997 [28] UK	To establish whether customers are being asked questions and provided advice when purchasing medicines and customers' attitudes to the provision of advice and questioning associated with such sales.	Questionnaires hand delivered to all 2190 residences in a sample of streets in Cardiff, Wales.	810 questionnaires were returned with a response rate of 37%: 540 females, 260 males, 10 were not documented.	81% of the respondents expected to be asked questions about medicines bought in the pharmacy and 90% thought it was a good idea to be asked questions when buying medicines. 83% of the respondents thought pharmacists know a lot about minor health problems.
Morris, Cantrill and Weiss 1997 [57] UK	To examine consumers' view of their requirements when making an OTC medicine purchase.	Semi-structured telephone interviews.	40 consumers (30 women and 10 men) recruited in two community pharmacies.	62.5% expected to purchase OTC medicine without being questioned.
Anderson 1998 [27] UK	To evaluate if consumers came to pharmacies for advice on general health matters, read health promotion leaflets and to examine if consumers saw pharmacists as a reliable source of advice about staying healthy.	Interviews of consumers who entered one of 6 pharmacies.	592 consumers aged 16 or older. 74% female, 40% aged 60 or over.	77% of respondents thought that the GP was the best place to get advice about staying healthy with only 8% considering the pharmacist as a source of information. Only 40% thought it was the 'usual' job of the pharmacist to give advice about general health, 19% thought it was not, and 41% did not know.
Cordina, McElnay and Hughes 1998 [26] Malta	To assess the views of the general public on services provided by community pharmacists and their opinions on extended roles for pharmacies.	Structured questionnaire administered in shopping areas of towns and villages.	912 members of the general public: 395 males and 517 females; age range 14-86 years.	GPs advice was sought preferentially for most minor conditions while the pharmacist was never selected as the first choice for advice; 11.5% stated they would never ask the pharmacist for advice. 90.2% of respondents felt pharmacists should promote health education; 85.7% supported screening services such as blood pressure and cholesterol measurement.

Reference/ Country	Objectives	Methods	Participants	Main Results
Larson 1998 [30] USA	To develop a total quality improvement tool to assess patients' ongoing satisfaction with delivery of products and information by the pharmacy; to measure veterans' tendency to agree with survey instruments, to measure patients' willingness to use potential future pharmaceutical services offered.	Questionnaire with a postage-paid envelope.	Patients visiting the ambulatory care pharmacy prescription-pickup window during five consecutive workdays (response rate of 48.3%).	Respondents' interest in future services: Pharmacist available to talk with patients by telephone: 82.7%; Having an opportunity to talk with a pharmacist about medications: 77.9%; Cholesterol testing: 75.9%; Blood pressure screening: 72.7%; Having a pharmacist available to talk to in the clinics: 66.5%; Diet information: 61.9%; Advice about disease prevention: 56.6%; Having educational tapes playing in the waiting area: 53.3%; Seeing a pharmacist in the clinic instead of a doctor for drug-related problems: 38.2%.
Hassell, Noyce and Rogers, 1999 [34] UK	Analysis of a range of pharmacy practice, health services and sociological literature on how the public use and view community pharmacies as a primary health care source.	Literature review of articles and reports published from 1980 to 1997 in UK.		Literature review demonstrates that the public do use pharmacies for advice about medicines and minor ailments. However, evidence also shows that the public infrequently seeks out pharmacy care as an alternative to the GP.
Abu-Omar, Weiss and Hassell 2000 [31] UK	To explore the existence and nature of the pharmacist-customer relationship.	Semi-structured interviews.	20 customers recruited from 2 pharmacies differing in type and location.	Most customers viewed pharmacists as drug experts and considered managing minor ailments to be part of their job. They were less supportive of a more extended role in the therapeutic monitoring of drug therapy.
Bell, McElney and Hughes 2000 [29] Northern Ireland	To assess societal perceptions of the role of community pharmacist and community based pharmacy services.	Structured interviews with members of the general public in five sites.	1000 members of the public; 41.9% males and 58.1% females. Age range not specified.	GP was the preferred source of information for treatment of minor ailments. Pharmacist was never the preferred option. 30% reported that they would never ask a pharmacist for advice. 65% reported they would initially ask their pharmacist regarding information or advice about medicines. 84% of the respondents were supportive of provision of services such as screenings by pharmacists; 92% were supportive of health promotion activities in the pharmacy; 76% supported health screening services within community pharmacies.

Reference/ Country	Objectives	Methods	Participants	Main Results
Iversen, Mollison and MacLeod 2001 [32] UK	To investigate the attitudes of consumers to expanding roles of the community pharmacist.	Subjects (a random sample stratified by age and gender selected from the computerized patient register) received a self-completion postal questionnaire with a personalized covering letter from the GP with a reminder sent 14 days after the initial mailing.	173 subjects identified from one urban general practice in Grampian, Great Britain. 96 returned surveys with a response rate of 55%: age range 18-70 years, and 41% male, 59 % female.	77% of the respondents were in favour of community pharmacists providing support for other health professionals; 74% for healthy living sessions; 71% for health screening. Only 22% were supportive of pharmacists monitoring long term illness such as asthma, 39% for providing antibiotics for minor respiratory infections, 35% for providing contraceptive pill without a prescription.
Hibbert, Bissell and Ward 2002 [58] UK	To consider the professional role and status of the community pharmacist in context of consumerist health care.	Non participant observation in 10 community pharmacies; 94 interviews and 7 focus groups with consumers; interviews with 10 pharmacists and 4 focus groups with staff.	Interviews and focus groups with consumers after they had purchased a deregulated medicine and staff who had sold the medicines. Age range:16-76 years; 58% women.	Consumers conveyed a strong sense of their ability to self manage conditions through personal experience or lay expertise and didn't want to ask or be asked questions by the pharmacists. The consumers challenged the pharmacy staff's expertise because of the belief of equivalent lay expertise.
Traulsen, Almarsdottir and Bjornsdottir 2002 [54] Iceland	To explore lay user perspectives on issues such as access to and quality of pharmaceuticals and pharmacy services.	Seven focus groups with a range of pharmacy consumers.	35 consumers aged 20 to 81 years of age: 40% male and 60% female.	Consumers perceived the GPs to be the most important source of information about their illness and its treatments. Consumers were unaware of the pharmacy as a source of information: expertise of pharmacists was not acknowledged as important to their health care needs.
Porteous & Bond 2003 [59] UK	To conduct a pharmaceutical needs assessment in a deprived area of Aberdeen.	Questionnaires mailed to residents and health professionals.	Residents (n=145: response rate 53%) randomly selected from the electoral roll, and randomly selected professionals (n=82 including 16 community pharmacists: response rate 74%).	The top five services required by residents were advice on minor illnesses (74%), use of OTC medicines (70%) and prescription medicines (62%); sales of first aid products (72%) and OTC medicines (72%).

Reference/ Country	Objectives	Methods	Participants	Main Results
Anderson, Blenkinsopp and Armstrong 2004 [20] UK	To systematically review feedback from pharmacy users on their perceptions and experiences of health related advice and services provided from community pharmacists.	Searches were conducted for peer-reviewed and non-peer reviewed research. Inclusion period was 1990-February 2001.	Seven peer reviewed and 13 non-peer reviewed reports in UK were identified for inclusion.	Consumer feedback appears, at times, to be contradictory. When asked on their perception of role of the pharmacist in providing general health advice, the public's response tends to be cautious. However when such advice and services are offered the uptake is generally good and the feedback positive, suggesting that the public may have current low expectations of the community pharmacist. Although users tended to cite the GP as the key source of health information and advice, they nevertheless perceived the pharmacist as a highly appropriate source of advice (e.g. use of aspirin in cardiovascular prevention, emergency hormonal contraception). These findings suggest that users are more likely to accept the community pharmacist's role as health adviser when related to medicines supply.
American Pharmacists Association, 2004 [60] USA	To collect and report information on how consumers interact with and perceive their pharmacist and how their relationship with their pharmacist impacts their knowledge of health and medicines.	Surveys mailed to a nationally representative sample of 2304 households in USA.	1260 respondents with a 55% response rate.	More than 70% of respondents said they do not ask their pharmacists questions. Only 40% of consumers read their medication labels. Only 34% reported knowing their pharmacists' name.
Bawazir 2004 [47] Saudi Arabia	To measure consumers' current experience of pharmacy services and their opinion concerning future additional services.	Questionnaires completed by consumers in participating pharmacies.	911 Arabic-speaking consumers (69% male; 31% female) (79.6% response rate).	Preference for new services: measuring height, weight and temperature: 66.8%; Monitoring glucose levels: 60.2%; monitoring blood pressure: 69.3%; Monitoring cholesterol levels: 53.3%; Patient medication record: 40.4%. For consultation about health problems, physicians preferred source of advice: 73.2% and pharmacists: 17.5%; 51% considered pharmacists more concerned with business.

Reference/ Country	Objectives	Methods	Participants	Main Results
Levy, 2004 [33] USA	To determine consumer expectations, needs and experiences.	Questionnaire survey mailed to 1000 consumers nationwide.	596 usable replies with a 60% response rate. Consumers of independent, chain, supermarket and mass merchandising pharmacies.	90% of respondents wanted written or printed materials. More than half of respondents were very or somewhat interested in services such as blood pressure screenings, cholesterol levels screenings, immunisations, diabetes screenings, osteoporosis screenings; 85% wanted pharmacists to be available to answer questions, explain possible side-effects, how medication should work, 76% wanted information on when and how to take medication, 64% on OTC drugs.

Table 7: Studies on consumer participation in Australia

Reference/Country	Objectives	Methods	Participants	Main Results
Benrimoj and Gilbert 1998 [35]	To develop standards for the provision of <i>pharmacist only</i> and <i>pharmacy</i> medicines in Community Pharmacy.	Focus groups with a number of consumers ('pseudo-patients'), who had been involved in the project and members of the Consumer Reference Group of the Southern Division of General Practice.	Number not specified.	Advantages and disadvantages of several methods to get consumer feedback were listed i.e. interview or questionnaire in the pharmacy, free mail-back questionnaire and telephone interview following purchase. A sample questionnaire and sample telephone interview were provided. It stated that pharmacies might also consider using consumer focus groups, establishing ongoing consumer advisory groups, visiting local community groups for feedback, having a 'pharmacy hot-line' for a short period of time and keeping a register of feedback offered informally in the normal course of practice.
CHF of Australia 2002 [37]	To develop a model for consumer reporting of experiences of pharmacy services in relation to the provision of <i>Pharmacist Only</i> and <i>Pharmacy</i> medicines.	An options paper was developed based on the available literature and distributed to interested CHF members, the professional pharmacy organisations, and community pharmacists to outline potential models for consumer reporting of experiences. The models chosen by the working group for inclusion in the options paper were: i. Pseudo-patron or Mystery shopper; ii. External audit; and iii. Direct consumer feedback.	16 representatives of consumer health organisations, the PSA (PSA); the Pharmacy Guild of Australia; and several community pharmacists (recommended by the PSA) based in the ACT.	Consumers were most supportive of using a direct consumer feedback model for consumer reporting of pharmacy experiences. The feedback from pharmacy was also supportive of this model. A combination of all three consumer reporting models (pseudo-patron, external audit and direct consumer feedback) was also highly favoured.
Mott 2002 [62]	To explore proposed messages and strategies to increase consumer awareness of Standards for <i>Pharmacist only</i> and <i>Pharmacy</i> medicines in Australia.	Consultations/interviews (both face to face and telephone) with consumer groups identified through CHF of Australia and Consumer Perspectives.	39 staff and members from 17 consumer organisations.	Suggested dissemination strategies to increase consumer awareness were advertising in the general media, campaigns through pharmacies, peer education through consumer groups.

Reference/Country	Objectives	Methods	Participants	Main Results
Bajramovic, Emmerton and Tett 2004 [24]	To explore beliefs and expectations of GPs, consumers and pharmacists in relation to concordance defined as an agreement between the patient and the health professional about the best use of treatment.	Two focus groups with consumers and pharmacists; in-depth semi-structured interviews with GPs in Brisbane.	7 consumers (6 females and one male) aged 65 and older and having one or more chronic conditions. 9 pharmacists (6 males, 3 females). 2 of the 9 pharmacists were hospital pharmacists and 7 community pharmacists.	All participants including consumers expressed support for the idea of more involvement by consumers, pharmacists and GPs in order to achieve better understanding and exchange of information in health care and therefore better concordance.
Dunphy et al 2005 [12]	To analyse the current and potential provision of services within community pharmacies (Change Management and Community Pharmacy Project).	Stakeholder interviews and consumer forums.	51 stakeholder groups; 68 consumers in consumer forums.	Consumer representative groups did not appear to have particularly strong on-going relationships with the pharmacy profession. There had been some contact around specific projects in the past but little feedback. Unlike their relationship with GP organisations, there was limited involvement at the national level so that consumer groups were not influencing ways the profession worked and how it impacted on consumers.

ATTACHMENT 15: REFERENCES

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