

To the review panel,

I write on my own behalf as a community pharmacy owner in Condobolin, NSW, which is a small rural town. I have some suggestions or issues that I feel should be given attention to in the Pharmacy Remuneration and Regulation Review. I will list them below in no particular order:

- Price disclosure: With the newly accelerated price disclosure mechanisms, community pharmacy experiences some difficulties, as a lot of lines go out of stock when financial pressure forces pharmacies and wholesalers alike to minimise stock holdings drastically. Whilst I applaud the savings to public expenditure, pharmacies are left in a tough position managing their stock at the time of price changes. A fairer system would allow a window of a week or two for new pricing to take effect for wholesalers and pharmacies each. E.g.: When a product is due to change price, the new price could be passed onto the wholesaler first, without passing it on to pharmacies for a week or two. This would allow wholesalers to manage stock more easily and not be left in a position where they are potentially selling stock at a lower price than they purchased it for. Likewise for pharmacies. Once the lower price takes effect, that same window could be applied between the list price and the dispense price so they are not dispensing script at a loss. This makes life a lot easier for managing stock and ensuring patients have continued access to medicines and cause less out of stock situations for pharmacies to have to manage and explain to their patients.
- Out of stock situations: As mentioned, the savings to public expenditure are welcomed, but the reality of the situation is that many generics manufacturers are unable to keep supply of their whole range due to financial pressure due to reduced margins/increased competition. This creates situations where many drugs (across multiple brands) are out of stock for extended periods and pharmacies are forced to change brands when dispensing multiple times. This creates frustration for patients and leaves pharmacy staff bearing the brunt of that frustration as well as the responsibility of explaining why this is occurring on a regular basis. I would welcome some sort of information fact sheet produced by Medicare or the PBS to disseminate to patients with easy to understand language and diagrams to educate them to the mechanisms that cause this.
- Fixed funding for professional services: Whilst I am happy to see funding available through the 6CPA for medication adherence programs (dose administration aids, clinical interventions and staged supply), it disappoints me that these services cannot be recognised as having a tangible merit and having fixed reimbursement through the 6CPA (or any other relevant body). If these services are to be funded into the future, I strongly feel there should be a fixed fee for service that recognises the part pharmacists play in the health of their communities. I ask the panel to consider whether or colleagues in the medical or dental professions would accept varying fees for MBS items due to program funding? Why should pharmacists not be afforded the same recognition?
- Schedule 8 monitoring: An online real time recording system should be in place for schedule 8 drugs to help monitor and reduce doctor shopping, drug overuse and illicit supply of prescription medicines. This would be technologically easy to implement and if it were made a mandatory requirement to dispense (but not to

prescribe) schedule 8 medicines, the benefits would include reduced abuse and potential overdoses of opioid medications, reduction in diversion of prescription medicines (many of which are PBS subsidised) and reduction in doctor shopping. Such a system should be designed so that it integrates with all approved prescribing and dispensing systems. An allowance should still be made for prescribers to hand write their prescriptions, but so long as the dispensing of medications was recorded centrally, the benefits could still be had.

- Taking advantage of technology: I believe there is huge room for improvement in the development of electronic based prescription services. Most (if not all) pharmacies would be claiming and dispensing prescriptions electronically. The use of a universal electronic based prescribing and dispensing exchange would virtually eliminate doctor shopping, duplication of therapy, fragmentation of care and a whole host of medication based problems. If a system were in place that was linked to a patient's Medicare number, this could allow prescribers to maintain a medication profile whenever they see a patient, rather than writing prescriptions. Prescribers could authorise a certain time and or quantity limit for each medication on the profile, eliminating forgetting to review each medication. This would ensure greater clarity regarding medication changes and less duplication. It would also allow greater access to PBS medications to those who need them. For example: a pharmacist could renew/refresh a patients access to schedule 2 and 3 medicines that are on the profile. It would also mean less environmental waste and filing requirements. Prescription summaries could be printed on one small piece of paper for patients to sign upon collection. This is not a fully developed idea, but one I feel has enormous potential. There would be obvious concerns regarding privacy of this data, but I feel it is simply an inevitability before this is put into place and such issues could be adequately managed.
- Complementary and alternative medicines (CAM)s: Trying to evaluate all the myriad of CAMs on the market and their evidence base can be overwhelming for a pharmacist with an already full work load. A system of accreditation (whether by the TGA or a separate body) for CAMs would be very valuable for pharmacy, as well as the wider health system. An idea I heard floated somewhere else envisaged a green tick logo, similar to the heart foundation tick for healthy foods, could be employed for products that are marketed only with claims that have a minimum level of evidence behind them. Details such as the minimum required level of evidence would need to be determined. This would give a clear indication what has a place in community pharmacy (and legitimate healthcare) and what belongs in the realm of pseudo-scientific quackery.
- Extemporaneous dispensing fees: The extemporaneous dispensing fee is paltry, considering the expertise required to prepare and dispense such medications. Even for a qualified and experienced pharmacist, to dispense and prepare a simple cream would take at least 15 minutes, possibly longer if a more complex item is required. The current fee is only \$2.04 higher than the standard dispense fee. Even using the base rate of a pharmacists wage (\$25.4368) as a guide and assuming all products are dispensed in 15 minutes (which they aren't) this equates to \$8.70 in wages (including superannuation and benefits). This is simply not good enough and pharmacists expertise in this area should be better valued.

- Potential of a minor ailments scheme: The New Zealand model of a minor ailments scheme is one that has great potential in Australia to reduce public expenditure and free up time for GPs to spend with other patients. With appropriate training and reimbursement, pharmacists could triage and treat a range of conditions such as erectile dysfunction and simple urinary tract infections. This would also function as a referral pathway to patient's GP in the event of symptoms or conditions that need medical attention. This model would rely on appropriate payment to pharmacists that does not rely on recommending/supplying a product to compensate their time. This could still be of net saving to the public health expenditure by reducing visits to GPs for simple ailments. It would also require a referral/communication pathway that does not fragment care between GPs and pharmacy.
- Rural location rules: I feel that the rural location rules do not provide enough security to patients as they currently stand. When the population criteria was removed from the pharmacy location rules it left a window of error for towns of our size in my opinion. I refer to rule 132, New additional pharmacy. I feel that our population would not be enough to sustain two pharmacies, yet if we had 4 GPs (or other doctors) full time equivalent, we could potentially have another pharmacy opened in our town. The reason the location rules were introduced (if I understand correctly) was due to an oversupply of community pharmacies and subsequent competition that made certain pharmacies commercially unviable. I feel the population of a town for a second (or subsequent) pharmacy should be taken into account in these instances. There is increased completion from online and mail order pharmacies already and ministerial discretion can always be exercised in instances where a proprietor is not acting in the best interests of their community.
- Small account fees imposed by wholesalers: Due to the increased competition in the generics medicines market, there has been a massive increase in the number of medicines that have gone out of stock, which creates more work in managing stock. We have on occasion resorted to using a different wholesaler to obtain medications for patients who may have otherwise waited even longer that they did. The issue becomes that some wholesalers (I am not aware of all wholesalers policies) charge a small account fee. In our instance we have ordered stock, that may be valued at less than \$50 and had to pay a small account fee of \$150 as we did not spend \$5000 during the month. This is particularly vexing when we are trying to serve members of the public and are left significantly out of pocket over one transaction. I feel it would be useful to have the CSO amended to accommodate pharmacies using alternative suppliers to access PBS medicines.
- Pfizer distribution model: I feel that the limited number of free deliveries allowed by Pfizer pharmaceuticals is in conflict with the spirit of the CSO and should be forced to allow daily ordering at no charge, as the other wholesalers do. If they are not willing to meet this obligation, they should be required to return to distribution through the main wholesalers as pharmacy owners are again wearing the out of pocket expense if a patient needs a medication that is only available through Pfizer.

I hope you find this feedback useful

Regards

Dave Rees

