

PHARMACY AND PHARMACEUTICAL SERVICES IN AUSTRALIA

1. In your opinion, is the ratio of community pharmacies to population optimal? What data would you use to support this opinion?

The data is insufficient to draw conclusions.

Do more pharmacies lead to better use of medications or do more pharmacies appear in areas of higher demand (NT vs TAS)?

I suspect the numbers are fine (as compared to similar countries) but the distribution is off

2. If it is desirable for the ratio of community pharmacies to population to increase or decrease in some areas, what in your opinion is the best way to encourage this?

Australia has a large divide between rural and urban pharmacy numbers. Due to the current payment model this incentivises Pharmacies to open with areas of large prescription volume and makes areas of lower prescriptions (that may have need) not viable. To encourage a shift in the mix of pharmacies between rural and urban would require a change in the payment system down to a review of the private/public model that may not be fit for purpose

PHARMACY INDUSTRY

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

Yes, unless you split off the pharmacy from the retail side

4. 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?

No, but I would argue that current funding methods mean that you need the retail to make a pharmacy profitable. To penalise pharmacies by taking into account their retail sales seems perverse. Surely the underlying aim should be to incentivise pharmacists to move away from retail sales and back to professional services (or not if retail is such a large part of their business)

REGULATORY LANDSCAPE

COMMUNITY PHARMACY AGREEMENT

5. Is the CPA process consistent with the National Medicines Policy? Is it consistent with the long term sustainability and affordability of the PBS? Is it consistent with good government practice in terms of value for money (for both patients and taxpayers), clarity, transparency and sustainability?

You could argue either way for all of these statements. It is definitely easier to maintain the status quo than to change the system but my personal view is that the status quo hardens prevailing interests from pharmacy owners.

6. What would be a preferable approach? Why would this be preferable? In particular why would this lead to better value for money and better meet the objectives of the NMP?

Seriously I have no idea.

One option could be to switch to a capitation system based on census/population data

7. 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 would leave all PBS funding through the CPA (or whatever alternative to CPA has been decided). Every other professional service I would put on the MBS

NATIONAL MEDICINES POLICY

8. 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?

Not appropriate. Guild only covers 70-80% of community pharmacies and this will only further fragment. Need to have one agreement for everything including hospitals (Which dispense a lot of PBS medication in certain states). Need to get representation from as close to 100% as you can. Would also include consumers, hospitals, wholesalers and states

9. 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?

It shouldn't be an adhoc system with individual/groups of pharmacies getting different contracts. A national list of "prices" for core services is desirable that all pharmacies need to offer

10. 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?

Due to current direction of government (Devolved funding) the small business route is probably fixed (Which does not mean it is the correct way)

11. 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?

No it is not. It is doing well up to a point (Urban) but does not incentivise rural pharmacies that do not have the prescription volume to become profitable

- 12. 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. The CPA talks about medication info and counselling

I would like it to be law that all medications come with the patient medication List included in the box.

COMMUNITY PHARMACY

- 13. 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?**

Yes it should be removed with appropriate safeguards put in place to go completely digital.

An order from a prescriber will always be needed and depending on the model chosen oversight and patient choice of pharmacy can remain

- 14. 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?**

Protection is definitely not needed in urban areas but there may be an argument to continue the practice in rural areas. Prior to 1990 with no location rules it did not work with too many pharmacies, too close together in urban areas and insufficient numbers in rural/remote areas

PHARMACY RENUMIRATION FOR DISPENSING

COMPONENTS OF PHARMACY RENUMIRATION

- 15. Is the 'swings and roundabouts' approach to remunerating pharmacists for dispensing appropriate? Does it lead to undesirable incentives?**

Yes it is appropriate. Without knowing what is coming through the door of the pharmacy in advance the risk of undesirable incentives is mitigated

- 16. 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?**

No. Dispensing is dispensing. Even a repeat can have complexity to it (i.e if other new drugs have been started, side effects found etc). The "swings and roundabouts" method has value in this situation

- 17. Are the current fees and charges associated with the dispensing of medicine appropriate? In particular, do they provide appropriate remuneration for community pharmacists? Do they**

provide appropriate incentives for community pharmacists to provide the professional services, such as the provision of medicine advice, associated with dispensing?

It still seems complicated (the fact you needed 2 pages in the discussion paper to do this) and should be streamlined to one dispensing fee per item only or scrap it completely and have capitation grants per head of local population.

OTHER FEES PAYABLE UNDER 6CPA

18. 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?

No, either the price control is good and you need it, or it is not and everything is free.

Government should not put this decision in pharmacy hands otherwise larger chains with better economies of scale will predominate (unless you want this?)

19. 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?

No. The flat yearly fee is insufficient (otherwise we would already have more than enough pharmacies in rural areas)

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

Not convinced it matters. Especially as electronic is the direction prescribing is going

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

Get rid of brands from the PBS as soon as generics come on market unless therapeutically necessary to stay on brand (antiepileptics?)

HIGH COST MEDICINES

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

Yes and should be included PBS submission (so if drug companies want something on PBS, put a payment time on the submission)

23. 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?

Government pay for it and reimburse pharmacy fees on presentation of a script through PBS online. If no claim then happens, government present individual pharmacy for bill after an appropriate time (1month).

24. Given that very high cost drugs are likely to become more common on the PBS, should this remuneration structure for hospitals change to more closely reflect the remuneration structure of community pharmacy?

Yes – it should mirror community pharmacy and hospitals should be involved in the CPA negotiations

THE ROLE OF PHARMACISTS

25. 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?

Minor Ailment Scheme

Supplementary Prescribing

Prescribing in GP practices

Public Health Service (PMS) - health promotion but also includes smoking cessation services and products, emergency hormonal contraception access as well as locally enhanced services such as prescribing and supply of gluten-free foods, urgent supply of repeats medicines etc.

ALTERNATIVE BUSINESS MODELS FOR PHARMACY

26. 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?

Yes. Where is the level of evidence for each item?

i.e Homeopathy has nothing but what about cough and cold remedies. Who decides a lack of evidence? It cannot be the pharmacies

27. 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?

An example of this model would be from Germany (Apotheken versus Drogerien). Whilst I believe that this model does give a better health environment I am unsure if this is the right direction to go. Consumers want all their health stuff in one place (band aids etc) and under the current funding arrangements this would not be financially viable.

28. 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?

Non dispensing pharmacist prescribers in GP clinics allowing GPs to see the sickest patients

Supplementary prescribers in community pharmacies (prescribing ongoing supply, again stopping stable patients from having to see GPs)

All on MBS (at cheaper prices than GPs) so it becomes cheaper whilst improving access for the patients that really need to see a GP to see one.

ALTERNATIVE ARRANGEMENTS TO RENUMERATE PHARMACISTS FOR SERVICES

29. Is it appropriate that the PBS links the remuneration for the provision of professional advice to the sale of medicines?

It is efficient to have one charge and one organising body. It is easier for pharmacists to claim but difficult to track value. Ideally you would only concern the PBS with medication repayment and all other charges through MBS. However this may increase inefficiencies

30. 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?

It would increase the value consumers place but I don't see a place for 2 separate funding sources for technically the same indistinguishable process – dispensing and advice on what has been dispensed. A (poor) analogy would be a GP to give advice from one funding stream and to write a prescription from another .

31. 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?

Depends what you mean by professional advice.

If it is just counselling then probably only the first time the drug is prescribed

32. What are appropriate ways for pharmacies to identify and supply the health services most needed by their local communities?

As they are private, pharmacies need to be told and commissioned by PHNs (or state health department). If they are not told by someone else then they will only give the most profitable which might not be what the local area needs.

If this is not possible then every pharmacy needs to be able to do everything. Dispensing and info about medications is the service done the best because it is a core business. To roll out great health services it also has to be seen as core business.

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

A better remote pharmacy funding model away from script volume and more money for professional services

34. 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?

Put them in the MBS – NOT funded in the CPA

New programs need to be core functions of a pharmacy so consumers know that every pharmacy will do the same services (otherwise they need to look different)

Review of Pharmacy Remuneration and Regulation
Submission #9; 11-Aug-2016; Richard Grygiel

With the HMR example I would get rid and go with pharmacy supplementary prescribing instead with payment through MBS

35. 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?

Ideally not but due to the remote areas of Australia there is probably no way around this. Pharmacies are the most ubiquitous health place allowing better access than other services

36. Would any of these remuneration models be generalizable to other medicine services offered by pharmacies? Why or why not?

MBS funded

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

Yes. The people these programs most affect are disproportionately poorer members of society and costs are a larger part of their disposable income

38. 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?

How do you know they have value? An independent trial? If so then it should be on the MBS

39. Should both direct consumer remuneration and government-based remuneration be applied for particular services or access arrangements?

Should be like MBS for GPs, Some bulk bill others add a co-payment on top. Should be the same with pharmacies

40. What pharmacy services should be fully or partially Government funded and what is best left to market or jurisdiction demands?

As many as have robust evidence behind should be fully supported by government. If they do not then they should not be

41. 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?

No support and reward in current remuneration model. My idea would be to have any evidence based programs on MBS. Anything else supported as pilots by states. After good evidence comes in the MBS takes over

REGULATION

PHARMACY LOCATION RULES

42. 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?

It would go back to pre-1990 levels with more pharmacies overall but all in urban areas with a reduction in rural pharmacies.

43. 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?

Increase access in urban areas, but access is already there. Rural access would remain the same

44. 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?

Neither. The ultimate aim of location rules is to get dispersion of services. This has not worked in rural areas as the payment system for pharmacies is built on volume, volume that does not exist in rural areas. Location rules are neither good nor bad but, by themselves, do not promote or negate access.

45. 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?

Supermarkets would get involved which could help rural areas.

46. Is the short distance relocation rule appropriate? Please provide examples to explain your reasoning.

The problem with this is setting up a pharmacy in an undesirable area knowing in 2,4,6 years you can get where you want to be (Chemist warehouse do this a lot). As it only really happens in urban areas I do not see any reason to change this rule

47. It has been suggested to the Review that this creates unintended consequences in locking pharmacies into specific shopping centres and transferring effective ownership of the pharmacy approval number to the shopping centre. Is this a reasonable assessment of the effect of the location rule regarding short distance relocation from a shopping centre? Should this rule be modified, and if so, why? If not, why not?

You either trap these pharmacies in or cluster them outside. With any location rule either one or the other will happen

48. A similar requirement exists with the same rule for relocation of pharmacies from within medical centres. Is this requirement for medical centres desirable or undesirable?

Should not matter, medical centres are much smaller so do not see issues with this.

49. 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?

Awful idea that is open to corruption and lobbying.

50. It has also been put to the Review that by limiting competition for existing pharmacies, the pharmacy location rules raise the profitability of some or all community pharmacies. Is this a reasonable expectation of the effect of pharmacy location rules? Please provide examples to explain your reasoning.

The argument is sound. If you limit locations you get pharmacies raising the profitability but also increasing access so pharmacies are spread around.

51. 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?

The 100hr pharmacies in the UK did not work and led to grouping of pharmacies with no discernible improved access. I would say the initial pharmacy should offer more services, not the interloper

52. 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?

Other business owners can open multiple shops; companies can produce multiple brands of the same product. I do not see a conflict of interest in opening multiple pharmacies in the same area

53. Recognising that restrictions on colocation 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?

Desirable

HOSPITAL PHARMACIES

54. Could hospital pharmacies complement medicine dispensing and related services currently provided through community pharmacy or other public and private hospital pharmacies?

Theoretically they could but I do not understand why this would be a valuable service. Hospital pharmacies are not built in places where the “man off the street” can easily access. They can run services like smoking cessation but funding for those can be got through state funded services. By attributing community pharmacy standards to hospital pharmacies you dilute the focus of hospital pharmacies

55. If pharmacies operating out of private hospitals were required to operate 24- hours a day, would this be beneficial for consumer access? Would it be viable or economical for private hospitals to provide this service?

Would not be economical for private hospitals and at 0200 why is any prescription urgent?

56. How might broadening the services provided by hospital pharmacies improve consumer access in rural and regional Australia?

In areas where it is uneconomical for a rural community pharmacy to operate then there may be a benefit but hospitals with pharmacies are usually built in reasonably sized towns that already have a community pharmacy.

57. If hospital pharmacies were able to complement the services provided by community pharmacy, should all pharmacies be able to access similar purchasing arrangements?

I think there should be a national drug price negotiator for all hospital and community medications. The economies of scale would bring tremendous savings to the Australian consumer but there would be large legislative hurdles.

58. Should hospitals be able to open dispensing pharmacies in the community? Should hospitals be able to contract with specific community pharmacies? Under these arrangements, should community pharmacies be able to access medicines through hospital supply arrangements?

I believe hospitals can theoretically open community pharmacies now (through legislative acrobatics) but by doing so this dilutes from what hospitals are for. Why is a public institution trying to “turn a profit” in a community pharmacy setting?

There should be a national drug price negotiator for all medications

59. Should hospital pharmacies be able to establish limited dispensing arrangements, either in-pharmacy or through a delivery or mail order service, to enable post-discharge services and continuity of care to patients in the community setting?

Why would hospital pharmacies want to do this? Not their core business and the only reason they would want to is so they can try and turn a profit (which should not be the goal of a public organisation). Should be a better transfer of care to community areas

60. Could dispensing arrangements by hospital pharmacies to patients be extended to the broader community to complement access to medicines through community pharmacy?

Review of Pharmacy Remuneration and Regulation
Submission #9; 11-Aug-2016; Richard Grygiel

Could be of value to those S100 drugs, but PBS is gradually making S100 also S85 so access is slowly being extended. Could allow community pharmacies the ability to dispense S100s. This restricts prescribing to specialists in hospital BUT allows better access to medication

61. What other opportunities are there for public and private hospital pharmacies in securing supply options for greater access to PBS subsidised medicines?

Probably nil

ABORIGINAL HEALTH SERVICES

62. Although s100 AHSs are able to fund the employment of a pharmacist from their primary health care budget, there are no specific funds to employ a pharmacist to conduct Quality Use of Medicines activities and manage the s100 program within the AHS. Do these arrangements impact on health outcomes?

Yes they do as no one is reviewing the prescribing patterns.

Could you use a better reallocation of funds for medication?

63. The s100 Support Program supports increased involvement of pharmacists in the supply of PBS medicines to AHSs. Is there further scope for pharmacists to be more involved without impacting on access to medicines? Should pharmacists be able to directly claim an MBS type payment for QUM activities conducted in AHSs? Could this be a trial program under the 6CPA?

Yes, Yes and Yes

64. Could general improvements in remote dispensing improve the delivery of medicines in Aboriginal and Torres Strait Islander communities?

Of course.

65. Should the s100 RAAHS program be extended to include non-remote AHSs? Similarly should the CTG Co-Payment measure and QUMAX programs be extended to include AHSs in remote areas?

Yes. Further expansion will reduce confusion and make sure that these communities can access medications without cost being an issue

66. Should AHSs in all states and territories be able to operate a pharmacy business?

Theoretically yes but safeguards would need to be put in place to limit fraud and to make sure it is safe. This step would be after all other ideas had been exhausted.

67. How could appropriate QUM activities be provided in all remote areas at a comparable level of quality to those provided in non-remote services?

Telehealth, good data gathering, more online electronic services that can be monitored at a central hub (fridge temps etc)

68. Would it be desirable if remote s100 Aboriginal Health Services were also able to write CTG scripts?

Yes – see Q69

69. Could the arrangements for s100 and CTG co-payments be merged to allow Indigenous people who travel to access both s100 while they are at home and CTG co-payments when they travel?

Yes. One simple system that everyone knows about will promote access. Also more efficient and cheaper to manage

70. Should access to electronic patient health records be required for all health professionals treating Indigenous patients across all locations?

Yes

71. Should hospitals be allowed to write CTG co-payment scripts for out-patients?

Yes. It is ridiculous that they cannot. Aboriginals can be patients in hospitals and without CRG how are they supposed to pay for their medication?

72. Could there be more scope for tendering for the supply of medicines through AHSs?

Probably, although the specifics of how this could happen are beyond my knowledge

WHOLESALE, LOGISTICS AND DISTRIBUTION ARRANGEMENTS

73. Is the current approach to CPA negotiations, as adopted in the 6CPA, an appropriate way to meet wholesalers' needs? If so, why? If not, why not?

Probably, mainly because I cannot think of an alternative that is as "clean"

74. Are there alternatives to the current CSO rules that would enable wholesalers to improve the efficiencies of their services without detracting from the consumer experience and access?

Not aware of any

75. 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?

It is not appropriate and should be all or nothing. i.e All manufacturers can supply to pharmacies OR none are allowed

76. Should s100 and RPBS items be included in normal wholesale arrangements and in the CSO? If so, why? If not, how do the current arrangements support consumer access to all PBS and RPBS items?

Yes. Federal government should take over all drug price negotiations to get better economies of scale

- 77.** Have recent changes to the CSO, such as the extension of the guaranteed supply period and introduction of minimum order quantities, had an impact on consumer access or choice? If so, what evidence is available to demonstrate this?

Not aware of any

- 78.** Currently not all areas are covered by the 24-hours CSO obligations (such as Christmas Island, Derby (WA) and Mission River (QLD)). Are these exceptions leading to detrimental outcomes for patients? If so, why? If not, why not? If so, should they be included in the 24-hour rule? If so, how is this logistically possible? If not, are there other areas of Australia that could be excluded from the 24-hour rule without adverse patient impact?

Not my area to know

- 79.** 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?

There should be minimum terms. The wholesaler part of the CPA should be more like a contract than it currently is

- 80.** 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? What impacts has this had and is there evidence available to demonstrate this?

No opinion

- 81.** 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?

This would be Problematic for the pharmacy. I would have thought the 7.5% would be sufficient to not need minimum order quantities. Again a reason that the CPA should be more like a contract than it currently is

- 82.** 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?

Should have requirements but it does depend on the product. Some products do have short expiry. This question should be focused on the longer expiry products where an expectation exists of a certain expiry date

- 83.** Does the current CSO arrangement lead to strategic variation in trading terms by wholesalers that is detrimental to some community pharmacies and patients. If so, how? How could the current system be modified to remove such undesirable strategic behaviours?

No Opinion

84. Is a percentage mark-up paid by the pharmacist an appropriate way to compensate wholesalers? Would an alternative compensation arrangement be preferred? If so, please provide details of preferred arrangements.

It is a good enough system

85. Could the Government provide either improved wholesale medicine delivery or equivalent wholesale medicine delivery at a lower cost to consumers and taxpayers by moving from a broad CSO system to an alternative system?

Without knowing the alternative system I could not comment

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

It should be but it would depend on the language used and punishments if they cannot manage this. i.e manufacturer stock issues

87. 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?

This should not be left to individual pharmacies to sort out. Collective approach in 6CPA will give better terms

88. Would an improved approach to wholesale medicine delivery involve the Government tendering delivery on a nation-wide basis to one or two wholesalers (with appropriate redundancies)? Should it be done on a national, state or local basis? Should tendering be limited to only Pharmacy Accessibility Remoteness Index of Australia (PhARIA) 2, 3 and 4 locations, with open competition in PhARIA 1 areas?

Nationwide tender should definitely be the way forward. With regards to the specifics, I do not have an opinion

89. The Review Panel notes that state and territory governments already tender for the supply of medicines to public hospitals, should the Commonwealth and state and territory governments work together for a single tendering model for relevant public hospitals and community pharmacy in the relevant state? If so, should it be for all medicines or specific medicines (e.g. biosimilar or generic medicines)?

Ideally it would be one tendering process for all. The complications I see would be the competing desires. State governments would want cheap NPBS items at the expense of cheap PBS items. Federal would want the opposite (do to cost shifting).

ACCOUNTABILITY AND REGULATION

90. Are there any other regulatory arrangements that should be introduced to promote high standards of delivery and accountability amongst pharmacies, wholesalers, manufacturers and other entities receiving funding under the PBS?

Review of Pharmacy Remuneration and Regulation
Submission #9; 11-Aug-2016; Richard Grygiel

Not aware of any

91. Are there any existing regulatory arrangements that are unnecessary or overly burdensome?

SAS stock ordering

How the TGA assess what scheduling a medication is but leave it up to the states drug and poison legislation. Streamline and set drugs and poison regulation nationally

92. What data is already available in pharmacy and other parts of the health system that could be used to inform the monitoring and assessment of standards of delivery and health outcomes? How might a patient's existing My Health Record be used to support this?

The data in pharmacy is not set up to record outcomes. I would argue that the majority of MBS is not outcome driven as well but is based on services required/needed for diagnosis and treatment (this diagnosis and treatment pathway does have evidence). If a service is in the 6CPA then my expectation would be that there is robust evidence behind this from previous pilots etc

93. Is there a role for pharmacists to work with patients and other health professionals, possibly relating to individual medicines or specific conditions, to better create the data to analyse the health outcomes for that particular patient or group of patients, including through the use of a patient's existing My Health Record?

If you need to provide evidence of efficacy then it should not be in the CPA or MBS. Evidence should be shown through trials and the like before being rolled out and scaled up for use in

94. 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?

Probably not need funding directly to pharmacies but would for data analysis and program set up (so data collection is easy for pharmacies)

95. Are consumers aware of what programs and general pharmacy services they are entitled to? Is there enough information available regarding the services for which they are eligible?

No but this is an issue with all government funding. How does the consumer know what they are entitled to? There is no central place to get a review of every entitlement

96. If they are not receiving the relevant service, do consumers know the avenues for feedback or complaint? Are these feedback mechanisms adequate or should they be improved? If so, are there ways of using technology to provide better feedback?

Consumers do not know how to complain and who too. APHRA can be complained to for individual pharmacists and the state boards for individual regulation of pharmacies but not much info out there to inform consumers

97. 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?

In urban areas it is but rural areas do not have the numbers of pharmacies to switch to another.

98. 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?

There are guidelines issued by the pharmacy board and the delivery of services is in the 6CPA. They seem to be upheld well

CONSUMER EXPERIENCE

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

Minor Ailment Scheme

Supplementary Prescribing

Public Health Service (PMS) - health promotion but also includes smoking cessation services and products, emergency hormonal contraception access as well as locally enhanced services such as prescribing and supply of gluten-free foods, urgent supply of repeats medicines etc.

All of these programs expand access to healthcare and have evidence of worth either in Australia or overseas

100. What are the minimum services that consumers expect (and should receive) at the time of dispensing? Do these differ between initial and repeat prescriptions? Are these services being provided by all pharmacies?

A minimum service should be medication safely supplied in a timely manner with sufficient information given at "point of sale"

They will not be by design the same from an initial vs repeat but important info can still be given at repeat events

Any "minimum" services are provided by all pharmacies.

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

Generally it means medication safely supplied in a timely manner with sufficient information given at "point of sale"

102. In your experience, are community pharmacies generally delivering these services?

As they are core services, these "minimum services" are being delivered well

103. 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' prescription dispensing involve different services?

Flick everything else to MBS with sufficient limits based on evidence. If no evidence then should not be on MBS until evidence exists.

DIFFERENT PHARMACY MODELS

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

Yes. Pharmacies that look less like pharmacies (discount pharmacies) do not seem to offer the same service with regards to engagement about medications than more traditional models

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

Yes. But only anecdotal evidence.

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

We currently don't measure the quality of individual pharmacies much like we do not measure (as far as I am aware) the quality of individual GPs and the like

CONSUMER EDUCATION AND AWARENESS

107. What do consumers expect from community pharmacy in relation to their medicines?

The bare minimum expectations are:

Medication safely supplied in a timely manner with sufficient information given at "point of sale".

108. 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?

I still don't understand the \$1 discount. If cheaper medications for patients the idea then remove all fees. If is desired between pharmacies then go for full competition. A \$1 reduction seems like cost shifting rather than a meaningful attempt at making medications cheaper. It has allowed larger discount shops to have more of a competitive advantage due to economies of scale

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

Nil

110. How informed are consumers of the scope of medicines and related services that can be provided by pharmacists without referral to a General Practitioner?

Limited

111. To what degree do current advertising restrictions limit the ability of pharmacies to promote medicines and related services available to consumers?

Current restrictions are adequate. I am unaware of what restrictions limit pharmacy advertising. Either way It should not go down the USA route of unfettered advertising

112. In your experience, do community pharmacists provide appropriate advice for schedule 2 and 3 medicines?

There is a wide gulf in advice. Smaller pharmacies in general give better advice. The discount pharmacies are less helpful

113. Are the current restrictions on the sale of schedule 2 and 3 medicines an appropriate balance between access and health and safety for consumers? If not, how could this balance be improved?

Yes – ideally run federally rather than discrepancies between states

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

Not aware of pharmacy income breakdown

CONFLICT BETWEEN THE RETAIL AND HEALTHCARE ENVIRONMENT

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

Yes.

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

Get any complementary medication out of pharmacies. Yes it undermines health care

117. 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?

Complementary medication does not work so who cares what the advice is

118. Does the 'retail environment' within which community pharmacy operates detract from health care objectives?

Unfortunately yes

AFFORDABILITY OF MEDICATIONS

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

They are not transparent (see your own diagram) and they probably are mainly appropriate

120. 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 health care is protected and promoted?

I would prefer a twofold approach.

1. A free list (under 16s over 70s, concession card holder etc) that is very restricted

2. The actual Cost of the medication printed on each label so consumers can see how much it actually cost

121. What do consumers expect for the value of the PBS co-payment, noting it is intended to contribute to the price of the medicine, supply to pharmacy, a pharmacy handling fee and a professional dispensing fee?

122. What is the objective of the co-payment? Is it to ensure patients use PBS medicines appropriately, by setting a price signal? If so, is this objective enhanced or undermined by allowing co-payment discounts?

123. Should pharmacists be able to discount the co-payment by more than one dollar if they choose to do so? Would such competition benefit or harm consumers? If competitive discounting is expanded for the co-payment, should any limit be placed on the potential discounts?

124. Is it reasonable for consumers to expect access to medicines outside of standard business hours? If so, why? What arrangements could be made to improve consumer access?

Longer hour pharmacies work in certain areas but the 100hr one in the UK didn't do much to improve access. PCNs etc should be able to trial longer hours in certain areas (or relax location rules for 5 years in these areas)

125. What services do consumers expect and value from pharmacists outside of standard business hours? Are there other settings or mechanisms that could deliver these services after hours?

Medication supply, that is it.

Fuller service up to 7pm for people who work (smoking cessation) may have a place but would probably already exist if there was value

126. Does more need to be done to encourage greater access to medicines and professional services through the expansion of existing rural and remote programs?

Yes. Completely

127. Is it reasonable for consumers to expect that all community pharmacies provide these specialist services? If so, why? If not, why not?

All services should be core services. This ensures reduced variability in service provision and consumers are aware that each pharmacy does the same. Traditional core services (dispensing) are performed at a high standard. If you want great take up of a service by consumers then it has to be a core service.

128. Would it be desirable to align the delivery of specialist services to population need in local communities? If so, what is the best way of coordinating appropriate and relevant services for populations of need?

If this is the way you would want to go then services would probably have to be commissioned by the Primary care Network. Then it would have to decide based on the local population what pharmacies supply what services based on local factors

129. How might access and service barriers identified above be resolved and consumer needs be better met? Is additional training and support within community pharmacy sites needed?
130. Are there other inequities in terms of access to and quality use of medicines? If so, how should those be addressed and what population groups could be targeted?
131. What can be done to increase public awareness of available pharmacy programs and services, particularly specialist services?
132. How can we encourage and support consumers to engage more with their local pharmacy and what specific patient groups require more general awareness about available pharmacy services?

CHEMOTHERAPY ARRANGEMENTS

133. It is the Panel's understanding that the additional \$20 payable for infusions compounded by TGA licensed compounders is remuneration for the cost of gaining and holding the TGA licence. Should the PBS provide additional remuneration for compounders that meet TGA licensing requirements?

Would need to know a greater understanding of costs involved as I believe the \$20 should be sufficient (50 items a day for 50 weeks a year = \$250k)

134. It is unclear to the Panel that there is any therapeutic difference between chemotherapy medicines provided by TGA licenced compounders and non-TGA licensed compounders. Is there any therapeutic difference, if so, what are they? If there are no therapeutic differences, should the payment of chemotherapy compounding be the same regardless of whether the provider is TGA licensed? If there are therapeutic differences, why should the Government continue to subsidise sub-optimal medicine?

No therapeutic difference. A TGA licence allows you to give a longer expiry date which can help rural areas or hospitals without manufacturing

135. Are the two compounding fees (\$60 for TGA licensed, \$40 for non-TGA licensed) reflecting a supply guarantee?

No

136. If it is appropriate to have differential payments for chemotherapy compounders, what is the best way for those payments to be made? What should form the basis of the difference of the payment?

Not really. Ideally there would be one charge and all clean rooms would meet this minimum level. The TGA licence is set at a higher level than is needed.

Payment should be included in the PBS rebate as it is now

Review of Pharmacy Remuneration and Regulation
Submission #9; 11-Aug-2016; Richard Grygiel

137. Are the levels of these fees sufficient to ensure long term viability of compounding services?

Yes

138. Should non-TGA licensed public hospitals be allowed to provide chemotherapy compounding services to other public and private hospitals?

No. Would need new insurance level and would need standards for non-TGA licensed clean rooms

139. Chemotherapy patients benefit from the ability of local chemotherapy manufacturing facilities to provide more timely medications to patients locally. These facilities generally do not hold a TGA licence. Is there a need for additional standards for non-TGA licensed compounders?

Yes – completely. At the moment it is much more guidelines etc

140. Are there other issues with the production and delivery of chemotherapy medicines which the Panel should be aware of?

Nil