

Review of Pharmacy Remuneration and Regulation  
Submission #48; 9-Sep-2016; Peak Pharmacies

Pharmacy Review

Department of Health

I act as the operation manager for a small group of four pharmacies in the Geelong region in Victoria. I thank you for the opportunity to contribute to the Pharmacy Review currently under way. Below I have provided a brief business background on our group which is a service based model so you can have an understanding of our position in the pharmacy industry.

I have then responded to a number of questions raised in the discussion paper, I have kept my response to the areas of pharmacy I have experience in. We do not have extensive resources therefore most of my responses are based on my experiences and those of partners of our group. We have not been able to conduct extensive research to respond to the question.

If you would like to discuss anything further please contact me

Thanks

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[peakpharmacies.com.au](http://peakpharmacies.com.au)

## Business Background

Peak Pharmacies have evolved over time. It was started in 1997 with the purchase of Bellarine Village Pharmacy, Newcomb. In 2008 the Newtown Pharmacy was purchased. Then in 2009 John Mitchell Pharmacy and the Leopold Pharmacy, both in Leopold were purchased these two pharmacies have been consolidated into one site in Leopold as of October this year. These pharmacies were operated under different banners, Bellarine Village and Newtown Pharmacies under the Guardian Pharmacies banner and the Leopold and John Mitchell Pharmacies as independents. In 2012 the decision was made to consolidate the pharmacies into one brand. After investigating the brands available in the pharmacy market place no brand was identified that truly represented the manner in which the group wanted to operate their pharmacies.

Peak Pharmacies Pty Ltd was developed in response to this and is owned by Shelley & Chris Thompson, Greg Porte and Zane Wright. The brand was launched in late 2012 and was positioned as a service based brand with a strong emphasis on evidence based pharmacy.

The Drysdale Pharmacy was purchased in July 2014 and has been rebranded as a Peak Pharmacy. It is currently undergoing a fit out to the specifications of the corporate Peak Pharmacies design.

These four pharmacies, Bellarine Village, Newtown, Leopold and Drysdale Pharmacies, are the pharmacies operated by the group and are the current Peak Pharmacies. All the owners reside in the Geelong region and are committed to provide the highest quality of Pharmacy Services to the local area. Peak Pharmacies operates in the traditional pharmacy markets of supplying products and information in the areas of health and beauty. With a strong emphasis on service and building personal relationships between the customers and staff.

Peak Pharmacies has achieved a reputation within the industry of providing excellent service and advice especially in the health area. It operates on principles of continuous quality improvement and strives for best practice within the industry, this was evidenced by one of the pharmacies within the group, Bellarine Village Pharmacy, winning the Guardian Pharmacy of the Year for 2009. Bellarine Village Pharmacy was also one of the finalist in the Pharmacy Guild's "Pharmacy of the Year" competition in 2014.

Visit our website for more information.

[www.peakpharmacies.com.au](http://www.peakpharmacies.com.au)

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

The more important ratio is the number of pharmacists per person. The number of pharmacies can vary person without having an impact on level of patient care, providing that there are adequate pharmacists in these pharmacies to service the patients. In saying that there would be a lower limit as the viability of the individual pharmacies if the pharmacist per patient ratio became too high. A ratio of 1 pharmacist per 1250 patients would be adequate. There is a trend towards larger pharmacies which is more economical and allows a greater offering of services. A three pharmacist pharmacy would provide a balance between economy of scale and service. Based on the pharmacist to patient ratio each pharmacy could service 3750 patients.

This information is based on WHO data,

[http://gamapserver.who.int/gho/interactive\\_charts/health\\_workforce/PharmaceuticalDensity/atlas.html](http://gamapserver.who.int/gho/interactive_charts/health_workforce/PharmaceuticalDensity/atlas.html)

*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?*

The government would need to control the issuing of licencing to operate pharmacies to ensure adequate access to pharmaceutical services for all Australians. Without this pharmacies would migrate to the most densely populated areas with the bigger organisations exerting their market dominance at the expense of traditional pharmacies. This would inevitably lead to an industry that is based on profit and no longer pharmaceutical services which would lead to an increase burden on the primary health network in areas other than pharmacy, such as Medicare and the hospital system.

*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. This would ensure that pharmacies would be offering a variety of professional services to utilise the space. This would contribute to better health outcomes for the patients and a greater return on the dollars the government is investing in pharmacy.

*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. I do not think this is necessary. A better option would be to remunerate the services that pharmacy is currently offering that are not funded by the government. For example, OTC consultations, free delivery of medicines to non-ambulant patients and pharmacotherapy programs to name a few.

*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?*

I believe the CPA process is consistent with the National Medicines Policy, it is ensuring positive health outcome for all Australians through access and wise use of medications. As to its consistency with the long term sustainability and affordability of the PBS, this is dependent on government policy. It can be made to be with commitment from both the industry and government. Both parties have an obligation to the Australian people to do this in a fair and measured way. I believe it is consistent with good government practice.

*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?*

I am not sure what would be a preferable approach would be but I do believe that the government needs to be involved in the regulation of the industry because if it were to be deregulated and left to market forces to determine how the industry would operate the NMP would not be ensured. The industry would be solely product based with services reduced and access restricted, especially in rural areas. This would place increased cost pressures on other areas of the primary health network.

*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 believe the CPA should be limited to community pharmacy programs only. Contestability and effectiveness could be ensured by professional programs by an independent body analysing the program and results and providing feedback to the stakeholders.

*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?*

No. All stakeholders should be involved in the negotiation process, including other pharmacy organisations such as the PSA. Consumers need to be represented as well in these negotiations, ultimately they are funding the services. I am not aware of a current partnership that would serve this purpose.

*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?*

No. This would probably exclude the smaller, traditional pharmacies that are providing services to their communities. This could lead to a reduction in services and diminish the quality use of medicines. I would imagine that to negotiate with individual pharmacies or groups would require more resources from the government than what it currently takes to negotiate the CPA.

*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?*

I think the Australian system stacks up internationally and there is no need to change it. It ensures that the NMP is achieved and places a lot of the cost burdens, (wages, rent, etc.) on the private sector and not the government sector. The hospital systems are already under immense pressures so I would not be adding to their burden.

*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?*

I believe that it is. I know in our pharmacies that our patients have ready access to medicines and services in a timely and cost effective manner. This is contributing to better health outcomes for them. The only issue we are experiencing is lines regularly begin unavailable for the suppliers. In most instances there are work arounds to ensure ongoing treatment.

The NMP notes the importance of information on medicines for both health practitioners and consumers for quality assurance and quality use of medicines.

*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?*

This is not always the case. At our pharmacies we endeavour to fulfil this requirement of patient care at all times. However, we do have instances of patient requesting information on medications dispensed at other pharmacies because they were not provided with this information at the time of dispensing. There are obviously pressures on the industry that are not allowing this to occur at all times which could lead to negative patient outcomes.

*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?*

A system where the doctor sent an electronic prescription to a designated pharmacy would be a system that would overcome the paper prescription. There would need to be an investment in the appropriate technology to ensure a robust system that would be secure to ensure that misappropriation of medicines did not occur.

*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?*

In the current environment that our pharmacies operate in there is enough consumer choice that our business are not totally 'protected' in our business operations. The discount pharmacies operate extensively in our region and provide choice for consumers. However, I do believe that protection is needed to achieve the NMP objective. The regulations provide us with enough protection to provide services to our patients over and above that of other pharmacies. We could not offer services such as;

- Ready access to a pharmacist for primary care consultations
- Health screening
- Delivery to non-ambulant patients
- Servicing aged care facilities
- Medication management

These services contribute to the health outcomes of our patients and reduce the burden on other areas of the primary health care network. Without the income from other areas of our operations, mainly dispensing medications, we would not be able to fund these services.

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

I believe that it is not appropriate. There needs to a greater alignment with remunerating each service appropriately. The current approach leads to an incentive to dispense as many scripts as possible to maximise the financial return for the time available for dispensing. The level of patient interaction with the pharmacist may not be appropriate for the medicines being dispensed. At our pharmacies we train our pharmacists to provide the appropriate level of interaction for each dispensing irrespective of the time and financial pressures. We believe this leads to better health outcomes for our patients. This may place us at a financial disadvantage when compared to some other high volume dispensing pharmacies.

*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?*

I believe it should providing that the pharmacies are providing the appropriate level of effect.

*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?*

I believe the current fees and charges are appropriate. They provide appropriate remuneration for the dispensing role that pharmacists provide. In our pharmacies it allows us to have the level of pharmacists that we deem necessary to deliver the desired service that should ensure positive patient outcomes.

*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?*

I do not believe that pharmacist should be able to charge consumers above the dispensed price for medicines. The prices are agreed to by the government and the pharmacist through the CPA, they have been set after taking into consideration a number of factors. For the same reason I do not believe that pharmacists should be allowed to discount medicines. The discounting will also lead to the requirement to increase dispensing volumes to maintain profitability. This could lead to a decrease in the ability of the pharmacist to counsel at the point of dispensing due to time constraints.

*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?*

The incentive does make rural pharmacy more viable. Community need would be a better measure of an appropriate location.

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

In our pharmacies the fee does not dictate the uptake of electronic dispensing it has more to do with best practice. Increased speed of dispensing and accuracy. It would benefit pharmacy more if all doctors did electronic prescribing.

*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?*

In our pharmacies it is an incentive. It would be more of an incentive if the fee was more. At times the fee does not compensate for time required to explain it some patients. I do not think there is a better way to achieve this.

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

Yes they should. We are avoiding dispensing these items in our pharmacies due to the increased financial risk associated with these items. Dispensing them also has a negative effect on our cash flow due to the GST requirements.

*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?*

I would prefer to see these medication handled by the hospital system to eliminate the financial risks to our pharmacies.

*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?*

I have provided a link to our website that lists the services that we offer, some government funded, some not. This is by no means comprehensive, but it is what we can fund under our business model.

[Peak Pharmacies Services](#)

*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?*

I agree with that it is confusing for the consumer to have non-evidence based products alongside prescription medicines. There should be limitations as to what pharmacies can sell with a focus on evidence based products. Pharmacy is its own worst enemy in this area with a number of pharmacy brands having a heavy focus on promoting non-evidence based products.

*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?*

I do not think the pharmacy can be only focused on dispensing because there are a number of pharmacy programs that provide positive health outcomes that are not dispensing. These program would need to be included in this model. I think a solely health focused model would be attractive to the public. Would it be viable? Probably not under the current funding model. As has been noted pharmacies use the income from their retail operations to provide some of their health programs. I do not think this model would be attractive to shopping centre operators either as it would probably not have the same level of foot traffic as the current pharmacies.

*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?*

The business model needs to be more health focused with more programs and remuneration for service as well as supply. I believe this would lead to better health outcomes for patients and untimely save the government money on the health spend further down the track.

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

I do not believe this to be the case. In some primary care consultations a product may not be indicated are the patient may already have appropriate products to treat there conditions. Therefore, the two should not be linked.

*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?*

As stated previously, they two should be separated. I believe this would increase the value that consumers place on this advice. It would also remove the sale of inappropriate products by the pharmacist as they seek remuneration for their time.

*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?*

I believe that it should be a flat fee and not linked to the complexity of particular medicines or groups with higher health needs. The complexity of working out a funding model would limit the implementation of this payment. We as pharmacist should be providing this service anyway and a flat fee would compensate for those that are less complex over those that are more complex. The claiming of these fees needs to time efficient as well as the complexity of claiming may be a barrier to implementation.



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

We as four pharmacies in the area have established contacts with the local health networks, local health funds as well as Barwon Health which we are working with on some targeted health services in the areas of chronic disease state management and pharmacotherapy. These needs have been identified by organisations larger than us, Barwon Health, GMHBA for example, through having close working relationships with these organisations they have approached us to be involved in these health programs. We as pharmacies in the local area have also identified health services needed at store level and run programs targeting these needs. Most of these programs are screening programs for disease state management.

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

Not all pharmacy services are accessible for all consumers because not all pharmacies run the same business model. Some concentrate on supply only while others having a large service offering. This is dictated by the pharmacies in any given area. Appropriate funding would make these services more accessible as more pharmacies would implement them if there was a financial incentive.

*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?*

I agree that HMR should be linked to a health event. This is an area that has been linked to a high level of re-admissions to hospital and the increase in costs. Any program needs to be designed, implemented and reviewed by the relevant stakeholders including consumers.

*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?*

No. We should concentrated on our field of speciality

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

In our experience it is a barrier

*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?*

Obviously, some form of funding from the government to reduce the financial burden on the patient. Some level of private health fund rebate may also contribute to the affordability

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

I believe a combination or co-payment system to be the most appropriate.

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

Any services that have robust evidence that they provide positive health outcomes and also reduce the financial burden on the community should be fully or partially government funded. The pharmacotherapy program and medication reviews upon discharge from hospital are two that should be funded.

Services without this evidence are best left to the market.

*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?*

Innovation takes on many forms. A lot of the time we do not know that something is innovative until we look back at it. Wound care programs were considered innovative a few years ago but are now part of the suite of pharmacy services been offered. The reward for being innovative is probably personal satisfaction and recognition. It is driven more by individuals than by policy.

*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?*

I believe that this would lead to a decrease in access and affordability. The traditional community pharmacies would become unviable with the resulting closure of pharmacies in smaller communities in all areas, metropolitan, regional and rural. Pharmacies would become concentrated in shopping centres and dominated by the big box retailers. This would drive down the price of pharmaceuticals in the short term but there would be a decrease in the levels of service and people would have to travel greater distances to access a pharmacy. Once the competition is decreased and consolidation of the market there would be an increase in prices. The decrease in service would also put pressure on the health budget in other areas such as hospital admissions and more GP visits.

*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?*

I believe that the rules need to address the whole of the population. Refer to question 42.

*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?*

My response would not change

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

I believe it to be appropriate. If a pharmacy cannot relocate in the local area they could be held to ransom by their landlord as they do not have options as to where to operate. This could drive up the rent and make the business untenable. Maybe the distance could be shortened to 500m to prevent undesirable outcomes.

*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?*

Shopping centres can already achieve this outcome by controlling the lease terms including options. They have too much power in Australia over all their tenants, not just pharmacy. This is an issue for the government to address through the retail tenancy act. I do not believe this rule should be modified as it will not change the situation.

*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?*

This approach would be undesirable. This could lead to a concentration of pharmacies in urban areas and lead to outcomes as discussed in Question 42. The government should not become a broker for pharmacy approval numbers, the current regulations provide adequate rules to address these issues. If a pharmacy wants to enter a new location they could purchase their current pharmacy, this is a fairer way to place a value on an approval number.

*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.*

I do not believe this to be the case. There is adequate competition in the market place to limit profitability. The competition is not just from other pharmacies but also other retailers. Down scheduling of medications has led to increased availability for the consumers and increased price competition.

A certain level of profitability is needed as a reward for the risks that small business owners take and also to reflect the professional service that most pharmacies provide. There is more to pharmacy than selling goods and if pharmacies have to decrease their professional services to maintain profitability then this will have a detrimental effect on the health network in Australia.

There also needs to be certainty in the ongoing profitability of a business to invest in new and innovative services that benefit the community.

*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?*

I believe this to be the case. With the holding of an approval number you should have minimum standards that you have to reach to service the community.

*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?*

I believe this rule should be changed to preclude a pharmacist from operating more than one pharmacy in a particular area as it would support choice and value for money for consumers.

*53. Recognising that restrictions on co-location 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?*

This would be undesirable as this would allow the supermarket to dictate the services being offered. They would not want competition in any areas they operate in. They could also affect accessibility by controlling the operating hours.

*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?*

If a medicine is listed on the PBS it should be available through the CSO. Pfizer have created a situation where there are increase costs to our pharmacies because of having to order direct. We have increase costs associated with placing the extra orders and processing them. There are increase stock holding costs because we have to hold more stock because of the time between orders. There are also increased financial costs with the wholesalers reducing our trading terms due to the lost income from the Pfizer products. The wholesalers pass these financial costs on to us. Who do we pass them on to?

The patients are also disadvantaged when we do not stock a Pfizer product as it generally takes two to three days to get it for them instead of next days which is the case with lines from the wholesalers.

Manufactures should have to work through the current wholesale system which is efficient and cost effective for all stakeholders.

*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 that I am aware of.

*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?*

They should have discretion as there are different services and terms required by different pharmacies. This does create competition between wholesalers for pharmacy business and a pharmacy can match their needs with the wholesaler that meets them the best.

*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?*

This has had no impact on our pharmacies.

*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 practice is undesirable. I have previously mentioned the high cost items and the Pfizer model shifting costs to community pharmacy. It is difficult for us to pass these costs onto the consumers due to competition.

*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?*

I think this would increase wastage in the system as wholesalers may be required to hold more stock than they need. They would ultimately shift these costs to community pharmacy and it would reduce the efficiency of the system.

*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.*

I believe this to be appropriate. The percentage mark-up needs to be fair and equitable for all parties

*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?*

No. this would ultimately lead to an increase in distribution costs that would be passed on to community pharmacies and then probably the consumer.

*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?*

Community pharmacy needs to concentrate on delivering medicines and health services. In our pharmacies we work hard to get this right. We do not have the time or the resources to deal with supply issues.

*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?*

I believe there should be a minimum standard of products and services that are being offered. The QCPP address this in community pharmacy.

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

No. There needs to be a level that ensures the best outcome for all stakeholders. I believe they are fair and reasonable. The issue is the monitoring and enforcement of the regulations. For example, at our pharmacies we adhere to the board guidelines for dispensing volumes to ensure patient safety and the best health outcomes.

Anecdotally, I have heard of local pharmacies not adhering to this. This puts patients at risks and does not provide the best health outcomes which may place a financial burden on our sections of the health budget. It would be maximising the profitability for these other pharmacies but at what cost to the community.

*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?*

In our pharmacies the My Health Record is not utilised due to issues with the technology. It is too unreliable and slows the dispensing process. The theory is excellent and it could be used to collect data on the health systems, but it needs to be more workable.

*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?*

In our pharmacies we actively promote all our health programs both government funded and self-funded. There is information available to patients to inform them what they are eligible for.