

Dear Prof King,

Thank you for running the Review of Pharmacy Remuneration and Regulation. I am pleased to make the following submission for the discussion paper.

We are a pharmacy in the small Victorian town of Wedderburn. Our pharmacy represents services offered to ageing population (Wedderburn has an older than average demographics with nearly 30% of its population is above 65 years old according to census 2011) in rural setting.

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?

Pharmacies expand their retail area either as a response to the pressure on the dispensary area profit due to price disclosure, to show competitive advantage over other competitors or just to increase profit. Anecdotal data show that discounters aim to have retail sales of more than 50% of the total pharmacy sales and advertise themselves as a retail destination.

Proportion of retail space to professional area should be limited for the following reasons:

- 1- Pharmacy should maintain a professional appearance as a healthcare destination
- 2- large retail areas are likely to include 'alternative' treatments with no or little evidence. Their inclusion in a pharmacy may either give the false impression of their effectiveness or may compromise the professional image of the pharmacy
- 3- Retail area is also time consuming to the pharmacists and may involve a conflict of interest when pharmacists as the usual shop managers are being evaluated by the proprietors according to the 'front shop' sales.

Summery: There should be a maximum ratio of retail space (e.g. 20%)

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?

Pharmacies should be adequately funded to be primarily healthcare providers. Adequate and sustainable funding should consider covering the financial obligation

of the business (reflecting the market value) and sufficient return on the pharmacists' investment and risk-taking. However, funding should vary according to the business commitment to provide mainly healthcare services i.e. more than 80% of the business turnover should be directed to healthcare.

Summery: Pharmacies with higher percentage of revenue from retail areas should have their government funding amended to reflect that.

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?

A core element of National Medicine Policy is accessible and affordable medicines, which may reflect on reduced risk morbidity and even mortality thus saving cost included in hospitalisation.

Consecutive CPA's have shown the ability and flexibility to maintain through the following:

- 1- Keeping the government in control of a major health spending: PBS
- 2- Allows government and other stake holders to apply periodic changes in the highly dynamic environment of medicines (including this Review of Pharmacy Remuneration and Regulation)
- 3- Have shown flexibility to apply savings to tax-payers (e.g. through price disclosure)

CPA, while managing to maintain that in the past, comes with the price of uncertainty to the industry.

Summery: An ongoing agreement between the government and stakeholders, based on experiences from the previous from previous CPAs, would offer more certainty.

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?

CPA is an agreement between the government and pharmacists to be paid for delivering professional services. It should be aimed at and handled only by pharmacists. Pharmacists have proven record of contestability and effectiveness

with the main CPA component: PBS. Any program added to the CPA can be inspired by the PBS in the following way:

1- Studied to offer cost effective service: e.g. Supply of medications (as in PBS) or improve medication management (as in HMR).

2- provide a simple and accurate documentation e.g. script dispensing

3- auditable e.g. in PBS

New communication technology should makes easier to apply the above measures.

Summery: CPA should be limited to dispensing and professional programs provided by community pharmacy.

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?

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?

A main aim of the NMP is to provide a universal access to PBS medications. Different agreements with different parties is likely to end up with different levels of funding and possibly different costs for supply PBS medications, with independent pharmacies being the most disadvantaged.

This cost effectiveness outcome is shown in rural areas where groceries and other retail items are likely to cost (businesses and consumers) higher due to lack of buying power. If this applies to PBS medications, cost to rural pharmacies is likely to be higher and they may have to pass it to patients or would result in higher cost to businesses increasing the challenge to their viability.

Summery: one representative to pharmacies would remain a preferable choice with other stakeholders encouraged to submit their ideas and concerns.

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

The main objective of NMP is providing universal access to PBS medications. The current system of independent small businesses encourages pharmacists like myself to endeavour serving small and rural communities.

Other arrangement is more likely to end up clustering the service where it's more economically lucrative i.e. in higher density population.

In a relatively small and highly dispersed market like ours, it's not hard to see that ending in a duopoly, as it is the case in grocery market. That would leave the most vulnerable rural and small towns with less chances of access to their essential medicines.

An example of that is in our small rural town of Wedderburn where no one could expect to being served by one of the big two grocery corporates and they end up paying more for their groceries.

Summery: the current system has shown to be working within our market specifications for provided the expected outcome.

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?

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?

There are few initiatives in the 6CPA regarding the use of medications e.g. HMR and medchecks. However, in our area of aging population, the limitations induced on the HMR made it harder to initiate the need or respond to GP-initiated HMRs.

Appropriate use of medications remains a continuous challenge and it may be addressed through proper funding to HMRs, while reviewing the effectiveness of other programs that are not adequately supported by evidence or have shown signs of excessive usage.

Summery: there are programs that may help the distribution of information, however there's a potential for more.

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?

Summery: It's hard to see that the current rule causes a significant impediment on the access of PBS medications.

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?

A main NMP objective is universal access to PBS medications. This should be provided through an evenly distributed pharmacy chain depending on the need.

Pharmacy business involves a professional and financial risk. It necessitates the availability of at least one pharmacist on premises in addition to highly trained staff. It also involves a substantial financial risk, as a pharmacy would have to carry expensive stock irrelevant of the number of patients in the area, with a capped profit due to current regulations.

In a vulnerable area like Wedderburn, with a small and aging population, business assurance is required to make a financially viable case that can be supported by a financial provider.

The absence of such assurance is likely to lead to clustering in areas with high population density, while rural areas would be left with no or limited services.

Summery: measures to provide assurances to pharmacy business are necessary to ensure services are provided to the highly vulnerable, especially in rural areas.

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

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?

Dispensing involves two main costs:

- 1- Constant cost: This includes the store (finance repayments including goodwill value, rent, bills & stock)
- 2- Variable cost: time and effort vary between dispensed items and situations and may reflect on the number of staff needed to cover this time and effort.

This may reflect on the remuneration in the following way:

- 1- constant remuneration: to cover the constant cost allowing a financially viable business that can provide a timely access to medications.
- 2- variable remuneration: related to the time and effort spent in each dispensing e.g:
 - a- New vs repeat
 - b- type of medication: e.g. warfarin vs panadeine forte
 - c- Disease area: e.g. Diabetes vs URTI
 - d- Specific aged group: above 65 vs 25-35
 - e- other considerations e.g. polypharmacy

With the availability of online claiming, it might be relatively easier to include these variables in each dispensing activity by ticking of a menu, and get the paperwork signed at the time of dispensing.

Summery: The overall objective of remuneration should remain:

1- Keep a viable business

2- Encourage more interaction between patients and pharmacists

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?

There could be many available modules to indicate the level of dispensing fees. Many of these modules are driven from overseas experience, which may have some common and uncommon grounds to our NMP and population.

The bottom line of any level of fees and charges, in our opinion, would be:

1- Return on investment to the tax-payers:

Fees and charges paid to pharmacists are aimed at making PBS medications timely available with the associated professional advice. This would reflect in savings in the healthcare system due to expected lower risk of hospitalisation and other morbidity and mortality end points.

The cost effectiveness of having timely access to medications (with the professional advice) would increase with the increase among groups of higher risk of hospitalisation and other morbidity and mortality i.e. aging population

This risk also increases in rural areas. e.g. In a survey in Wedderburn pharmacy (data on file), nearly half of the patients involved indicated that it may take them more than 3 days to access their medications if they would not have a local pharmacy.

When calculating pharmacists' fees this cost effectiveness measure should be considered in any alternative scenario i.e. the impact on increased risk of hospitalisation, morbidity and mortality with the associated cost.

2- Return on investment to the pharmacist:

As the service provider, pharmacists need to be running a financially viable business with a sufficient return on investment to encourage financiers.

Costs that need to be covered in pharmacy include higher than average rents, wages (including pharmacist wages), stocking expensive items (including the risk of out-of-date expensive items) in addition to keeping a professional working place that complies with pharmacy regulations.

Current levels of remuneration and foreseen cuts lead to many pharmacies putting pressure of staff availability and other costs including opening hours to manage a viable business.

Summery: Current remuneration levels reflect an industry under strain which, with foreseen cuts, may not be able to offer sustainable required services.

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?

One main aim of the NMP is to provide a universal access to medications. Cost have been regarded as a main reason for reduced medication concordance that may increase the risk of hospitalisation.

Allowing pharmacists to change prescriptions' copayment (as in the example of allowing a discount) or by allowing extra charges would not serve this objective and would be counterproductive in the following ways.:

1- Areas with lower competition and higher expenses (including rural areas) may see higher costs of medications disadvantaging this group of patients, compared to their counterparts in the cities where the competition is higher.

2- Areas with lower than average socio-economy demographics may see pharmacists having to supply medications at lower copayments, which may affect their financial sustainability.

3- Patients may defer filling in their medications until they have an access to a 'cheaper' provider, which may put them at higher risk.

4- Pharmacists will be more engaged in a 'bargaining' spree rather than be freed to provide the professional service that they are paid for.

Summery: all cost associated with medicines to the end consumer should provide a universal access.

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?

Main deterrents for starting an expensive business like pharmacy in a rural area are:

1- Low population: low turnover

2- Aging and declining population: high risk of negative potential in the future

3- Rural: Away from main service including high schools, Unis and entertainment for the pharmacist's family (probably moving from an urban atmosphere) which puts pressure on the family.

4- Low access to relief pharmacist and/or trained staff.

5- Usually lower than average socio-economic demography reflecting on lower spending.

Summery: It imperative to have measures to sustain pharmacy business in rural areas. RPMA considers the location and the number of scripts. However, we think the following factors need to be further represented:

a- number of residents

b- socio-economy

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

Summery: Yes.

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?

Generic conversion has saved tax-payers a substantial cost over the years by reducing the listed price of out-of-patency molecules. It remains one of the most effective ways that can help to make the PBS sustainable. For this to be achieved, pharmacists' initiated switching is a key factor.

Switching brands is one of the most time consuming elements in dispensing. Pharmacists' need to follow guidelines to help patients make an informative decision, in addition to minimising potential of confusion that may occur as a result of changing brands.

Generic manufacturers used to contribute in the switching by offering encouraging packages. This package has been regarded as de-facto dispensing and resulted in the current generic contribution and savings to the system.

With the price disclosure approach, the generic manufacturers are continuously reducing their trade terms to pharmacies. In a precedent, one generic manufacturer

declared that they are delisting two very popular PBS medications, as they can't make it available with the current listed price.

It's highly anticipated that the generic manufacturers will eventually have no trading terms to offer to pharmacies to encourage them to switch to generic brands.

The PFDI offered is complicated, and do not reflect the time consumed in switching and is unlikely to encourage pharmacists to go through this process. It also means that pharmacists will have little, if any, encouragement to switch brands with no brand premium.

As a result, generic companies will have no tools to compete and will have little reasons to reduce their prices further, thus eliminating the chances of further price reductions and saving to the tax-payers.

Summery: PFDI is unlikely to encourage pharmacists to switch medications. Better incentives related to generic switching need to be endeavoured.

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

Summery: Yes.

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?

We had two patients on the hepC medications. They contributed to nearly half of our payment to the wholesalers. Having to deal with highly expensive stock put us under pressure, especially considering the risk that, like any other medication, the prescriber may ask the patient to cease.

HepC medications are not the only expensive ones. We have to deal with cancer and RA expensive medications, including fridge items e.g. Orencia, Humira etc.

However, the outcome from the patient side is really encouraging. Having an access to these essential medications through their local pharmacy and, in our case, reduce the need to travel to get them, have been much appreciated by the patients and would have reflected positively on their compliance and therefore treatment outcome.

We think the supply of expensive/highly expensive medications through local pharmacies should continue and need to be encouraged through the following:

1- Relaxed returning conditions for uncollected medications

2- Better credit terms

3- Better remuneration

Summery: community pharmacy offers good access to highly expensive medications with some measures needed to maintain this service.

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?

Pharmacists are qualified health professionals who are trained to offer healthcare services related to medications and minor ailments.

They have the advantage of immediate access by the public.

The core of any program to be offered by pharmacists should include the following:

- 1- within the training scope of the pharmacist
- 2- would help to improve medications' usage and the treatment outcome
- 3- identify and properly refer specific conditions

Currently available programs include the HMR which involve a higher level of collaboration aiming to get maximum treatment outcome.

Other areas of future programs would be:

- a- Screening: Programs by Stroke Foundation for screening of previously unidentified high blood pressure and referring them has been conducted.
- b- Minor ailment treatment: Especially in rural areas, where access to medical practitioners is limited. Documentation and timely communication with the medical practitioners can be easier now with the involvement of online communication.
- c- Maintain patient independency: Pharmacists are in an ideal position to monitor medications' usage by providing dose administration aid. Delivering, monitoring and reporting would need extra resources.

Summery: There's a room to reducing limitations on current programs and offering new programs aimed at improving medications usage and early detection.

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?

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?

A pharmacy should be mainly focused on providing professional healthcare services. Many pharmacies have been pushed, or choose to, rely more on the retail part to remain viable. This may compromise the professional appearance of a pharmacy and engage the pharmacist, who's usually the business manager/owner/ in non-professional areas taking his/her time and attention from the core service.

In our model, more than 90% of our turnover is provided by the dispensary, which made us a healthcare destination for the local residents. However, in order to remain viable, better remuneration need to be considered.

Summery: Pharmacies should be encouraged to adopting a mainly professional model focused on supplying of medications and professional advice.

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?

HMRs have shown to be an effective tool to maximise treatment outcome. They should be performed according to the need of the patient within certain criteria and not limited by certain frequency or doctor's referral.

An example is hospital discharge, where HMR is highly indicated to assist patients with their new medications and communicate changes to the GP. However, referral after hospital discharge is usually delayed until the patient visits his GP. A more efficient way would be a hospital or pharmacist initiated HMR.

Summery: HMR should be initiated by a health professional (including pharmacists) based on patients' need.

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

Summery: Pharmacy services should be government funded according to set criteria to secure universal access.

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?

It's not practical to expect pharmacies to stock all PBS medications at all times. Stock challenges are higher in small rural pharmacies. In our case, numerous brands are being used by one or two patients in the town and are likely to be ceased at a certain point of time due to a change by the prescriber or the patient departure.

Timely access to medications is the core principle in the supply chain. Allowing 72 hours to make a PBS medication delivered may have a serious impact on the most vulnerable. In our rural pharmacy, PBS deliveries are only available 5 days/week. If a fridge item (e.g. insulin) is ordered on Wednesday and, if the 72 hours allowance is applied, it means that the item would be delivered on next Tuesday (no weekend delivery, no Monday fridge item delivery).

Add to the above scenario the not unusual situation of delivery errors and regular delays to rural areas. If, in the above scenario, the wrong item has been delivered (due to pharmacy or wholesaler's error), it means another week delay of an essential medication like insulin.

Wholesalers, while delivering healthy profits to their shareholders through the CSO agreement, would complain that delivery to rural area is highly expensive. There is no proof that competition between the main 3 wholesalers delivers any advantage in terms of delivery or conditions.

If dividing the market into 3 suppliers makes it financially unviable for each of the main wholesalers to deliver to rural areas, as they claim, an alternative could be a 4 or 5-year tender to have one wholesaler delivering nationwide according to agreed conditions would provide an efficient mean of delivery both to the wholesaler and to pharmacies.

Summary: A 24-hour delivery of PBS medications is imperative and should be a condition to CSO agreements.

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?

Experience from DHL direct (delivering Pfizer products) shows that putting limitations on orders including number of free deliveries and/or value of orders would have a negative impact on the customer and the pharmacy. We have numerous examples of patients prescribed an unusual Pfizer item, pushing us to make a special order, which would bring us above the free 8 orders/month. This means an extra \$25

charge/extra delivery that we cannot add to the patient's co-payment i.e. a \$25 loss/extra order to the business. On the other hand, with a handful exception, Pfizer accepts no returns. We are still to live with a loss of many hundreds of dollars, the cost of an out-of-date Revatio 20mg that was ordered for a patient who never picked it up.

Summery: if wholesalers find it financially unviable to offer the essential ordering requirements to achieve timely access to medications, one wholesaler tendered for the entire market may be a solution.

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?

Short dated stock put an enormous pressure on pharmacies. Despite being a small pharmacy, and despite applying efficiency measure in ordering and stocking, we end up with thousands of dollars stock write-off/year. Wholesalers' sale of short-dated stock reflects inefficiency of stock management from their end, with the cost being paid by the pharmacies.

Summery: There should be a requirement of a minimum of 12 months usage date of stock.

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?

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.

Wholesalers offer different terms and conditions that favour some customers e.g. their own pharmacy brand (Priceline with API & Pharmacy Alliance with Sigma) major chains (Chemist Warehouse with Sigma). Better conditions include better discounts. These conditions use funds included in the CSO. Small rural pharmacies are mainly independents and would get the least conditions including discounts and delivery times/week.

The outcome would be that independent small rural pharmacies end up getting their medications at higher cost compared to chain pharmacies and their city counterparts.

It's not practical or fair to expect these (independent rural pharmacies) to pay extra cost allowing wholesalers to utilise their share of the CSO to secure agreements with chain pharmacies and to deliver more profit to their shareholders.

Summery: If wholesalers argue that they cannot deliver timely access to medications in rural areas, the solution would be putting better regulations for this incentive and not to abolish it or to get small rural pharmacies to pay the cost. Alternatively, a 4 or 5-year tender to have one wholesaler delivering nationwide according to agreed conditions would provide an efficient mean of delivery both to the wholesaler and to pharmacies.

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?

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 the manufactures as part of their listing requirements on the PBS?

The government is the main investor in the healthcare system. Being not in control of any part of the supply chain to save, would impact on higher cost in another end of the healthcare spending. E.g. reducing CSO by leaving it up to the wholesalers or manufacturers to ensure timely delivery is likely to end up by worse delivery conditions to the most vulnerable in the rural areas compared to cities and is likely to lead to higher costs in hospitalization for patients missing out on their essential medications.

Summery: Government should fund/control all levels of the supply chain.

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?

Any approach to leave part of the supply chain up the pharmacies will end up by having a higher cost on the most vulnerable i.e. rural small pharmacies as any available resources to the wholesalers or manufacturers will be channeled for more financial gain by securing deals with the chain pharmacies.

Rural pharmacies may have to pass this extra cost to patients if possible, which will disadvantage the elderly, or, if passing extra cost is not possible, it will challenge the viability of the rural pharmacies and put an aging community at the risk of not accessing their medications.

Summery: Government should fund/control all levels of the supply chain.

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?

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)?

Summery: As above, and considering the size of the Australian market, nationwide tendering would be the better approach. Tendering should be across the nation and not only to certain PhARIA, as it would make it more achievable for the tendered wholesaler to offer better delivery conditions than if it (the wholesaler) would be delivering to remote areas only.

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

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

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

As a dispensary focused pharmacy (dispensary contribute to more than 90% of the turnover) we often receive queries from patients who had their initial dispensed script by a discounter. Their comment is that they had no or little interaction by the pharmacist in this model. This may not be surprising given the workload pharmacists in discount models are subjected to, including high volume of scripts/pharmacist and retails sales workload that the pharmacist (who's likely to be the manager in duty) has to deal with.

Summery: There should be a cap of dispensary workload/pharmacist, whatever the business mode is. While there is a general recommendation by AHPRA, it's not currently mandatory.