

Gulgong Dispensary

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In your opinion, should there be a maximum ratio of retail space to professional area within pharmacies to maintain the atmosphere of a healthcare setting for community pharmacies receiving remuneration for dispensing PBS medicines?

Fascinating question. Whilst it would be terrific to see pharmacies limited to this sort of situation, we would have to work out where to draw the line between 'professional area' and 'retail space'. For instance, therapeutic skin care – products in this department are routinely sold in supermarkets, including our local supermarket, but the advice on use and need is given by the pharmacist. In fact, on a regular basis I am stopped in the supermarket by locals requesting information on the products in the healthcare aisle. I have the same product in my shop 500m down the road and am giving the same advice I would give in my own business, in order to profit the supermarket.

Interesting anecdote – Priceline recently opened in our nearest town and someone has just said to me that they are disappointed that the pharmacy has turned into a beauty shop because they used to get their scripts there and now they have to go somewhere else. Of course Priceline still do scripts, but they don't look like they do....Of course, in the interests of good customer relations I did explain that Priceline actually continues to dispense prescriptions.

On a regular basis I consider re-organisation of the shop along these lines. I would get rid of gift care – both adult and baby, the makeup section, jewellery and scarves, manicure (nail products), and I would largely decrease the size of first aid, natural medicines, skin care, hair care, sports care and natural medicines. It is possible that my business would actually become more profitable in some ways. I would upset my customer base because they are used to buying these products from me – there is also no other shop in town that supplies the giftware, makeup, jewellery, scarves, sports care. Indeed, I have just increased the gift section because our local jeweller has semi-retired and we agreed to take on the stock and sales that he no longer wanted. If alternatives open up locally, I will happily give up these items. Dispensing is 85% of my business. The other 15% is over-the-counter – maybe half of that is the stock I would no longer carry. And then I would probably need less staff hours. So one of the three retail employees would have their hours cut – two of these are actually the major breadwinners for their families on their jobs. Is it really such a problem that in a well-respected, professional health-care environment I sell some extra lines and employ more staff (all of whom are trained pharmacy assistants)?

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Should Government funding take into account the business model of the pharmacy when determining remuneration, recognising that some businesses receive significant revenue from retail activities?

Maybe...I know that my split is very different from the average that you have presented. Ours is about 85% dispensing, 15% OTC. But that is the small rural pharmacy situation and the reason why we small one-pharmacy town independents feel so strongly about this whole discussion. I spend a lot more of my time on the floor talking to customers about both their medications and their general health and life problems than I do selling retail products. That is the part of my job that I love.

There is a significant degree of vertical integration in the pharmacy and wholesaling sectors in Australia, and five pharmacy groups account for around 65% of the total market revenue. Notably there has been a rise of the 'big box' discounter model, with their price competition appearing to increase pressure on traditional, smaller pharmacies.

Indeed, there has and I believe that this is the major problem in Australian pharmacy. This is what changes the small business, healthcare focussed model into a supermarket. I think that services/healthcare outcomes are not related to the model of pharmacy, they are dependent on the pharmacist who is responsible for running the business, but I find the franchise-type model a little disconcerting, because it strikes me that the pharmacists in these models are not always able to operate completely according to their own principles. I employ a pharmacist colleague and I try to be very aware that a professional healthcare decision she makes cannot be measured against impact on profit. But I know not all owners feel that way and it's pretty unrealistic to think they will.

I was surprised that there is no mention of Blooms in your table and would like to have more details of "Others" which are over 35% of the group. Does 'Others' include independents or are independents not included in this sample? It is not clear.

Should the CPA be limited to dispensing and professional programs provided by community pharmacy only? If so, how can contestability and effectiveness be ensured in professional programs? If not, why not?

I am assuming that this implies that pharmacists that are not aligned with a community pharmacy (Section 90) would be able to be reimbursed for delivery of such programs. I think that would be great. I actually think community pharmacy struggles to deliver the services due to the demands of the retail environment and dispensing. I look at the community nursing program in my town and think there should be a community pharmacist

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employed by the hospital to deliver some of the services that we as small business operators don't have the time or money to commit to. We really want to implement things like weight/smoking management but the upfront cost of implementation in both time and dollars is prohibitive, even with the CPA funding available. I can confirm that the funding of in-pharmacy review certainly added to my willingness to employ a colleague pharmacist so we could start delivering these types of programs.

I would happily work with any pharmacist to better benefit the health in our community, whether they were employed by me or not, as long as I was fairly compensated for that partnership. I guess I would anyway, because I already do this without any compensation. I am in constant contact with our local health workers and get nothing in payment. Eg. We have just discussed local activities with our community nurses for NPS MedicineWise week. We will host the nurses in the pharmacy and do various activities for the local population, all of which will be funded by me with no compensation at all. That is what pharmacy currently does.

Is it appropriate that the Government continues to negotiate formal remuneration agreements with the Guild on behalf of, or to the exclusion of, other parties involved in the production, distribution and dispensing of medicines? If so, why? If not, why not, and which other parties should be involved? Is there currently an appropriate partnership with these other parties, including consumers? Who are the other appropriate partnerships?

Why is this important for pharmacy but not for other government funded programs? For example, are Medicare remuneration discussions open to all parties involved?

I don't have any problem with open discussion but I think there needs to be some sensible thought around this? Can anyone with an axe to grind get involved in any Government funding decision?

Perhaps we should look more basically at this –

1. There are formal remuneration agreements on a regular basis about production, distribution and dispensing of medicines.

2. The players in this arena are – Dept of Health, patients, pharmacy proprietors, warehouses involved in distribution and manufacturers. 3.

Those are the stakeholders and those are the parties that should be involved. I think that each of these parties or their representatives should be involved. No one else needs to be a part of the discussion unless they can prove they are part of the process.

Finally, I just want to raise my issue with regard to this. I pay just over \$3000 per year to be a Guild member. I support them in their efforts to ensure equitable health care access to Australians and the current

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pharmacy system. I don't always agree with them, but I support their efforts. I think that pharmacies who are not Guild members shouldn't be allowed to dispense PBS scripts. Why should I pay for the negotiations when they don't, but they still reap the benefits?

Should the Government move away from a partnership arrangement? If so, what would take its place? For example, should the Government move to a more standard contracting or licensing approach with individual pharmacies or groups of pharmacies? How would such alternative arrangements be implemented?

Is the current system of dispensing of medicines in Australia, that focuses predominantly on community pharmacies operating as small businesses, the best way to achieve the objectives of the NMP? Should there be alternative approaches for the dispensing of PBS medicines beyond a community pharmacy, such as through hospitals or different pharmacy arrangements? If so, what could these alternative approaches look like?
As stated above. An individual approach would be a logistical nightmare and the only scenario I can imagine as an outcome is the development of a Guild.

I did start to consider a whole new model of government dispensaries – maybe the hospital approach would be a future scenario, whereby we no longer have community pharmacies but patients are treated at GP level and then given a prescription and sent to the government dispensary, which is solely set up to dispense PBS prescriptions. Each dispensary is run by pharmacist/s who are employed by the government. But that's a lot of investment by government to develop and run. And what happens to private prescriptions? And how does the GP suddenly cope with the increased number of people presenting with their 'funny rash' and their 'sore eye' and their 'wart' – I saw these three patients yesterday amongst the other 250-odd that came through my door.

Is the 6CPA achieving appropriate 'access to medicines' as defined in the NMP? If so, why? If not, why not and how could access be improved?
You can't have it both ways. Your introduction said that community pharmacies are considered one of the most accessible of all health organisations. I think we are achieving this aim in Australia and we should be proud of the system we have. It may not be perfect but what is? I raised in the previous point the completely state-owned system. Alternatively, we could consider the completely private system? I guess that is similar to the USA? Is that working? I understand the economics driven idea of no government controls over pharmacy but I don't think it would work. And I understand that there are times when a patient in my

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town can't access medicines from my pharmacy. But there are also times when a patient in my town can't access the post office or the newsagent or even the supermarket. And if they are truly in need of medical help, there is the hospital which operates 24/7 and the ambulance which ditto. So accessibility strikes me as kind of a cover for some other hidden agenda.

Do current arrangements under the 6CPA lead to the appropriate creation and distribution of information relating to the use of medicines? If so, how and why? If not, why not and how could the distribution of this information be improved?

Yes, but only in those pharmacies that do their job properly and only to the degree that humanity allows us to do this. I can't speak for all pharmacists; I can only speak for myself. The current model has these dimensions:

- 1. My and my family's livelihood depends on me doing my job and getting paid fairly for it.*
- 2. My personality and training as a pharmacist mean that I have a vested interest in health and a passion about sharing it.*
- 3. The fact that I own the business and have invested a lot of money, and have a large mortgage means that I live or die by the decision I make – both ethically and financially.*

On a regular basis I tell a patient or a customer (depending on whether you call me a health professional or a retailer) that they DON'T need to buy anything. So my ethics drive my day to day actions, not my profit. But I can't let that happen unless I am getting some financial reward as well as the glow of good feeling that I am ethical.

Is this requirement a significant impediment to online ordering and remote dispensing? If so, should this impediment be removed? In this scenario, what compensating arrangements would need to be implemented to ensure that there is appropriate oversight and control over dispensing and patient choice of pharmacy? To what degree is it appropriate that community pharmacies be protected from the normal operations of consumer choice and 'protected' in their business operations? Is such protection required to achieve the NMP objective of access to medicines? If so, why? If not, why not?

I think that the correct advice and counselling cannot be given via an online ordering system; however, I am in two minds about this issue. There are of course, times in the shop when prescriptions are dispensed to carers/messengers/delivery drivers and clearly there is only the possibility of provision of written information to get directly to the patient. So this is not that much different to an online consultation. The only caveat is that

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my patients know where I am, who I am and how to get hold of me. I think that is really important. We also have a relationship with many of our patients, which makes it easier for them to come to us in times of need. But, in saying all that, I realise that I buy my contact lenses online. I can make lots of excuses as to why I do that, but it is rationally no different from filling a pharmacy script online. Honesty isn't always easy! Having said all that, I believe in the service I offer to my community so I think pharmacy is definitely separate from the ordinary retail businesses in the town. There is no other shop into which a customer can walk and seek counsel and advice and tissues. We offer this service (free of charge) every day we are open and it is taken up at least three times each week. The other day the mother of a 24-year-old man with mental health issues came in with his script and talked to me, with tissues at hand, in the counselling room for well over an hour. I have training in First Aid for Mental Health Pharmacy and I truly believe that I have helped her and her family and her son during that consultation. I was not paid by the government for that at all - the family is not on benefits so the script was dispensed at the Safety Net price. There is no other business where that interaction could take place except for Australian Community Pharmacy and part of the reason it can take place is the protections that are in place around pharmacy.

Is the 'swings and roundabouts' approach to remunerating pharmacists for dispensing appropriate? Does it lead to undesirable incentives? Should dispensing fee remuneration more closely reflect the level of effort in each individual encounter through having tiered rates according to the complexity of the encounter? For example, should dispensing fees paid to pharmacists differ between initial and repeat scripts?

I think the sense of the unfairness came when the rules changed regarding ownership and when the 'franchising' type of buying group came in. Before that, when one pharmacist owned one pharmacy, there was a sense that the system was funded by government and protected but that was OK because no one could get so many ownerships that it became ridiculous. Now you have things like the 'franchise' type shops in the same funding pool and remuneration as the small independents and it looks unfair for the big guys, whilst still being reasonable for the small pharmacy in the single-pharmacy town.

Dispensing fees are pretty reasonable given the amount of work we do for them. There is the straightforward cost of maintaining the dispensing systems - computers, printers, ink, labels, scanners, computer technicians, internet services, electricity, paper and just the system itself - MINFOS costs me nearly \$750 a month alone and that doesn't include all the other

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bits I have just mentioned. Quick calculation: Average 3000 scripts each month, MINFOS software costs me 0.25c per script. Then add in all the other costs and \$7.00 per script suddenly doesn't seem an enormous amount to make. I understand the concept of the repeat script being seen as 'cheaper' to produce than the initial one, but the fixed costs are the same. Repeats can often be more complicated than other scripts anyway because things have changed, patients have more questions, other new medications have been initiated etc - all these things make up the work that the pharmacist does each time they check a script. Just FYI, here is the process from the moment that I pick up the dispensed item after it has been processed and labelled (this means that someone has already done the work of data entry and review, printing, labelling and dealing with any issues that come up during data entry - different dosages in history, prescribing errors, interactions, unavailable medications, allergies and any phone calls to the doctor that need to be undertaken:

1. Check the details on the label match the actual original copy of the script and deal with any issues/changes/differences. (regardless of script type)
2. Go through each script in the patient's script folder to review what other medications that they are using and whether there are any issues to consider (regardless of script type)
3. Ensure the product matches the label (regardless of script type)
4. Ensure a CMI is available if required (usually with new scripts or dose changes)
5. Ensure all cautionary advisory labels are affixed (regardless of script type)
6. Packing in a bag to maintain patient privacy (regardless of script type)
7. Handing over the script to the patient (must occur for all new medications, dose changes, issues, differences, prescriber errors, brand changes (usually due to manufacturer Out of Stock of normal brand), allergies, inhalers). It also occurs for certain patients who we know will have questions, worries or just want to be served by the pharmacist, whether they have been taking this medication for twenty years or are just starting it today.
8. Talking through all the issues etc. This can take anywhere from the patient saying "thanks very much everything is fine" to an hour or so in the counselling room reliving the latest family issue that the patient has been having and hearing about how the poor doctor doesn't have the time to listen to them because he is so busy, but I just have a couple of questions that I didn't like to bother him with."

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9. *Going back into the dispensing system and recording all the details that we discussed so I remember next time that Mrs B doesn't like the green box because it doesn't look like her normal yellow box of tablets or that Mrs B needs to be seen by me next time because she is caring for her disabled grandson and she looks perilously close to a breakdown.*
10. *Thinking to myself that I must just review some information because Mrs B's grandson sounds as if he actually might have Schizophrenia not Aspergers and maybe I ought to fax the doctor about that because I too know he is really busy and his first language isn't English so it might be easier for him to read it rather than hear it.*

In reading that back, maybe there should be a tiered rate! Here's a thought, maybe if it takes me longer than 10 minutes to actually counsel a patient I should be allowed to swipe their Medicare card and get my dispensing fee that way. So we have a very small and basic flat fee for dispensing every script and I have the opportunity to charge Medicare when I have a complicated one. If this is classified as a Clinical Intervention, which it quite often isn't because the classifications are fairly specific, I get about \$14 for my time (calculated from my last claim payment). Just for comparison, a GP gets just over \$36 for UP TO 20 minutes of consultation. If I was a private counsellor I would be doing a whole lot better.

Some incentives are pretty strange. Firstly, the premium free dispensing incentive. Don't apply an incentive and then tell me that I can't force a patient to take it. I don't want to force any patient to take a generic ever, if that is going to compromise their care, but why should I sacrifice the opportunity to make more money because I'm following the rules? And anyway, if the government wants the consumer to use generics, then make them pay the price of choosing a more expensive drug and leave it at that. In that sense a choice is made at the till - I shouldn't be swaying that decision at all.

The other incentive payment I don't understand is the electronic dispensing incentive. This maybe simply because it is misnamed - it is really just a refund of the cost of electronic dispensing as I understand it. So I pay either ERx or Medisecure 0.15c per script scanned and then the government refunds it. Why doesn't the government just give this amount to the companies so the companies don't have to charge it to us? This seems simply double-billing.

From a positive point of view kudos to whoever actually finally agreed to pay me for my time and effort in providing subsidised diabetic supplies to patients on NDSS. For the past 14 years I have been doing this as a service - filling out the paperwork, ensuring we have the stock, maintaining

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the stock levels and expirys, answering the questions, submitting the paperwork and covering the fixed costs - all for free. Now I get the princely sum of \$1 per patient! Better than nothing but really? Especially this month, when I have spent at least 5 hours a week explaining to people that "No, when the media said that the price of your subsidised strips was going to increase, they were mistaken. The price hasn't changed, the process has changed. No, not for you, apart from the fact that we need this form signed by your GP every six months, the process has changed for us. Don't worry. Yes, this is a bit like Mediscare, isn't it?" Sorry....it is frustrating to feel that I have to justify my job.....

Currently community pharmacists have discretion over some charges. For subsidised PBS prescriptions, should community pharmacists be able to charge consumers above the 'dispensed price' for a medicine in some circumstances? Should community pharmacists be allowed to discount medicines in some circumstances? If so, what limits should apply to pharmacist pricing discretion? If not, why not?

I strongly disagree with the discounting of PBS medicines. Basically it comes down to the fact that the bigger you are, the better pricing you get from your wholesaler and the easier it is to provide discounted scripts. We went from a fairly level playing field to an unfair system overnight. I think there should be a standard price for all PBS supplies. If a pharmacy wants to discount their pricing, it should be deducted from their dispensing fee, not from their bottom line. Again, some perspective: Many of my patients are pensioners and many reach their safety net each year. Concession patients: At \$6.20 per script – that is 60 scripts; at \$5.20 per script – that is 72 scripts. So you are paying for 12 extra prescriptions at \$5.20 each – paying an extra \$62.40 to save \$1 on each of 60 scripts – the discount will cost you \$2.40 in the long run.

We haven't implemented the discount model. My staff actually explain the above calculation to the affected patients. To patients who would be unaffected by the safety net issue, they simply explain that if I charge \$1 less per script, that is approximately \$36,000 per year that I would not take in sales. That is the cost of one of my employees. Who would you like to nominate to go first? The patients have been extremely understanding. I actually think all medication should be standardised in price, regardless of whether PBS-subsidised or not. I fully support brand premium payments, but I think that optional discounting models mean that if you live in a populous area you are able to access cheaper medication simply due to economies of scale and that isn't fair and isn't in the spirit of equitable access to healthcare for all.

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Is the RPMA the best way to encourage pharmacies to operate in locations where they would not otherwise be viable? Is community need a more appropriate measure than geographical location?

Interesting concept. How do you measure community need?

Is the Electronic Prescription Fee achieving its intended purpose of increasing the uptake of electronic prescribing and dispensing?

Answered above.

Is the Premium Free Dispensing Incentive achieving its intended purpose of increasing the uptake of generic medicines? Are there better ways to achieve this?

Answered above.

Should the timeframes for payment settlements for very high cost medicines be lengthened throughout the supply chain and mandated by Government?

I would never refuse supply based on this. I have patients on a number of high cost medications - some who come to us from other towns where pharmacies refuse supply. However, we do negotiate in good faith with these patients. We explain that the medication is high cost. We only order if we have a valid prescription in the store. We let the patient know that we do not routinely stock the medication due to its high cost and that they need to let us know in advance (and supply us with the script) so as to be sure they do not run out of medication. I have found that if I am honest as to my reasons, my patients are very willing to work with me. Just a note about this - it is often an issue from a wholesaler point of view too. Some high cost medications are only available from the manufacturers and delivery is not always overnight. Some high cost medications are refrigeration products. This discourages us from keeping them in stock as they are unable to be returned for credit because they are fridge lines.

Are there better ways of achieving patient access to very high cost medicines through community pharmacy that reduce the financial risks to the supply chain and facilitate consumer choice?

Our process has worked for us so far. We have had minor issues with respect to delivery turnarounds and forgetful patients but generally it is acceptable. The remuneration isn't worth the amount of effort it takes with ordering, managing and losing a bit of money in the payment turnaround, but in order to maintain equity of access for patients, I just have to grit my teeth on that one and hope I can make it up elsewhere (or in goodwill, or good feeling? - Not very rewarding)

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As medicine specialists, what are the professional programs and services that pharmacists should or could be providing to consumers in order to best serve the consumers?

I really think that these are only limited by the amount of staff that we can afford to pay and the amount of planning and input that we can manage. I think the current programs are really worthwhile and work really well where we can implement them. I am just starting to consider the PSA Health Destination program so that we can increase our service model - it's going to cost me \$1500 a month just to implement so it's a big decision. Put that in perspective - it is just under the cost of a full time junior staff member. I would love to have the time and resources to implement more things like Weight Management and Smoking Cessation but we can only do so much with the resources we have. We don't do vaccinations - our local surgery requested that we leave them for now and I am happy to do so. I would rather focus on the services that are not currently available in town. For the same reason, I have no need to implement a baby clinic - the community nurses do that already. I would like to see much more interaction with our local hospital - it would be good to have a process in place whereby we could be notified about patients who are discharged and involved in following them up. We work well with our community nurses and our local surgery - a patient considered 'in need' is discussed between us all and managed. It would be great if we could do this proactively rather than reactively but there never seems to be time and resources to implement this sort of program.

I would love to be more involved with the local schools and pre-schools. I would like to implement some medication education programs with them at various levels and to help the teaching staff with their knowledge.

Historically I couldn't do it as I was on my own in the pharmacy and so I could never leave the shop, but having accepted that I need a colleague pharmacist, I could possibly give up my day off to do this. Putting that in perspective, it has cost me at least \$75K per annum to get a day off and I am considering using that day to implement new programs, for which I will get no remuneration.

Actually this is one of my passions - I have a background in clinical research and would love to get involved in the clinical trials in pharmacy program. Unfortunately, these programs always end up in the bigger pharmacies where there are more staff available to implement them. I am currently studying my Graduate Certificate in Public Health as well (in my spare time!) and it is inspiring me to try and find a way to implement other programs.

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Should there be limitations on some of the retail products that community pharmacies are allowed to sell? For instance, is it confusing for patients if non-evidence based therapies are sold alongside prescription medicines? It has been put to the Panel that a non-retail environment may improve the health outcomes for patients. For instance, some hospital pharmacies have their service area resemble a clinic rather than just a counter, providing a private environment without distraction, which maximises the professionalism of patient-pharmacist interaction. Would a community pharmacy that solely focused on dispensing provide an appropriate or better health environment for consumers than current community pharmacies? Would such a pharmacy be attractive to the public? Would such a pharmacy be viable?

More generally, is there a need for new business models in pharmacy? If so, what would such a model look like and how would it lead to better health outcomes?

These are all really great questions and paint an ideal model of a pharmacy in the real sense of the health care environment. For me, this would be a viable business model to aim for - which is the reason I am heading in the PSA Health Destination direction. I don't think a sole focus on dispensing is the answer - perhaps a focus on health care would be optimal so that we can continue to provide the primary health care function that we do so well - triaging the presenting patient and supplying an OTC medication as needed, or referring to the GP. With respect to provision of natural/complementary medicines, I think we need to be careful not to throw the baby out with the bath water. If complementary medicines are considered so 'non-health' why is their market so huge? They must be doing something? We are careful with advice on such products, which have less evidence-based proof of efficacy. We ensure that patients are aware of their limited evidence and their potential side-effects. We spend a good deal of time counselling patients on the use of and issues with products that they have purchased from the supermarket that really should have included more information at point of sale.

BUT and this is a big but - we need to be careful with new models. Are we running the risk of taking a working system that provides an accessible health care professional to the public and changing to another clinic?

What access advantage do we lose if we become an appointment-based model, rather than a walk-in, service system.

I like the thought of losing the departments that I listed above. In fact, I currently include them only for historical reasons and because our town has no competing business. Anecdote: we have always had a small baby and gift section. We don't keep diapers or general (non-therapeutic) infant formula any more as regular stocked items because the supermarket sells

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them at prices that I can't match. When a local girl opened up a baby supplies and gift store in town a few years ago, we went out of that section completely. The supermarket has some, and the new store could then open with a good chance at getting the business, keeping shoppers in town. We got a bit of grief from customers for no longer having the baby gifts and feeding items (even though we still had the truly health-related products) but we referred them to the new shop or the supermarket. Within 12 months the new shop closed down - I am not sure of her reasons but we bought all her stock and re-opened our section just to provide the service. But I don't need the baby section to be as large as it is - it has just been there forever and provides an alternative to the supermarket. As far as viability goes, with respect to a dispensing only business, with everything as it currently stands it may be viable. I wouldn't need as many staff so there would be savings there. I would probably operate with 2 pharmacists and one other staff member. We currently have 2 plus 2. But with the way that dispensing income has decreased over the past few years, it would be a hard decision to sell!

It has been put to the Review that there is an opportunity to improve outcomes in the care of patients with chronic diseases and complex care needs by optimising the contribution of pharmacists in multidisciplinary care teams and primary health care settings – areas of the MBS which may be better utilised to reduce the impact of medication misadventure. One organisation highlighted the Chronic Disease Management Service as an example of a service funded through the MBS which represents high value care for patients with chronic disease and complex care needs. However, this service is currently underutilised due to the exclusion of pharmacists as eligible allied health providers.

Other changes that have been proposed include:

- establishing a Pharmacists in General Practice Incentive Payment, analogous to the Practice Nurse Incentive Payment. It has been contended that pharmacists should be eligible to provide services, where appropriate, in the same way as services under the MBS are provided by practice nurses

Interesting that there is all this discussion about the cost of the PBS and the remuneration of pharmacy services but there is enough money to propose giving the owners of general practices an incentive to hire a pharmacist? Give me an incentive to hire a pharmacist and I will provide the service without needing alignment with the general practice. We can set it up in a room adjoining the pharmacy and have appointments in exactly the same way that the general practice would and the GP can refer patients to the consulting pharmacist.

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- supporting after-hours services through the introduction of an after-hours pharmacy payment through the MBS

I guess we have to ask whether there is a real need for after-hours services before we add to the Health budget. We actually used to open until 6pm but when our new GP started, the practice hours changed so they only opened until 5.30pm. We soldiered on for a while, but when we looked at script numbers in that last half hour it became obvious that it was not financially useful to be open until 6.00pm. Weekends may be different. In small towns patients don't expect Saturday afternoon or Sunday opening, but in the larger towns that service is available. Perhaps some data could be produced. If you can show that my patients are travelling the 30km into the nearest open pharmacy on a Sat afternoon or Sunday, then I might see the need to open. But I always assumed that the hospital could deal with those patients who needed prescription medication out of hours.

Is it appropriate that the PBS links the remuneration for the provision of professional advice to the sale of medicines? Would it be preferable when a medicine is dispensed if advice given to consumers is remunerated separately; for example, through a MBS payment? Would this be likely to increase the value consumers place on this advice? If an MBS payment for professional pharmacy advice was introduced, what level of service should be provided? Should the level of payment be linked to the complexity of particular medicines? Should it be linked to particular patient groups with higher health needs?

Answered above. Yes, I think this would be great. However, I don't understand why the level of payment would be linked to complexity of medicines. Are doctors' levels of remuneration linked to complexity of presentation/diagnosis? They are linked to time spent, which would be the most appropriate way to link pharmacist payments.

Closer integration of pharmacists and medical centres would be desirable, including clinical pharmacists being employed by the medical practice to deliver advice, with or without dispensing. What are appropriate ways for pharmacies to identify and supply the health services most needed by their local communities?

The PSA is introducing the Health Destination model. That looks to be a pretty good start for identifying health services in local communities. Of course, the pharmacy owner is expected to pay for that out of their own budget as discussed above.

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Are pharmacy services accessible for all consumers under the current community pharmacy model? If not, how could pharmacy services be made more accessible?

Again, as stated above, you can't have it both ways. We already know that pharmacy is considered one of the most accessible health providers. Do we need it to be more accessible? Of course the remote area service needs consideration with respect to this question. I don't know enough about that situation to comment.

How should government design the provision and remuneration of new programs that are offered through community pharmacy to ensure robust provision, value for taxpayers and appropriate supply for patients in need? For instance, should all patients be entitled to an annual HMR? Should HMRs be linked to a health event, such as following hospital discharge? Should they only occur following referral from a medical practitioner?

As I mentioned above, I think the current model is too reactive and I also think it has no consequential outcome. When we had regular local HMRs being performed it was disheartening that the GP at that time never actually made any of the recommended changes. If the Department is going to further fund HMRs or other medical reviews they should be:

- 1. Done on a proactive basis - similar to your suggestions above*
- 2. Funded as a professional service to the pharmacist conducting them (I can see no reason that the community pharmacy should be funded unless they are the provider of the service). Should the community pharmacy get involved then some degree of remuneration can be worked out, probably via the government so that the community pharmacy has an obligation to supply data and is confident of remuneration.*
- 3. The GP should be accountable for their end of the process. If the funding comes from the government then there must be accountability for action otherwise the process is pointless.*

Are there non-medicine-related services that pharmacists can or should provide to consumers due to their expertise as pharmacists or for other reasons (e.g. consumer ease of access to community pharmacies)? If so, why are these services best provided by community pharmacy?

I talked a bit about that non-medicine-related role above, but it is a relationship-based role, not a professional one. We do provide some of these non-medicine-related services eg witnessing of documentation which happens all the time and is not remunerated in any way. Most of the other services are medicine related - BP, weight management, smoking cessation, medical certification.....I don't think there is a role for non-health

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related services in particular - you then run into the whole issue of compromising your health care destination by providing non-health-care-related services/products.

Would any of these remuneration models be generalizable to other medicine services offered by pharmacies? Why or why not?
I don't really understand what this question is getting at. There appears to be only one remuneration model discussed in the paper in this section and I think that model could be applied as discussed above.

There are a number of programs and services available in community pharmacy which consumers may be charged for, such as dose administration aids, or blood pressure monitoring. Some pharmacies also offer weight loss or quit smoking services.

Is cost a barrier to accessing worthwhile health services offered by pharmacy?

Do you mean for the patient or for the pharmacy? Actually, I guess the answer to both is yes. BP monitoring, we still do for free. The community nursing service will also do it for free - I guess it's just a bit more convenient to come to the pharmacy as it is near the shops anyway. We record it meticulously, but rarely contact the doctor after the measurements as the patient is usually coming to us because they were directed to do so by their GP and record the data and come back for the follow-up appointment.

DAAs are a whole new ball-game. These actually cost us money to produce, even with the 5CPA and 6CPA payments and allowing for the \$5.00 per week charge that we put on them. I have a staff member who works the equivalent of 3 days a week in order to pack and manage DAA supply to our local 22-bed nursing home and to our community-based patients. The cost of the computer system, computer, printer, actual packing materials and time for liaising with the general practices about scripts, issues, changes, problems is not covered by the DAA payment plus our charge. I haven't included the benefit we get by dispensing prescriptions because it is 90% likely that these patients would come to us with their scripts anyway. I have no idea how pharmacies are managing to do this without charge - they must be running them at an extensive loss. Patients don't want to pay for extra services if they can help it. We charge for the medical leave certification, but they are OK to pay for that as our local general practice is so busy that it is difficult to access the service there. With regard to weight loss/smoking type programs I haven't done them (as discussed above) due to lack of resources. I don't think that the patients who need these services would be willing (and in some cases

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able) to pay for them. So if we can get remuneration for them that will at least help cover costs, that would be great. Bear in mind that the biggest cost in implementation of extra services is having more than one pharmacist available. When I was giving this consideration a few years ago I had to accept that even if I only wanted an extra pharmacist one day a week, that wasn't going to fly as no one is going to move to our rural location for one day's work each week. So we had to bite the bullet and employ someone for a minimum of 3-4 days a week to make it worthwhile for them to come. Even then, it was tough to find someone. I advertised for a full-time young pharmacist who was open to future partnership. I had four enquiries:

1. A young pharmacist from Sydney who was too scared to be left alone in the shop in a rural town (!!!)
2. A pharmacist in Newcastle who wanted to commute daily (it is a four hour drive each way) - I suspect he had no idea where our town was located.
3. An overseas pharmacist who I would have happily hired.
4. A locally born young pharmacist who had done 3 years work interstate and was ready to move back to be near her mother. She is wonderful but not interested in partnership at all.

If particular health services were deemed to be of clinical value and delivered good patient outcomes, what other mechanisms could allow these programs to be disseminated around the country to relevant communities and groups on an affordable basis?

Both the Guild and PSA are completely able to do this as has been proven in the past.

Should both direct consumer remuneration and government-based remuneration be applied for particular services or access arrangements? What pharmacy services should be fully or partially Government funded and what is best left to market or jurisdiction demands?

Already discussed above that both would be best as patients are unable or unwilling to pay, especially when services are proactive.

What does innovation look like in community pharmacy? Is there sufficient scope and reward for innovation embedded in the current remuneration model? How could this be achieved?

Isn't that what this discussion is all about?

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Would the removal of the location rules with the retention of the current state ownership rules for pharmacies increase or decrease access and affordability for pharmaceuticals to the public? Why and for what reasons? The pharmacy location rules have been the subject of numerous reports and reviews over the past 20 years, including the Wilkinson National Competition Policy Review of Pharmacy in 2005 and the 2005 Productivity Commission Review of National Competition Policy Reforms, 2010 Department of Health Post-Implementation Review of Pharmacy Location Rules, 2014 National Commission of Audit and the Competition Policy (Harper) Review in 2015. These reviews reached a range of different conclusions. Vogler et al found that "access to pharmacies usually increases after a deregulation but this is likely to favour urban populations with already good accessibility".

OK so how many times do the government waste money re-doing the same report and review without starting to wonder whether they might be getting it right?

Are there any negative studies to this? Why don't you include either the negative studies or the fact that there aren't any?

Finally, can you imagine how depressing it is to live through this constant background review of your life's work, with governments and people who have hidden agendas questioning the system within which you operate over and over again and coming up with nothing. I love my job - I feel strongly and passionately about the health system and I feel that my life's work is constantly under attack and criticised by those outside it.

Thankfully I get constant positive feedback from my patients who seem to recognise the true worth of pharmacy as it stands in Australia. Show me a system which works better and we can have ANOTHER review!!!!

Would the removal of pharmacy location rules in urban areas with their retention in other areas, particularly rural and remote areas, increase or decrease access and affordability for pharmaceuticals to the public? Why and for what reasons?

Well didn't the Vogler study answer this for you?

Why would you assume that this may improve access and affordability for the public? Do you think that there will be more pharmacies that charge somehow less money to the public if you change the location rules in the cities? I don't understand why anyone would open a business just because they can - they have to be able to actually identify a customer base in need. And then why would you assume that they would somehow be able to charge less for their business services? This question does not state that the remuneration rules would change, so the same current government payments would apply to new businesses as well.

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Would the removal of the location rules in urban areas with their retention in other areas, particularly rural and remote areas, discriminate against rural and regional consumers or benefit those consumers relative to consumers in urban areas? Why or why not?

This is not about location rules - it is about remuneration, which is a separate topic. See my comments above.

If the states and territories were to amend the ownership rules so that any party could own a pharmacy, subject to requirements for dispensing only by a qualified pharmacist, how would your response to the full or partial removal of pharmacy location rules change?

It wouldn't change. As far as I can see, these two issues have nothing to do with each other. Are you talking about location rules or opening pharmacy to supermarkets? If you are talking about opening pharmacy to supermarkets, then perhaps you should have a look at what has been done to the butchers' industry. I can also see a number of GPs who become keen to open a pharmacy - write a script, get it dispensed and then pocket both ends of the government subsidy. Or the big supermarket chains who will simply open up, put everyone out of business and then own the market and set the pricing themselves.

The current location rules allow for the re-location of a pharmacy within a kilometre of its original location, provided that pharmacy has been at its original location for at least two years (Rule 124 - Short distance relocation). Although intended to ensure flexibility for pharmacies to relocate within the local area, it has been put to the Review that this rule has allowed unintended and undesirable grouping of pharmacies in desirable urban areas. Is the short distance relocation rule appropriate? Please provide examples to explain your reasoning.

This question seems a little confusing. Why would a restriction on moving away from your old premises increase the number of pharmacies in any particular area?

It has been suggested to the Review that pharmacies should be allowed to enter new locations subject to the payment of an appropriate approval fee to Government to prevent excessive entry to the pharmacy market. Any pharmacy then having been competitively impacted by a new entrant, or who would prefer to exit the market, would be able to receive compensation for surrender of its own approval number. Would such an approach be desirable or undesirable?

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Again this question is confusing. Why would increasing the number of new pharmacies (if they can pay enough to satisfy the government - a bit like bribery?) prevent excessive entry to the market. Surely this would increase entry to the market? And why on earth would the government say, oh yes if you pay you can open a new pharmacy there and then turn around and compensate the current pharmacy for having to close? This is bizarre.

Should an approved pharmacy operating in an area for which the pharmacy location rules preclude the operation of a second pharmacy be required to provide a minimum level of services in addition to the dispensing of PBS medicines? Should such pharmacies also be required to maintain minimum opening hours in addition to those typically offered by community pharmacy?

I think you can only require a pharmacy to provide a minimum level of services if they are going to be able to actually make a profit from the services. If you do this and the services are not appropriate for the community in which the pharmacy operates, then you will be sending businesses broke for no apparent reason. I think that you will find that if there is a community need for extended hours of trade, a business owner would already be providing that service, provided it was financially viable. One would be crazy to ignore a potential increase in business profit.

The current pharmacy location rules do not preclude a pharmacist from operating more than one pharmacy within a particular area. To the extent that this may allow an approved pharmacist to restrict local competition by opening a second pharmacy in the same area, should the rules be amended to support choice and value for money for consumers?

As I stated above I don't support the concept of multiple ownership.

The current pharmacy location rules preclude the operation of a pharmacy from within a supermarket by specifically requiring that the premises from which an approved pharmacy operates are not directly accessible by the public from within a supermarket. The Review would like to better understand the objective of this requirement.

Recognising that restrictions on co-location of pharmacies and supermarkets exist under state and territory legislation, would the removal of this restriction from the pharmacy location rules be desirable or undesirable?

Undesirable. You may as well open ownership to supermarkets if you are going to support opening a pharmacy within a supermarket. The

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supermarkets are too powerful to allow an independent business to operate under their roof without having control.

Pfizer supply direct and do not provide their medicines for supply through the CSO. Should all PBS medicines be available through the CSO, or is it appropriate for a manufacturer to only supply direct to the pharmacy?

All PBS medicines should be available through the CSO. End of discussion. What Pfizer has done has caused supply problems and been a difficult problem to manage, particularly in rural locations.

Should CSO wholesalers have such discretion, or should they as part of the CSO arrangements be required to provide minimum terms and conditions for PBS items?

Until Pfizer managed to get around the CSO system, I was under the impression that the whole basis of CSO was that there were agreements that they had to meet in order to get the funding. Somehow Pfizer seemed to manage to defeat that whole system.

In the 6CPA there was a change in the CSO requirements relating to 72-hour delivery for the 1000 highest volume medicines. Was this a desirable change?

Yes.

What impacts has this had and is there evidence available to demonstrate this?

It has had no impact as far as I can see and is not enforced in any way. In fact, have a look at the availability of sustained released metformin for an example.

CSO wholesalers can require minimum ordering amounts for specific medicines. This is likely to reduce the cost to the wholesaler while increasing inventory costs and wastage for the pharmacy. Is this desirable or undesirable? Are there other parts of the wholesaling arrangements that create or encourage cost shifting that are undesirable for community pharmacy or consumers?

Of course this is undesirable. I own a pharmacy with a customer base of approximately 2000 people. My nearest town has 5 pharmacies in a customer base of 18,000 people. Who do you think benefits/suffers from minimum orders?

With regard to the other parts of wholesaling arrangements - the wholesalers should not have been allowed to fund pharmacy purchasing

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and in the process create the 'franchise-type' situation that now exists. This has caused inequities in pricing power similar to the supermarkets.

Should there be requirements on wholesalers relating to minimum usage dates of stock? Would such requirements increase or decrease wastage in the system? Would this shift costs to community pharmacy and reduce the efficiency of the system?

This hasn't been a problem for us. Careful stock management and surveillance has meant we don't lose an excessive amount due to written off stock.

Should the onus for the delivery of medicines to community pharmacy around Australia in a timely fashion (e.g. 24-hours) be imposed on the manufactures as part of their listing requirements on the PBS?

Manufacturers shouldn't be a part of the delivery to pharmacy - that should be via wholesalers, so that isn't relevant. Manufacturers should be accountable for unavailability of stock though - the out of stock situation at the moment is untenable and dangerous.

Should the onus to negotiate the delivery of PBS medicines from manufacturers be placed on community pharmacies, either individually or as collectives? Would this be desirable or undesirable?

As above. Delivery should be via wholesalers not manufacturers.

It has been put to the Panel that partnerships between the pharmacist and patient could deliver opportunities for further data collection and information on the specific utilisation of medicines and health outcomes in real time. If this data collection and analysis is desirable, would funding be needed from Government or from another source? If so, what would be the avenue for such funding?

Sounds a bit dangerous. Sounds like opening up the option of selling the data to the highest bidder. It is one thing to provide such data to the government (and this should only be with agreement from the patient and only data where the government has subsidised the goods, but to provide to anyone who will pay opens an enormous ethical debate.

Is the ability for the consumer to choose their pharmacist, and change pharmacists if they are dissatisfied, the appropriate or best mechanism to provide feedback?

It would be great if customers could provide feedback in some formalised way but it may become difficult. I know we get a lot of off the cuff information about other pharmacists, doctors and hospitals amongst other

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health providers, but we need to sift through the feedback to find out what is real.

Are there appropriate standards for the dispensing of medicines and delivery of services by community pharmacy? If so, are these standards being upheld? If not, how could the current standards be improved?
I am disappointed that standards are not upheld. Not that I feel that we are perfect, but there are so many situations where I experience inappropriate care as a patient in a pharmacy. It is a sad indictment of our profession that making money seems to come before health care.

What services should a consumer expect to receive from a community pharmacist who dispenses their medicines? Why should the consumer expect these services?

Every patient is different and every transaction is different. I have one patient who is a registered nurse. On one day she will come in and tell me I don't need to talk to her - she knows more about healthcare than I do. She has then come in on the following day and complained because I said that I wouldn't counsel her on her repeat insulin script because she would already know about it - she complained that sometimes she 'just wants to be treated like a patient, not like a nurse'. You can't please all of the people etc.

What are the minimum services that consumers expect (and should receive) at the time of dispensing? Do these differ between initial and repeat prescriptions?

As above. It's different for every patient and for every transaction.

Are these services being provided by all pharmacies?

No - even the most perfect pharmacy will sometimes just slip up, or not have time or be tired or be feeling off or something.....We are human.

What does 'transparently cost effective' mean for consumers in the context of remunerated pharmacy services?

I think a consumer should answer that one.

Are there currently some programs that are viewed as additional to dispensing which should be included as part of the service provided by a pharmacist when a prescription medicine is dispensed (for example, a medicines check or review)? If so, how should pharmacists be remunerated for providing these services? Should such services be included each time a prescription is filled or should 'initial' and 'repeat'

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prescription dispensing involve different services?

Answered above.

However, some consumer experience is mixed in terms of the quality of advice on offer and having their specific healthcare needs met. Some individuals have suggested that, in their experience, the provision of services as part of dispensing in community pharmacy depends on how busy the pharmacy is at the time, and the nature of the consumer (initial script versus repeat, regular consumer versus once-off). It has also been suggested that some consumers face implicit or explicit discrimination in the dispensing process due to the nature of their condition and the medicines that they require.

Is there a variation in service standards between different pharmacy models?

There is a variation in service standards in every transaction conducted in every business/service in every country on every day. Sometimes I think we forget that the providers of these services are human beings. Every now and then everyone makes a mistake or is a bit off in their service approach. I have definitely improved in my service consistency since taking on a colleague and decreasing the sheer amount of time that I am facing a patient over the counter. I hope that I have never discriminated against anyone but I am sure that there are times when a patient leaves my store feeling disgruntled or unfulfilled. I just do my best.

Do community pharmacies that offer discount medicines provide lower levels of service? If so, what evidence is there available to support this?

I don't know. I don't know if there is any evidence.

How do we measure the quality of services provided by the pharmacy?

I wish I knew. I would love some feedback on how we measure up.

It has been put to the Panel that when it comes to choosing a community pharmacy, there is not a 'one size fits all' pharmacy model for every consumer. It depends on their personal needs and preferences, the costs versus the benefits of each model, and their comparison of the level of programs and services on offer.

Yes, see my comments above.

Has the \$1 discount had an impact on the access and affordability of PBS medicines? Has the introduction of the \$1 discount been a successful implementation of policy?

Already answered above.

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What examples can you provide of variation in prices for regular PBS prescriptions?

These vary all the time. Usually a patient will tell us and we will do our best to give them the best price possible. One thing I hate is the dispensing of PBS prescriptions as private scripts. There is no way to tell from the repeat that this has occurred and it is causing a big price discrepancy issue. I think I stated above that I think there should be set prices for all medications.

Is the sale of schedule 2 and 3 medicines an important contributor to the income of community pharmacies?

Yes, and also an important contributor to a well-rounded health service.

Does the availability and promotion of vitamins and complementary medicines in community pharmacies influence consumer buying habits?

Ask a consumer.

Should complementary products be available at a community pharmacy, or does this create a conflict of interest for pharmacists and undermine health care?

As long as supply is performed in a responsible way, giving the patient the information that they need to make an informed choice, I believe that complementary products have their place in health care. I cannot believe that these products are not useful, given their market size. In fact, I am a user of complementary products.

Do consumers appreciate the convenience of having the availability of vitamins and complementary medicines in one location? Do consumers benefit from the advice (if any) provided by pharmacists when selling complementary medicines?

Yes. Patients have told us that they want us to stock these products. They ask questions of us about the products and we help. In fact, they ask me in the supermarket when I am doing the family shopping and they are buying the product there.

Does the 'retail environment' within which community pharmacy operates detract from healthcare objectives?

Sometimes, and sometimes it is advantageous. It is useful because it is accessible and familiar and comfortable. It is non-threatening and a place where relationships can be built and friendly, reliable advice can be discussed.

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That depends on the pharmacy and the pharmacist though doesn't it? I have been in pharmacies where I cannot find a staff member, I cannot see a dispensing counter for high aisles and I have been given a prescription item without a paper bag and been told to take it down to the front desk and pay for it. I felt quite astonished that there was such a lack of privacy. But as I said, every business is different.

Are the current consumer payments for the supply and dispensing of PBS listed medicines transparent? Are they appropriate?

No. And they are too variable to judge whether they are appropriate.

Is the PBS Safety Net adequate to address the needs of low income consumers who face high pharmaceutical costs and other medical-related costs? If not, what other strategies can be employed to ensure access to cost-effective healthcare is protected and promoted?

The system as it works! It is not broken, it is not growing rapidly and I cannot understand why we are spending so much money constantly demeaning a system that works. I am all for ongoing review, especially of projects funded by my tax dollar, which has been decreasing over the past few years as the government continues to make pharmacy pay for the rising costs of the whole health system, whilst ensuring that doctors are protected against any income review. Sometimes I feel that the Guild should take lessons from the AMA!

Seriously I would like to see a system that provides free health care to everyone - no means testing because we are talking equitable access aren't we? But that is impossible. I am pretty impressed by the way the system works in Australia. I think pharmacy is tenuous but that is because of greed - I would love to see us go back to the one pharmacist, one pharmacy model because that should be enough to allow a profitable, comfortable lifestyle with the added benefit of satisfaction that every day I make a positive contribution to someone's health situation.