

Submission to the Review Panel of Pharmacy Remuneration and Regulation

Riccardo Seeber
Employee Community Pharmacist

09/10/2016

Thank you for accepting my submission. I have also completed the survey available online, and below I expand on specific items and questions of the review. My submission is structured as such that a statement or question from the review is in bold, and below are my responses, views and opinions.

I feel that the views and opinions of employee pharmacists are under-represented by industry leaders and in saying so that viewpoint should be considered in every aspect of this review. I also feel that pharmacy has lost its way, a constant dichotomy of healthcare and retail, and congested with aspects regulation that only satisfy a bureaucratic need that doesn't necessarily translate to better work conditions or patient safety. Clinical Interventions recording being one example to support that statement, which were ironically, negotiated to maintain a pharmacy agreement and retain current business models.

It is for the above reasons, and many reasons below mentioned, that I welcome this review and am grateful to be given the opportunity to have a say and contribute to important decisions that will define our industry for the next generation of pharmacists, and their patients.

"The Commonwealth contributions include payments to pharmacists and wholesalers for medicines dispensed under the PBS"

- It needs to be recognised that these payments go to pharmacies, thus pharmacy owners who are pharmacists. These contributions are not necessarily passed onto the employee pharmacists who are providing the service in store.
- I'm sure this is known but the distinction is not made in this review.

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

- Remuneration is accepted by pharmacy owners (therefore the business) and not necessarily the working pharmacist.
- The incentive is only undesirable if pharmacists are committed to data entry (ie dispensing) by the pharmacy owner/business, as this leads to reduced consumer interaction. Therefore remunerating being undesirable is a function of pharmacist management and placement by the business, as the incentive is paid to the business whether or not a script is dispensed by a dispensary assistant or a pharmacist.
- The incentive can be viewed desirable when the focus for the pharmacist is customer service, not a focus on data entry. The management culture of individual businesses determines its desirability, not the mere existence of an incentive fee itself.
- The fee therefore should be paid in light that a medication was simply dispensed, not because a pharmacist dispensed it. Anyone trained can dispense.
- Pharmacists and pharmacy need to redefine their pharmacists, and move pharmacists away from simple data entry.

“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?”

- No. It should reflect the risk and technical work required to dispense the product. DD fee should remain. A higher fee should be paid for drugs with a very narrow therapeutic index, fridge lines, and products compounded or suspensions that require reconstitution.
- Pharmacists are at the forefront of assessing medication compliance and safety as they have increased exposure to patients on a regular basis. The assessment of compliance or adherence to a medication does not change between a repeat script and an original.

“Is the Premium Free Dispensing Incentive achieving its intended purpose of increasing the uptake of generic medicines? Are there better ways to achieve this?”

- The fee tackles the problem of premium brand dispensing. However, this practice is the result of a cultural problem between doctor, pharma company and patient. Many doctors prescribe by brand name, rather than drug name. This practice is supported by pharmaceutical representative visits to GP's. Much of the time this effort is made redundant at the end dispensing pharmacy by generic substitution policy.
- Legislation needs to be introduced that instructs prescribers, to prescribe by drug name, not by propriety/brand name. This is better reflective of health care practice.

“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?”

AND

“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?”

AND

116. Should complementary products be available at a community pharmacy, or does this create a conflict of interest for pharmacists and undermine health care?

AND

117. Do consumers appreciate the convenience of having the availability of vitamins and complementary medicines in one location? Do consumers benefit from the advice (if any) provided by pharmacists when selling complementary medicines?

AND

118. Does the ‘retail environment’ within which community pharmacy operates detract from health care objectives?

- The image of pharmacy is tainted with retail garbage that is not evidence based. If pharmacy is to differentiate itself from a standard retailer image, then the products it sells need to reflect the integrity and purpose of the profession.
- Household items, toiletries and commodities that in no way are reflective of health care, do not belong in a community pharmacy.
- Medication of any kind does not belong in a grocery store.
- Scheduling of medication needs reform. Example; the amount of ibuprofen tablets in a packet should not be related to the scheduling of a product. There is nothing to stop a consumer from buying more, unchecked by a pharmacist at a supermarket. Therefore, scheduling should solely be determined by the nature of the drug itself, as a molecule, and as such should only be available at a healthcare destination, such as a pharmacy.
 - o This is not the case, and the current effect is a direct consequence of government legislation appeasing grocery and commodity retailers.
 - o The effect of this is a need for pharmacy to compete in the commodity retail arena, and thus sell sub-standard products that are either:
 - Not relevant to health care at all, or

- Not supported by a strong level of empirical evidence.
- The TGA charges exorbitant fees to register a product (AUSTR), which serves as a disincentive to pharmaceutical companies to present and submit empirical evidence.
 - This creates an environment of ineffective or assumptive scheduling of products available in pharmacy, and a culture of anecdotal evidence being referenced – here creates the confusion of the patient.
 - The TGA's fees and processes in regards to products registration therefore require investigation and reform.
- As a healthcare destination, a pharmacy needs to offer holistic solution based outcome for patients.
 - Therefore, a community pharmacy solely focused on dispensing is a terrible idea especially in the current PBS climate.
 - A community pharmacy needs to be a healthcare destination:
 - Dispensing
 - Professional Services
 - Dermatologics and beauty
 - Evidence based complimentary medicines and products.
- For pharmacy to be an attractive and exclusive professional healthcare destination, other aspects of industry directly affecting pharmacy require investigation and change to reflect that vision, which have been abovementioned but not limited to;
 - Restriction of all medicines to pharmacy regardless of unit size.
 - Reform of TGA process, accessibility and fees regarding AUSTR.
 - Reform/changes of Scheduling.

These areas require attention in the near future if pharmacy is to survive as a professional healthcare destination. These factors need to be taken into account in this review.

The Australian government needs to be a leader in this area, not a follower. Australia is a unique landscape and the government should not be basing its future economic and regulatory decisions regarding pharmacy, on other systems other countries had the foresight to create and adopt first, such a deregulation. In any instance, they should be comparators only. In this regard of foresight, leadership and creation, we have a lazy bureaucratic government not prepared to step up to ideas of merit purported by health professionals and industry leaders here in this country.

“Is it appropriate that the PBS links the remuneration for the provision of professional advice to the sale of medicines?”

And

“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?”

No to both of these questions. Professional advice is not necessarily only given when the sale of a medication takes place. Pharmacists are the most accessible health care professionals in the healthcare system. They require no appointment, and historically the advice and guidance provided is without consultation fee.

The feeling with the MBS payment for advice is really an insulting question to the pharmacist community as it masquerades a real intent of such a payment; which is to create a measurement, and thus transparency in regards to pharmacist advice given in the community. This question, secretly comes from an assumption that maybe pharmacists are not providing the service or advice they say they are, so let's measure it. This would create tedious measurement protocols in an environment that is already congested with such systems – such as clinical interventions currently. If I am incorrect, then let there be an MBS advice micro-fee paid for every S3, S3R, S4 and S8 medication sold.

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

Yes there is, intuitively speaking, a pharmacy that is price driven or competing on price will have this reflected in its day to day operations; from cheap commodities it sells, to the minimum employment and wage it pays its staff.

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

I believe this question is asked in full knowledge that not much empirical evidence exists, and that any evidence that does is anecdotal or based on a customer review.

I will point out that a satisfied customer may simply only be happy because they saved money, which doesn't necessarily pertain to good professional service either.

With reference to question 104, and my response to that, discount pharmacies inevitably provide a lower level of service. One need only look at their business model, to deduce that this will inevitably be the case. The offsets required, and met by cutting staff and poor wage structures does lead to reduced service, in a pharmacy that is dependent on large stock turnover, large customer flow, with few staff to manage it effectively, with poor incentive to support them.

108. Has the \$1 discount had an impact on the access and affordability of PBS medicines? Has the introduction of the \$1 discount been a successful implementation of policy?

This question is asked in the full knowledge that the \$1 discount in its creation, was never about the *affordability of PBS medicines originally*, it was a submission by chemist warehouse as part of a strategy to increase their customer base, in line with their discounting structure and capacity to do so. Its existence demonstrates poor leadership by our government.

What the dollar discount has done is eroded further, the quality and integrity of the profession and created and encouraged a behaviour that supports price over quality. 'Knowing the price of everything and the value of nothing' is one such subconscious process this measure has embedded into the community. Panderers to such basic and subliminal instincts have manipulated the community into worrying more about a dollar, than the value of their healthcare.

It has been ineffective, as in my experience most customers driven by convenience will pay the extra dollar, and most pharmacies that can get away with not offering it, will continue doing so. The policy has no value whatsoever to the community or to the profession. It is a cheap and dirty stunt.