

My personal response to the Pharmacy Review for Remuneration and Regulation is based on 20 years of experience as a community pharmacist owner, various roles in representative pharmacy bodies [REDACTED]
[REDACTED]

I intend to only answer questions relevant to my knowledge base and my responses relating to location rules are objective and are not based on any personal influence the location rules may have had on my businesses.

Regulation

Q1. In your opinion, is the ratio of community pharmacies to population optimal? What data would you use to support this opinion?

Yes, based on the Review document itself and the population to pharmacy ratio in other OECD countries, it appears to be optimal.

Q3. 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? 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 pharmacies receiving remuneration for dispensing PBS medicines?

Q4. 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?

With respect to retail activities in pharmacies, I don't believe it should be relevant to the remuneration of dispensing. Firstly, retail space is required to sell products to complete health solutions for patients. Secondly, I believe that the remuneration of dispensing should be based on services provided and not be reflective of retail activities.

Q5. 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?

Over the course of the 5CPA the PBS proved to be sustainable due to the implementation of price disclosure as a government policy. Ultimately the sustainability of the PBS is a matter of government policy as the government of the day has the ability to approve new medicines on the PBS e.g. Hepatitis C treatments which can influence PBS sustainability independently of any negotiated agreement.

With regards to transparency, in the 6CPA, payments through the PBS are more transparent than ever with the introduction of the AHI which supports the dispensing fee and negates the need for product markups along the dispensing product pathway.

Q7. 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 that the dispensing process and programs that are administered through community pharmacies should be funded through the CPA. This is not to say that individual pharmacists cannot be funded in the future for other approved programs. However, if this is not performed in a community pharmacy setting, it should be funded through the MBS.

Q8. 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?

Q9. 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?

I believe that negotiating the agreement with one party, which is representative of the majority of community pharmacies, is the most efficient way to produce a desirable outcome of all parties involved in the agreement.

Licensing or negotiating with individual pharmacies or groups of pharmacies would be a significant waste of tax payer money and as the government process would be inefficient and expensive. It also introduces the potential for individual pharmacies or group of pharmacies to push self-interest agendas which are not representative of the larger organization.

Q11. 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?

In my opinion, accessibility can vary greatly based on the area. A needs analysis, such as those done by PHNs is a much more appropriate measure of patient access to pharmacy services.

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?

Community pharmacy is a deliverer of government funded medicines, health advice and other associated services. This provision of government product and service requires significant investment, infrastructure and personnel. Pharmacies can establish anywhere they like, however, the location rules are only relevant to PBS approved pharmacies which deliver government funded products and related health advice and services. The location rules were established to promote efficient and equitable access for all Australians, whilst maintaining a viable network of community pharmacies. The location rules do by nature provide certainty for a pharmacist, which encourages them to invest in order to provide infrastructure for service delivery of government programs.

PHNs recently commissioned needs analysis to determine priorities for the delivery of government health services in localities. Ultimately, the decision to determine where services are provided is not based upon the requirement of every consumer but is based on the relative need of a whole population and the priorities of the population within that area. Similarly, the pharmacy location rules may not benefit every individual consumers but will provide equitable access to sustainable pharmacies across the larger population which provides certainty for all.

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?

Fundamentally, I don't have a problem with pharmacists being remunerated to a higher extent for complicated dispensing processes, as long as the administration of payment is not onerous. It is difficult to say that initial dispensing should be paid to a higher extent than repeat scripts, as often repeat scripts can involve longer consultations. It depends on the patient interaction.

Q19. Is the RPMA the best way to encourage pharmacies in locations where they would not otherwise be viable? Is community need a more appropriate measure than geographical location?

In my personal experience, rural pharmacies certainly have higher wages and purchasing costs. The RPMA and the nature of the location rules certainly encourage the establishment of pharmacies in rural and remote locations. I do believe that these drivers should continue and are effective government policy.

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

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 believe that as a requirement of PBS listing, manufacturers supplying high cost drugs should be mandated to supply product to community pharmacy on a consignment basis and provide terms that do not impact on pharmacy cash flow. This will ensure equitable access for consumers. I believe that hospitals and community pharmacies should have the same remuneration structures for high cost drugs.

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?

Total health care solutions for consumers require the supply of prescription and non-prescription medicines. As a practising pharmacist, my pharmacy requires a sufficient OTC offer to adequately treat my patients. A dispensing only pharmacy would provide a less than adequate service e.g. A patient who comes for a prescription for Isotretinoin (acne treatment on prescription), will require a sunscreen with moisturisers, lip balm and oil free cleanser. This will lead to better compliance and outcome as the whole health solution is being offered.

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

I am offended that this question correlates the dispensing process purely to the sale of medicines. I refer you to the PDL guide to good dispensing, which clearly indicates that the whole process of professional dispensing includes many cognitive processes each individual's health requirements and suitability to treatment.

Q34. 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?

All new programs need ongoing monitoring to ensure desired outcomes. This should be done by a third party annually, by either a government body or as part of an annual assessment of QCPP.

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?

Based on my observations of ■ what has happened in overseas models, I would suggest the following trends would occur:

- a. A reduction in service levels in marginal and rural areas, resulting in decreased service and increase price to consumers.
- b. In urban areas, there will an initial increase in clustering to satisfy perceived customer requirement. This may result in negligible improvements in service level and marginally lower prices, due to competition. However, in the medium term, I believe the competition will result in rationalisation of pharmacy numbers and ultimately lead to decreased competition, reduced service levels, reduced diversity and potential increased prices to consumers.

Q44. Would the removal of the location rules in urban areas with their retention in other areas, particularly rural and remote areas, discriminate against rural and regional consumers or benefit those consumers relative to consumers in urban areas? Why or why not?

I encourage government policy which is a reflection of a needs analysis of pharmacy services. Pharmacy licenses in already over serviced urban areas should be restricted. Pharmacy PBS licenses should be encouraged and be more flexible in urban growth areas and regional/rural Australia. In my opinion, the current pharmacy location rules have been successful in doing this. Criticism of the location rules is common by individuals who feel aggrieved by them through individual circumstance, however, I stand by my objective evaluation of their success.

Q45. 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?

Ownership structures and location rules are two distinct issues which should not have an impact on each other. The location rules were established with a twofold purpose:

- a. Equitable access to all consumers for government subsidised pharmacy services
- b. For a viable network of community pharmacies

Thus, location rules can be maintained and managed regardless of ownership structures.

Q49. 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?

I don't agree that the ability for someone to pay a financial amount should gain them entry into a location to provide government services. The prerequisite should be based on a needs analysis process and the intended services that the licensee is capable of providing to the community.

Q50. 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.

The intention of the location rules is to ensure a viable network of community pharmacies with equitable access to all Australians. The location rules were not altered during the 5CPA, however, the profitability and resulting valuation of my pharmacies suffered significantly during this period. Confidential evidence is available on request. This proves that values of pharmacies are much more linked to government decisions regarding dispensing remuneration (e.g. Price disclosure) than any impact from location rules.

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?

Yes, if the existing pharmacy is capable and willing to meet the needs of the community by embracing programs, minimum trading hours etc. it should preclude a second pharmacy being allowed to enter the area.

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?

In my opinion, it's nonsensical to offer health prohibitive products and services alongside government funded health services. This would not happen in a hospital, so why would government legislate to allow this to happen?

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

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?

48. A similar requirement exists with the same rule for relocation of pharmacies from within medical centres. Is this requirement for medical centres desirable or undesirable?

In my experience, the short distance relocation rule has historically worked well to provide flexibility for pharmacists whilst providing certainty to consumers over local service levels. There have been certainly unintended problems associated with short distance relocations from shopping centres and medical centres. This has created a situation providing substantial power to landlords and leasing agents of shopping centres and medical centres, whilst paying little attention to overall service levels to the community they serve.

In my opinion a modification of this rule would be to allow PBS approved pharmacies to relocate short distance from premises within shopping centres and large medical centres creating an amnesty to exclude a PBS approved pharmacy to operate in that previous facility on the proviso that the relocated pharmacy meets minimum standards required by the community it services. This would ensure protection for the community whilst taking back some of the power enjoyed currently by landlords and leasing agencies where pharmacies have become rental hostages.

Pharmacy Remuneration for Dispensing

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

The drivers for improved uptake of electronic prescribing and dispensing should be based on monetary incentive and or improved efficiency in workflow. Currently, lack of funding and the lack of a comprehensive electronic health record, provide little incentive for pharmacies to uptake.

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?

Historically, generic incentives to pharmacy have been a combination of flat fee and product terms. With the impact of price disclosures, the only ongoing incentive will potentially be the flat fee per dispensing, where a price differential between the originator and generic band exists. This incentive will not be sufficient to encourage the industry to promote the use of generic medicine and should be increased and applied more broadly.

Wholesaling, Logistics and Distribution, Arrangements

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?

It should be a manufacturer condition when listing a PBS medication that it will comply with a set of standards such as the CSO. This should ensure all Australian consumers have timely access to all PBS medicines.

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?

I don't believe the changes have had an impact in urban areas where significant competition of wholesaling to pharmacy exists. However, there is a potential to impact service delivery to remote areas.