

Review of Pharmacy Remuneration & Regulation Submission July 2016

Dear Members of the Pharmacy Review Panel,

I have been a practicing pharmacist for the last 36 years and a community pharmacy owner for 21 years. I would like to address a few points in the discussion paper in areas of which I have some experience.

Q1&2

- The ratio for community pharmacy to population currently appears optimal.
- As per the discussion paper the pharmacies per capita reflects the UK, South Africa and New Zealand. The ratio in Australia compares to similar countries where the governments have similar health policies and preferred outcomes for their populations.
- Market forces and the current government location rules appear to have dictated the ideal pharmacy per capita already in our country.
- I suggest we continue with our current policy.

Q3&4

- I am in agreement that a patient receiving a prescription or scheduled medication should be entitled to a professional area that allows prescription privacy and a private conversation with a pharmacist, and that professional services that are funded by the CPA should be undertaken in a counselling room.
- Rather than a ratio I believe that a minimum area should be required to access these funds. Currently the regulations in WA require all new business refurbishments must include a consulting room and dispensary of a minimum size. As a Western Australian I do believe that all Schedule 2 and 3 medications should be out of reach of the public and should be included in the professional services area in a pharmacy.
- The government does not dictate product selection in other small businesses so I am unsure as to why they would want to do this in a pharmacy. Other activities or products that a pharmacy chooses to range in the business is usually dictated by the clientele, their landlord, the pharmacists personal preference and other market forces which are sometimes out of our control. These products and activities have been part of a pharmacy business for hundreds of years worldwide. These other activities or products do provide employment for over 60,000 pharmacy support staff in Australia.
- I don't agree that the CPA should differentiate between pharmacy models because dispensing and counselling a medication takes the same time in a discount model as a full-service model. The quality of the counselling could be different in a full-service model.

Q5&6&11

- The NMP aims to bring better health outcomes for all Australians with a focus on supporting timely access to the medicines that Australians need at a cost individuals and the community can afford.

- Currently community pharmacy provides access to every Australian of essential medication within 24 hours in most cases, which is consistent with the NMP.
- The cost of medications is subjective depending on your income status, point of view and the type and quantity of medications you require to assist with your health needs. I believe that we currently have an excellent medication delivery system for the personal income and other taxes we, as taxpayers, are prepared to pay in Australia. It has been acknowledged that the Scandinavian countries have the best healthcare in the world but their personal tax rates range between 45-55% of income. And their excellent healthcare has not produced better mortality rates than Australia. (1).

Q7

- The CPA is negotiated to provide timely medicine to the Australian public to achieve better health outcomes. Community pharmacy has provided the infrastructure and significant investment and employment to achieve this provision of timely medicine to the Australian public, so CPA programs should be provided by community pharmacies. For non-pharmacy owners to “cherry-pick” particular programs out of the CPA without providing the basic provision of medicines to the public could be economically damaging to our network.
- I agree there should be some accountability in the provision of professional programs as we are accessing public funds. Currently a patient signs they have received a health review. Patient surveys? Funding for health research to ensure effectiveness?

Q8&9

- The CPA is negotiated so all Australians receive equal access to medications in a timely manner. The current approach achieves this desired result in our vast country, with our small population.
- As the Pharmacy Guild is the peak body for the majority of community pharmacies of all different business models, it would be the simplest way to negotiate an agreement that provides the same access to medications in our remote and rural areas as is the metropolitan areas. Negotiating with individual pharmacies and groups of pharmacies that have vested commercial interests may not be the long-term interests of a sustainable PBS, and could lead to anomalies between states, metropolitan versus country or affluent versus marginalized suburbs.
- To achieve timely access to medications we require a strong manufacturing and wholesaling sector. Supply and logistics are just as necessary as dispensing to form the complete package for the Australian health consumer. Representation from their peak bodies should be more directly involved. A sign that PBS reforms have really hit our industry hard is the current lack of supply of Metformin XR, a very common medication, which has been in short supply for months. We are also seeing a de-listing by manufacturers of generic medications that are no longer viable to bring into our country.

Q14&42&43&44

- In 1990, rationalization of pharmacy numbers was undertaken by the Australian government to reduce the number of pharmacies, which were at the time around 5600 or 1 pharmacy for every 2211 people. (2)
- The current rules have provided a more even distribution of pharmacies than was seen prior to the commencement of the 1<sup>st</sup> CPA in 1990, which in turn has provided the government and the public with timely access to medication in more convenient locations.
- Consumers have always been able to choose their preferred pharmacy location, and often vote with their feet by bypassing businesses they don't like.
- Changing the location rules will just proliferate pharmacies in locations of high wealth and high population rather than motivate pharmacists to open pharmacies in rural or low-income areas or new areas. Doctors, who have no restrictions on opening practices, are often located in affluent suburbs, not in marginalized suburbs or rural and remote Australia. So changing the location rules would decrease access by the public for pharmaceuticals in remote and rural areas, which in turn would decrease affordability as travelling distance costs money.
- From a pharmacy owner view, since the implementation of the location rules, it has given owners the confidence to invest in technology and better services for their clients. So rather than protection, it has been the impetus for investment in our industry, which in turn has provided efficiencies for the government ie. dispensing computerization, payment efficiencies, access to real time prescription/patient medication usage.

Q15&16

- From a taxpayer point of view the "swings and roundabouts" minimizes the impact of the higher priced pharmaceuticals on the budget and from a pharmacy owner point of view it does lessen this impact of losing margin for these higher priced medicines.
- Should a pharmacist receive less money for dispensing a repeat rather than an initial prescription? All prescription dispensing does require a similar level of care, and sometimes problems with prescription medication is discovered when a patients comes in for a repeat. Changing the payments would create undesirable incentives where pharmacies located next to doctor's surgeries would receive a higher level of remuneration. This could skew the location of pharmacies to close to surgeries rather than more evenly distributed.

Q17

- As a pharmacy owner, I believe we are providing a greatly undervalued service to the Australian public. I think we are worth more money. We do provide many services over and above dispensing and counseling on prescription medication. One of the payments we received as part of the 5CPA and the 6CPA is the Clinical Interventions payment, which demonstrates the value we give to our patients and an indication of the amount of money we save the public. Attached is a 3 monthly clinical intervention report from 1<sup>st</sup> January to 31<sup>st</sup> March 2016 for one of my

pharmacies and a breakdown analysis of the report. During this time we recorded over 600 interventions. 87 of these (14%) were for OTC analgesic problems. This included analgesic abuse, duplications, contraindicated with current prescription medication and the most worrying were the 6 patients who came in requesting ibuprofen, who were taking warfarin or other blood thinners. A few of these patients could have been hospitalized, which is very expensive, if we had not intervened. These CI's are paid out of a pool of money and depending on how many pharmacists are motivated to document the interventions we receive a fee. Currently it has been around \$3-\$3.50 per intervention. This is the cheapest money the government spends in preventative health in Australia. And is a good reason why analgesics should not be sold anywhere but a pharmacy.

#### Q18&19&20&21

- The discounting and increasing of maximum prescription pricing is very confusing for patients. The PBS is considered universal healthcare and consistent pricing is considered fair and should be the norm.
- The RPMA is allowing pharmacists to open pharmacies in previously unviable locations. I have a few pharmacist friends who are accessing these funds in remote locations. Geographical location would be a less subjective and more transparent and appropriate measure than community need for this payment.
- Electronic prescribing would be greatly increased if GP's would use their computers correctly. Or use a computer rather than hand write prescriptions. So I don't think the fee is fully achieving its aims with the medical profession.
- Yes, the premium has changed patient behavior. The higher the premium the quicker the change. Regardless of this premium there will always be a handful of patients in every pharmacy that will never convert to a generic medication.

#### Q22&23

- The newer high cost drugs are a big problem throughout the whole supply channel. I have 1 patient whose monthly prescriptions cost over \$60,000 wholesale plus \$6000 GST. And it is just going to increase as more of these life saving medications enter the PBS.
- The best way forward for the supply channel for high cost drugs is for the government to directly pay the manufacturer for the drugs. Then imprest these high cost items in the local wholesalers for free. Then give wholesalers a fee for logistics and pharmacists a fee for ordering and dispensing and counselling.
- If I can make a comment about GST in this section. Currently prescription medication attracts GST throughout the supply channel until the end user takes the medication. The patient does not pay GST on prescription medication. Manufacturers, wholesalers and pharmacies are spending time, effort and money claiming and remitting GST for no purpose in the area of prescription medication. And the government is spending time, effort and labour doing GST refunds through the supply channel. Legislating S4 and S8

medication as GST free would free up a lot of cash flow in our industry and reduce unnecessary paperwork and expense.

#### Q25&35

- Pharmacists are the medicine specialists but we are also experts in primary care. Because we are so accessible there are a few programs I think pharmacists are ideally placed to help the Australian public. We already provide a number of programs but we could provide -
  - Wound Care – dressing of chronic and acute wounds
  - Travel vaccinations – after the success of Flu Vaccination clinics
  - Continence – with an ageing population this is only going to become a bigger problem.

#### Q26

- 29% of Australians take a complimentary medicine every day. (3) There is a misconception there is no evidence for the support of vitamins and herbals. They have been used for many thousands of year and our own western medications were originally based on these plant extracts eg digitalis. In some instances products that were considered quackery 20-30 years ago are now being recommended by GP's and specialists eg CoQ10, Fish Oil, Glucosamine, Turmeric, Probiotics to name a few. In Germany, there is more of an emphasis on "natural" medicines and herbal medicines are considered drugs and rated for safety and efficacy. And Germany is the home of some of the major drug companies in the world. There are numerous reputable references including the APF that have monographs on herbal products. The difference is that companies that manufacture complimentary medicines are not big Pharma companies and do not have the resources or funds to run big population clinical trials.

#### Q29&30&31&32&33

- Any funds that can be accessed to provide pharmacists and pharmacies with funds to improve patient health are welcomed. If these funds become available they should not be used to reduce the funds provided by the government for the CPA.

#### Q34

- HMR's are a very great service provided by community pharmacy and consultant pharmacists, but in the 5CPA funding was quickly depleted and funds were transferred from the MedsChecks program to the HMR's.
- MedsChecks are currently capped at 10 per month, which are not enough. These are of great value for a newly diagnosed patient as well as patients taking multiple medications and compensate community pharmacists for a long consultation. A few weeks ago I had a newly diagnosed diabetic present with a prescription for Metformin. The GP had told her to go to the pharmacy to get a glucometer, had half filled an NDSS joining form, booked a diabetes educator for the following week and sent her on her way. 45 minutes later we had trained her on her new glucometer, filled out the cash back form for the device, completed the NDSS joining form and faxed it, given her access to appropriate diabetic testing strips at the NDSS price, counselled her on her

new medication, given her diet and lifestyle advice while she was waiting for the diabetes educator appointment, and calmed her concerns. If we had already used the 10 MedsChecks allocated per month, we would not have been able to access funds for this long diabetic consultation.

#### Q37&38

- Lack of medication management is one of the principal reasons for hospitalization and admission into aged care facilities. DAA's are a health service that promotes better compliance, which in turn delivers better health outcomes and allows a patient to live outside a care facility.
- Cost can be a barrier to a patient accessing a DAA. DAA's are very beneficial for many patient subsets but especially the elderly who are taking multiple medications and can get confused and some mental health patients who may not have the funds to pay for medication or DAA's. Funding of DAA's would promote better compliance and deliver good health outcomes. Currently the Department of Veterans Affairs funds DAA's at \$10 per week for their veterans, not including the costs of the prescriptions.
- Appropriate and realistic payment is the key to disseminating health programs of clinical value. Community pharmacy cannot be expected to do programs for little or no cost because it is not sustainable.

#### Q45

- It is not the scope of this discussion paper to advise government on deregulating pharmacy. This question is unnecessary.

#### Q46&47&48&49&50

- Every subsequent CPA has seen some amendment to the location rules as our population increases, new areas are opened and areas of unmet public need are ascertained.
- Yes, the location rules do limit entry into areas where there are existing pharmacies. But this is what they are designed to do, and as detailed in the discussion paper is a feature of public health funding to pharmacies in various locations around the world. We do not want to go back to pre-1990 where there was 1 pharmacy per 2211 clients, which is inefficient, would make a number of pharmacies unprofitable, which in turn would impact public health.
- Whatever the location rules, there will be someone who wants them to be different for vested commercial interest which may not be the same as in the interest of public health.
- The current government distance location rules appear to have dictated the ideal pharmacy per capita in our country and should remain unchanged.
- The one location rule that does need to be amended is the provision of PBS licenses in shopping centres. Some landlords of shopping centres that can support 2 or more pharmacies are behaving unscrupulously in rental negotiations. If a pharmacist decides not to renew their lease because the rent does not support a financially viable pharmacy, the landlord can offer a pharmacy location to another interested party with the knowledge the pharmacist will be able to access a PBS number. So in effect the landlords own the PBS license, not the pharmacist. If a pharmacist vacates premises in

a shopping centre due to the unviability of the site then the number of PBS licenses that centre can support should be permanently reduced.

Q53

- It is not in the scope of this discussion paper to change existing state and territory legislation regarding direct public access to a supermarket. This question is unnecessary.

Q90&91

- Pharmacy is the most highly regulated industry in Australia. Please, no extra regulations.
- Regulations that can be reduced are -
  - Keeping paper prescription duplicates for 2 years. Now that community pharmacy has to keep original PBS prescriptions on site why is it necessary to keep 2 sets of the same prescriptions for 2 years?
  - Keeping S8 prescription duplicates for 7 years. Even the tax department requires you only keep financial information for 5 years so can this requirement be reduced as well?

Q92&93&94

- There is data available with HMR's, MedsChecks, CI's. But the analysis of the information can be very time intensive. If the programs used to maintain this information were slightly changed to allow an evaluation of the cost benefits with each intervention or review that would be a start.
- I am not sure that 99% of patients would even know if they have a My Health Record.

Q95&96&97

- Most community pharmacies are very proactive in providing information to patients especially about services that are government funded. And a lot of the banner groups do advertise a number of clinical services the public can access.
- From experience if a patient has a complaint they will tell you about it. In this day and age complaints can come in the form of face-to-face meetings, Facebook reviews, emails, letters, representation to the pharmacy banner group, to more serious complaints to AHPRA and the Pharmacy Board, which both have online complaint forms on their webpage.
- Ultimately the consumer can choose to purchase their medication elsewhere. As a pharmacy owner this is financially the worst form of complaint that can befall a business.

Q98

- There are appropriate standards for the dispensing of medicines and deliveries of services. Most pharmacies are QCPP accredited, which are standards that have been devised by industry peers, and are designed with public health benefits and professionalism of our industry as their core focus. As in any industry there are varying levels of proficiency in upholding these standards.

In closing, a pharmacist's, and other health professionals, greatest ability to improve health outcomes comes from the relationship and the trust that is built with their patients. If we could all be allowed to focus on health and our patients, rather than have to justify our position in the health pyramid every 5 years, and worry about knee-jerk changes in government policy, we could probably achieve a better result for the Australian public.

Regards,

Gia Cecchele  
B.Pharm. M.P.S.

1. [http://stats.oecd.org/index.aspx?DataSetCode=HEALTH\\_STAT](http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT)

2. [https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjvIr07uvOAOhVEOJQKHxpdDl0QFggdMAA&url=http%3A%2F%2Fwww.aph.gov.au%2F~%2Fmedia%2Fwopapub%2Fsenate%2Fcommittee%2Fclac\\_ctte%2Fcompleted\\_inquiries%2Fpre1996%2Fpharmaceuticals%2F01ch1\\_pdf.ashx&usg=AFQjCNHAt4\\_TrObFVGX9Q5tpYrLziY5moA&sig2=ApCwXLlcBs65DaefV-u4PQ](https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjvIr07uvOAOhVEOJQKHxpdDl0QFggdMAA&url=http%3A%2F%2Fwww.aph.gov.au%2F~%2Fmedia%2Fwopapub%2Fsenate%2Fcommittee%2Fclac_ctte%2Fcompleted_inquiries%2Fpre1996%2Fpharmaceuticals%2F01ch1_pdf.ashx&usg=AFQjCNHAt4_TrObFVGX9Q5tpYrLziY5moA&sig2=ApCwXLlcBs65DaefV-u4PQ)

3. <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.007~2011-12~Main%20Features~Supplements~400>