

Review of Pharmacy Remuneration and Regulation
Submission #31; 2-Sep-2016; Community Pharmacist Employee

I am an employee community pharmacist and a consumer. I believe there are major problems with current pharmacy remuneration and regulation. I believe pharmacy has a lot to offer patients on improving health outcomes but is underutilised. This review is very welcome. It is my last hope that it will make pharmacy what it should be. If the sector does not change I will be leaving it.

The first point I would like to clarify is that the community pharmacy business and the individual professional pharmacist are not one and the same. This needs to be carefully considered by the review. I believe the community will be served better if individual pharmacists are able to provide services directly to patients and be remunerated directly by government without being linked to a community pharmacy.

The main question that this discussion paper needs to answer is:

What, as patients, do we want from our community pharmacies and separately what do we want from our individual pharmacists?

What does the government want from our community pharmacies and separately what does the government want from our individual pharmacists? What health outcomes does the government want to achieve?

Then design a model that will deliver it and review the model and adjust as needed.

Pharmacy remuneration and pharmacist remuneration is inadequate and inequitable. I have been a fulltime registered pharmacist for 15 years. I have worked in rural, hospital and metro areas. In that time I have advanced my career from 2nd pharmacist to now pharmacist manager. I have up skilled to provide extra services in community pharmacy that was not part of my original degree. Despite this increased skill set, higher employed positions, length of experience and level of responsibility my income has stagnated in the middle of my career and my income is now reducing. There are multiple occupations I could list that require cheaper and less education to obtain employment that offers higher salaries. There are multiple occupations I could list that require no continuing education or less continuing education than a pharmacist is required to do by law at considerable cost. I understand there are multiple factors that impact on remuneration but a major factor is pharmacy government remuneration and regulation. If the community and government wants individual pharmacists to provide high quality health services with a high level of education then individual pharmacists must be remunerated adequately. If you don't want high quality advice, added pharmacy services on top

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of dispensing or to pay for them, then consider requiring a shorter less intensive pharmacy course. On another note, pharmacy assistant's expected knowledge to work in pharmacy and supply medicines is significant, despite the poor pay they receive. Turn over of pharmacist staff and pharmacy assistant staff out of the sector due to poor pay is very high.

The current system is skewed significantly in favour of pharmacists that own pharmacies. Many of these own a part share in multiple pharmacies. Many have localised monopolies in regional rural areas. Many groups owned by separate owners operate as a cartel in regional and rural areas. None of this serves the patient, community or government goals. A significant number of these owners do not even work one day a year in a community pharmacy providing healthcare. These owners have a significant conflict of interest. Their primary goal is profit. Their interest in the ethical part of the business rarely extends beyond ensuring a life threatening dispensing error is not made. Any 6CPA service offered is about doing the bare minimum and cutting corners to get remunerated as opposed to improving health outcomes. The pressure on individual pharmacists is relentless and constant. The pressure is all for financial goals, never for patient outcomes. In pharmacies across Australia the work environment is depressed and anxious at the least and at worst staff are being verbally abused frequently by employers focused on profit. If the current model is considered good then open it up to everyone and have all ownership and location rules scrapped. They currently serve only one group and that is pharmacy owners.

I am broadly in favour of regulations that serve to provide a good pharmacy service but there are some changes needed. I do not believe opening up ownership to big corporate non pharmacists will result in better patient outcomes. I believe ownership should be restricted to 1 or 2 pharmacies and that the owner should be working in the business as a pharmacist. Despite my comments above, when I have worked in a pharmacy where the owner works fulltime in the pharmacy, their approach to patient and profit is significantly different. The patient becomes the focus again as it should be. I believe that pharmacies should be viable businesses without any retail component. The current model does not support that unless you are a pharmacy focused on script volume and nothing else. There should be stricter regulation on the ethical component of a pharmacy. What products can be in the ethical area, size and position of a consultation room or rooms, maximum number of scripts dispensed by one pharmacist per time period, maximum scripts dispensed by one pharmacist plus pharmacy technician per time period. Regulation in place to stop pharmacists being distracted by retail issues. The practical operation of the ethical side to a community pharmacy should be completely separate to the retail side. Pharmacies should stop looking and operating like supermarkets. If not get rid of the regulation and allow anyone to own a pharmacy such as major supermarkets

The following are some other regulation views I have. I believe that pharmacies should be able to increase co-payment above minimum set by government, just like Doctors that don't bulk bill. I believe in metro areas and some regional areas there should be fewer pharmacies but the pharmacies should be larger with multiple pharmacists. This will allow additional services to be provided properly. Single pharmacist pharmacies should not exist in metro and large regional areas. There should be technical checkers in dispensaries or dispensing robots to allow pharmacists to do the clinical role effectively as they are trained. I believe that schedule 2 class of medicines should be deleted. Medicines that were schedule 2 should be reviewed and some should be open sale and some should be schedule 3. Some schedule 4 medicines should become schedule 3 as well. This would allow pharmacists to focus on schedule 4 and schedule 3 (essentially pharmacist prescribing) and be able to provide a high quality consultation in a private area/room. I would expect tighter regulation of schedule 3 in this scenario. This private area room should be defined in the regulations. I have bought many medicines as a patient over many years in multiple states. Victoria and New South Wales are the worst offenders with Queensland not far behind (Qld only slightly better as the medicines are behind the counter so the patient must interact to get the medicine. I receive nil to pointless interaction with a pharmacy assistant when purchasing a medicine and can count on 1 hand the times that a pharmacist was involved. It essentially is purely a transaction. It does not reflect expectation in the regulation nor in pharmacy professional standards. What is the point? Exactly the same transaction can be offered in any retail store. Why should it be restricted to pharmacy? Also surely I am not the only patient in Australia that has no interest in discussing in public with no privacy my thrush problem, piles issue, worm problem, etc etc etc. It is just not good enough. Pharmacy owners have been given enough chances to fix this.

Remuneration should be negotiated with multiple bodies not just the pharmacy guild. Despite anything the pharmacy guild says they only represent pharmacy owners. Dispensing remuneration should be separate to providing advice. Higher remuneration should be provided for initial scripts and less for repeats. Higher remuneration should be provided for medicines that require more detailed advice. Remuneration should be provided when a patient seeks further advice or clarification from a pharmacist on a PBS medicine post dispensing at a later date. Remuneration should be provided for health promotion activities. Remuneration should be offered to pharmacy and medical centres to collaborate for community health outcomes. Bonus remuneration should be offered for reaching health outcome targets.

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Please consider my thoughts on the discussion paper. I look forward to the report as it will give me a clear idea on where the sector is heading.