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Feedback: Pharmacy Remuneration and Regulation Review 2016

1. The Panel should look at pharmacy as different models
2. Currently the market place is operating two general types of operations - Pharmacies are either: Product at a price focused (e.g. Discounters) or patient focused (e.g. small professional pharmacies)
3. Future pharmacy models could be based upon: Urban shopping Centres, Urban Strip pharmacies, large Box discounters, large suburban non-discount pharmacies, small suburban pharmacies, small rural or isolated pharmacies, or large rural or isolated pharmacies
4. Non-discount pharmacy models could also constitute specialized niche pharmacies e.g. Staged Supply speciality (Methadone Program & Other); Diabetes Education; Aged Care; Asthma Care; Cardiovascular Care; Dermatological Care; Mental Health Care; Dental Care; Surgical & First Aid Care; Clinical Pharmacy Advice Pharmacy (collaboration & consultation with doctors, other health professionals & patients)
5. It is possible to separate supply function of dispensing versus professional consultation, intervention & advice. A current model which closely mirrors this model is "Pharmacist Advice" Brand owned by API. Its model is designed to have pharmacy technicians doing the mechanical duties of dispensing, whilst the pharmacist is position at either a stand up or sit down pod - checking the dispensed products from the technician, whilst sitting down with the patient to direct counselling, education and advice of the products dispensed.
6. The PBS could fund both these functions separately as two fees: (1) The supply function – this fee should be no less than the mark-up given to the wholesalers (ie 7.4%), in fact given that a pharmacy's economies of scale are smaller (thus risk of out of date, etc), then pharmacies should be paid more than wholesalers in their mark-up (say 10%); (2) The professional consultation with the pharmacist
7. The professional consultation with the pharmacist fee needs to be set by not only considering the pharmacist award wage, but needs to consider operating costs of the pharmacy employing the pharmacist, the professional operating risks, its opportunity cost, and its required return on investment.
8. Reported average national pharmacist's wages indicated in the Pharmacy Remuneration and Regulation Review Draft Report of \$55,000pa is a extremely low professional wage

when compared to comparable professionals i.e. doctors, nurses, physiotherapists, dentists, etc.

9. Pharmacist national wage needs to be addressed URGENTLY; otherwise there shall be a mass exit from the industry, creating a shortage of pharmacists in the medium to long-term. This increase in pharmacist wage needs to be factored into the calculation of the professional consultation with the pharmacist fee.
10. The pharmacy wholesaler network in Australia is in-efficient and needs transformational change e.g. Sigma and Symbion have a warehouse in Hobart and Launceston to service a State with only 145 pharmacies. There is no reason why they could not operate out of Melbourne or Sydney, with only a distribution centre being placed in Launceston. DHL (one of the largest logistics companies in the world) do this very thing (in Hobart) for Pfizer and many other companies. DHL's ordering & supply system is extremely efficient and professional.
11. Maybe there is NOT enough room for THREE pharmacy wholesalers in Australia, and rationalisation to TWO may improve the system?
12. Alternatively, maybe DHL distribution system may provide a more efficient wholesale distribution system for the PBS? This works superbly with the alike of Pfizer.
13. Why should pharmacies pay for the in-efficiencies of wholesalers by constantly having our trading discounts slashed (mostly smaller and rural pharmacies), and now they want to supply the top 1000 PBS products in shelf packs, otherwise trading discounts shall be lost. This shall have an enormous negative impact on smaller pharmacies that represent 20% of the Australian pharmacy market with a combined estimated turnover of \$2 billion. Pfizer, Genrx, Ranbaxy etc. currently supplies the best price on non-shelf pack quantities. Thus if pharmacy wholesalers insist on shelf pack quantities, then maybe the PBS should be supplied via DHL?
14. The PBS should select logistic companies who are specialised distribution companies like DHL. Currently the THREE pharmacy wholesalers in the pharmacy market compete with customers by diversifying into ownership of banner groups e.g. Amcal, Terry White Chemists, etc. By owning these groups, they are distracted from their main role: wholesaling and distribution of products, whilst encouraging pharmacy owners to expand their retail offer.
15. There is little or no evidence (level 1 to 3) available that these banner groups produce improved profitability or competitiveness to their member pharmacies, or better health outcomes for the public.
16. The Panel questioned to the audience at Rydges in Hobart in August 2016, whether the Location Rules should be tiered. I agree with this suggestion, as many locations of need have no pharmacy throughout Australia, and in others, there are too many. In instances in Hobart there are concentrations of 5 or more pharmacies within a square kilometre, and in many instances pharmacies have closed down in some areas leaving no pharmacy in that area, to be in what is thought to be a better commercial location e.g. Kingston Beach to Kingston. Discounters often do this e.g. Lindisfarne Pharmacy (on East Derwent Highway) relocated to location between two existing pharmacies (250 metres apart) in Lincoln street, Lindisfarne. Overnight the discounter took a large proportion of these pharmacies businesses, one who had recently been purchased a large sum of money.
17. Location Rules thus could be tiered to encourage or discourage pharmacy start-ups or relocations into what is considered a location of public or patient need, not economic desire to improve one's return.

18. If the tiered system is introduced, maybe consideration on cost of operation should be taken into account. I know from personal experience that rents of pharmacies in city centres and shopping centres can be astronomical, and thus, providing a significant cost on the operation of the pharmacies involved. Maybe pharmacies should be encouraged to locate in strips rather than shopping centres?
19. If the tiered location system was to be introduced, then introduction of increasing incentives would be required to direct pharmacies to be sited into the "desired" location?
20. A part of this tiered system is the Remote Pharmacy Allowance Scheme. For my pharmacy on Bruny Island (estimate population 1200), this is a critical funding factor. Without it I would have to close 2 days a week. A review on the level of the RPMA scheme is also required as indexing has not occurred for the past 3 years, thus reducing the time-value of money.
21. Having owned and operated some 8 pharmacies over the past 35 years, being small and large, shopping centre, strip, suburban and rural I have gained a lot of experience in the industry. I have operated these pharmacies in banner and non-banner situations. On graduating with an MBA I have gained insight into the critical elements for pharmacy survival.
22. One of these elements on my analysis centres on the questions of: what is the critical or core target market? And what core competencies are directed at this critical market? The answers - question 1: the elderly, sick and a less minor role of health promotion and preventative health. The answer to question 2; pharmacists and qualified support staff.
23. From my past observations: 80% of pharmacies' turnover comes from 20% of the space, yet 80% of the pharmacies operation costs comes from 20% of the sales (front of shop). I came to the conclusion, that the non-core pharmacy products needed to be culled (e.g. cosmetics, fragrances, gifts, etc) to downsize the space of the front of shop, so that it better aligned to serving the core target market i.e. sick, elderly, and preventative health. Under this conclusion the operation costs are slashed and the focus is on a pharmacist core role.
24. My conclusion above includes the premise that large front of shop (OTC) segments in average pharmacies produce a loss, which is then subsidised by the more profitable dispensing and pharmacy medicines segments.
25. One fact which seems to give this weight is the calculation (from Guild Digest data) of "Total Expenses" (TOE) per prescription dispensed for the 2015 average pharmacy, the 2015 "low" sales, and 2015 "high" quartile sales. The figures used for calculation were taken from the reported "total expenses" and the "prescriptions dispensed (total)" of the 2015 averages, low and high sales levels in Table 4 page 24 of the Guild Digest 2016. The calculated total expense for each prescription dispense is as follows:
 - (1) 2015 Average Sales Pharmacy = \$14.57 total expenses per prescription dispensed;
 - (2) 2015 Low Sales Pharmacy = \$11.02 total expenses for each prescription dispensed;
 - (3) 2015 High Sales Pharmacy = \$17.51 total expenses per prescription dispensed.
26. This reveals the fact that it costs an Australian Pharmacy proprietor an increasing amount of total operational expenses per prescription dispensed as the size of the annual turnover increases. And is more than likely related to the less profitable front of shop retail sales and its associated expenses for progressively larger pharmacies?
27. This is a surprising result, and maybe reveals that it is more cost efficient for dispensing prescription items in smaller pharmacies, a position that has been assumed to be the reverse.

28. Small Pharmacies, like my own, are patient focused servicing the core critical target market of the sick, elderly and associated preventative health, thus more likely to produce improved health outcomes, as well as being cost efficient.
29. From my past experience and research, I have come to the conclusion that Small Pharmacies, are more likely to be patient focused, and are less likely to have large front of shop offerings, and therefore unlikely to have excessive operational costs. My calculation of total expenses per prescriptions dispensed (for each pharmacy sales group) adds huge weight to this argument.
30. The following link provides research from the US which provides some evidence about the positive health outcomes of smaller pharmacies versus larger discounters: -

Article (PDF Available) in American Journal of Health-System Pharmacy 54(5):531-6 · April 1997 with 269 Reads
Impact Factor: 1.88 · Source: PubMed

https://www.researchgate.net/publication/14145155_Patient_satisfaction_with_pharmaceutical_services_at_independent_and_chain_pharmacies

This article provides a template, of which similar broader studies could be done in Australia to substantiate these results or prove otherwise.

31. My belief is that big box discounter's price driven strategy is to maximise product sales (many non-evidenced based product) with minimum or no direct patient contact between pharmacist and patient – positions them as just suppliers.
32. My thoughts are that PBS negotiations should be via all stakeholders within the pharmacy industry – not just the Guild. The stakeholders other than the Guild should be The Pharmacy Society of Australia, The Small Pharmacies Group, and Chemist Warehouse.
33. The Pharmacy society should have the pivotal role as it is this organisation which represents all pharmacists, their professional role, and how pharmacist's professional skills and training can best be fit to achieve maximum health outcomes via their existing and expanding professional role.
34. The Pharmacy Guild only represents pharmacy owners as the "average" pharmacy and does not consider, or make special consideration of variances of particularly the smaller pharmacies. For example, Pharmacy Guild or QCP fees charged by the Guild are the same for all pharmacies. I have written to them several times requesting for an equitable system of user pays, but my requests have always been rejected. By the way of equitable system I mean the larger the pharmacy, the greater the use of the PGA or QCP resources, thus why should smaller pharmacies subsidise larger ones in this instance? PGA and QCP are some of the largest expenses of smaller pharmacies.
35. May I suggest the introduction of professional Fees for important roles pharmacists play: (1) Professional Collaboration with other health professionals concerning patient/s medical on/or medication profile; (2) Pharmacy First Minor Ailments Scheme to compensate for advice and recommendation to patients .