

To the panel of the Pharmacy Remuneration and Regulation review

We are a group of community pharmacists that operate in partnership together; Carolyn Wynn, Lynette Calabrese, Zoltan Toskov, Chris Kelly and Anthony Tassone.

We co-own two pharmacies together Casey Central Pharmacy and Pharmacy on Clyde located in Narre Warren South and Cranbourne East respectively

The pharmacies within our partnership group have operated since 2000 and have been the recipient of a number of awards of recognition; five time Victorian Chemmart pharmacy of the year and also National Chemmart pharmacy of the year in 2014.

We declare that one of our co-proprietors, Anthony Tassone, is an elected official of the Pharmacy Guild of Australia, serving as Victorian Branch President (and have done so since 2013). This submission is lodged in our capacity as practising pharmacists and community pharmacy proprietors.

PHARMACY REMUNEATION FOR DISPENSING

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?

This question appears to assume there is a significant difference in the 'level of effort' when dispensing an initial vs. a repeat prescription. Pharmacists are registered health professionals under the National Law and scheme administered by the Australian Health Practitioner Regulation Agency (AHPRA). The Pharmacy Board is the practice board that is responsible for the registration of pharmacists.

The Pharmacy Board has a published document *Guidelines for Dispensing of Medicines* (latest version September 2015) and is available from:
<http://www.pharmacyboard.gov.au/Codes-Guidelines.aspx>

The purpose of the guidelines are;

These guidelines have been developed by the Pharmacy Board of Australia (the Board) under section 39 of the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law). They provide guidance to pharmacists in relation to the dispensing of medicines.

These guidelines do not differentiate between an initial or repeat script. The expectation of the professional regulatory board in terms of the dispensing process and the offer of counselling is the same regardless of whether it is an initial or repeat prescription dispensed.

Furthermore, the administrative effort (not accounting for the clinical review) of processing a repeat prescription that was last dispensed or initially dispensed from another pharmacy can be comparable to that of an initial or original prescription.

For this reason, we feel that there is little basis to the proposition of a tiered rate of remuneration in dispensing in this sense.

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?

Pharmacists are strong supporters of the tenets of the Pharmaceutical Benefits Scheme (PBS) in delivering national medicines policy, namely, equity of access and affordability of medicines.

The discounting of medicines in some circumstances leads to an undermining of the PBS and not the 'same fair deal for all'. What can occur is that consumers living in say Fitzroy (metropolitan Melbourne) may be more likely to receive a discount off the prescription co-payment than consumers in say Fitzroy Crossing in remote Western Australia (and would be a more disadvantaged community). This does not make sense in a national medicines policy sense.

There are some exceptional circumstances if a CSO wholesaler was to impose an additional charge for a pharmacy not ordering within a minimum buy quantity, or for certain S100 lines if a pharmacy does not hold a first line wholesaler account with particular wholesalers where the pharmacy could in fact face a financial loss in dispensing an item. Pharmacies are not authorised to pass on any additional charges for PBS items under the *National Health Act 1953*, but unless such instances are remedied, it could be to the financial detriment of pharmacies which is unsatisfactory and unreasonable. One could argue that if a pharmacy felt compelled to supply a PBS medicine even at a financial loss this could constitute 'conscripted'.

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?

Our pharmacy support the continuation of a premium free dispensing incentive as it goes some way to promoting uptake of generic medicines. Other ways to help assist with greater uptake of generic medicines is for there to be an actual price differential between originator and generic brands so that there is a genuine incentive for the consumer to consider taking a generic medicine. An example is the molecule, clopidogrel, where originator brands Plavix® does not have a brand price premium and is the same price as generic brands.

The Federal government could consider ensuring that it is a requirement that prescribing software amongst prescribers does not allow 'Generic Substitution Not Permitted' to be selected in all instances as a 'default' setting. That is, to 'opt in' to endorsing the prescription as 'Generic Substitution Not Permitted.'

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

With the recent PBS listing of Hepatitis C anti-viral medications in March 2016, there was significant cash flow pressures on community pharmacy dispensing products from the manufacturer 'Gilead' when distributed by wholesaler Symbion, as the initial payment terms were 15 days from date of purchase (and in some cases the items were \$20,000 plus GST in the case of the prescription item 'Harvoni®'). With time, Symbion lengthened the payment terms to 25 days after the end of the month in which the product was purchased and this made a significant difference to cash flow.

Pharmacies would welcome payment terms that are at least the following month after the date the product was purchased to be able to facilitate payment from Medicare Australia prior to paying suppliers.

What would also be welcomed would be the removal of GST through the prescription medicine supply chain. Currently, through the prescription medicines supply chain, GST is applicable until the point of dispensing to the consumer, with the consumer receiving it free of GST. Given most community pharmacies derive most of their income from dispensing of prescription medicines, they are continually in a 'refundable' position with GST Business Activity Statement (BAS) returns which places cash flow pressures on community pharmacies (relying on monthly BAS returns).

The PBS listing of high cost goods including the Hepatitis C lines has generated additional pressures on payable GST to suppliers and seeking this refund a month later from the Australian Tax Office. It would make a lot of sense, and be welcomed by the supply chain to remove GST from prescription medicines.

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?

The Commonwealth government could consider liaising with manufacturers to have a consignment type model that places certain high cost items in community pharmacies at no initial cost (and it may be targeted in particular areas where there is distinct prescribing patterns or demographics).

24. Given that very high cost drugs are likely to become more common on the PBS, should this remuneration structure for hospitals change to more closely reflect the remuneration structure of community pharmacy?

Our understanding of the remuneration structure for PBS dispensing of section 85 listed items by those hospitals that participate in the PBS (excluding NSW hospitals who aren't participants in the scheme) – have not had a funding agreement reviewed for over 10 years and still work on a 11.1% mark-up. This would translate to a significant difference in remuneration for high cost goods when compared to that of community pharmacy (under the 6th Community Pharmacy Agreement, which is administration, handling and infrastructure flat fee of \$70 for goods costing over \$2089.71 plus dispensing fee).

If our understanding of the remuneration to hospitals is correct then it would be reasonable for a closer alignment of remuneration between hospital and community pharmacy settings. It would probably be somewhere between what is currently understood to be what is being paid to hospital pharmacies vs. what community pharmacies are receiving.

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?

Continuing pharmacy programs (from the 5th Community Pharmacy Agreement) are undergoing a cost-effectiveness analysis as part of the 6CPA – these include; clinical interventions, MedsChecks, Home Medicine Reviews and Dose Administration Aids. Assuming a favourable or positive outcome for these services, then these services should continue.

Furthermore, assuming a positive outcome on cost-effectiveness – with appropriate and targeted selection criteria there should be a lifting of the caps on medication management programs such as; MedsChecks and Home Medicine Reviews.

In 2014, the Victorian Government held a parliamentary Inquiry into Community Pharmacy. It was run by a bipartisan senate committee and produced a report with a number of findings that would help expand the role of pharmacists in primary and preventative care that included;

- A pilot of a minor ailments scheme;
- Working with the government to expand the Commonwealth's continued dispensing initiative;
- A pilot of an evidence-based chronic disease screening and management program (with collaboration between pharmacists and a patient's GP);
- Consideration of a funding model (e.g. a Medicare provider number) to adequately recompense pharmacies for providing a standardised evidence-based opioid dependence treatment;
- Calls for further research into the beneficial role of pharmacists in supporting the provision of aged care in the home.
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Some recommendations including supporting pharmacist immunisation have already been legislation and implemented. There could be consideration for broadening the scope of vaccinations allowed such as travel vaccinations (currently depending on the state or territory, pharmacists may be able to deliver adult influenza, whooping cough or measles vaccine).

The full report can be found at:

http://www.parliament.vic.gov.au/file_uploads/Community_Pharmacy_FINAL_Report_2BnB3N99.pdf

The first three priority areas of the Pharmacy Trial Programs from the 6CPA are all appropriate and the sooner that these programs can be trialled for further evaluation the better;

- improved medication management for Aboriginal and Torres Strait Islanders through pharmacist advice and culturally appropriate services;
- pharmacy based screening and referral for diabetes; and
- improved continuity in the management of patients' medications when they are discharged from hospital.

Regarding this question, there is a significant amount of funds currently allocated within the 6CPA to expand the role of the pharmacist in primary and preventative care and the community pharmacy sector would strongly support a timely utilisation of these funds well within the 6CPA period.

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?

Our regulatory system relies on the Therapeutic Goods Administration (TGA) to register products on a register of therapeutic goods.

Pharmacists would welcome the TGA undertaking additional scrutiny of the efficacy and evidence behind some of the claims behind complementary medicines to allow them to make such claims. Prohibiting pharmacies from offering certain products seems non-constructive when if they were allowed to be sold in a non-pharmacy environment without the ability to check potential interactions with other medicines being taken or contraindications with other health conditions.

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?

Australia's scheduled medicine framework including over-the-counter (OTC) medicines include access to consumers for products that have been determined by the TGA to be; safe, of quality and effective. OTC scheduled medicines can be used to help assist with minor or self-limiting ailments that do not necessarily require a consultation with a GP. A pharmacy that is solely focused on dispensing would not be able to provide such products and treatment solutions for minor-ailments.

Such a pharmacy may not be attractive to the public if it was not able to provide choice or access to appropriate therapies for common or minor ailments.

Whether such a pharmacy would be viable could be in part answered by the number of such pharmacies in existence today. If there was a strong business case, you would expect to see more of such pharmacies and the fact there isn't is suggestive of the likely answer. With the ongoing PBS price reductions with price disclosure – relying solely on the remuneration from dispensed medicines without any remuneration from the sale of other items would be very challenging to maintain a viable business.

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?

It's unclear whether this question is proposing that advice is remunerated and undertaken as a complete separate action from supply or as part of supply but with a formal remuneration structure included. Advice cannot and should not be separated from supply as it could potentially compromise quality use of medicines and not achieve optimal patient adherence. Formal remuneration (whether it be through the MBS or other means) could be considered for certain activities such as; ongoing patient adherence programs, inhaler or device technique check.

A consumer's value on a service could be influenced by a number of factors, whether they need to pay a co-payment, the quality of the service, whether the service meets their specific needs etc.

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?

There is the potential for specific remuneration to be targeted towards pharmacist involvement in assisting with particular therapies for particular patient groups such as encouraging the uptake of biosimilars with patients (that could include patients diagnosed with rheumatoid arthritis) – and there may be a need to demonstrate an injection device that could differ from a biologic originator.

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

With current caps on medication management services such as MedsChecks and Home Medicines Reviews (10 per month and 20 per month per service provider) this does reduce accessibility to consumers.

Pending a cost-effectiveness analysis of these programs, the targeting, funding and selection criteria could be reviewed in the future.

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?

Without wanting to re-invent the wheel, the programs that are being considered for the Pharmacy Trial Programs are undertaking an evaluation process via the Medical Services Advisory Committee (MSAC) of the Department of Health.

MSAC are also involved with the cost-effectiveness analysis for the continuing pharmacy programs mentioned previously – and pending the outcome of this analysis there may give some direction on the ongoing targeting and eligibility criteria of these programs.

We do not feel that every patient necessarily requires a HMR annually, Our pharmacies have had accredited pharmacists conducting HMRs regularly since 2004 and even those patients who have received services previously may not necessarily require another service in the future depending on their circumstances. A number of factors should be considered to ensure efficient use of taxpayer dollars rather than necessarily allocating an annual HMR in all instances.

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

Yes, cost can be a potential barrier. Our pharmacy has provided 'Health Checks' that include; waist measurement, blood glucose, blood cholesterol, blood pressure and a body mass index measurement for a fee of \$20 for a number of years.

The uptake has not been significant, and this could be due to the perception of being able to obtain similar services from a medical centre at little or no cost if it is subsidised via an MBS payment. However, pharmacies provide a greater accessibility and visitation than medical centres (and other primary healthcare destinations) so are potentially underutilised in this area.

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 can take on various forms. In our pharmacy we have implemented a consumer smartphone app that allows patients to see what prescriptions they have on their file at the pharmacy, be able to order them for a refill and for the pharmacy to communicate with them when the order is ready.

One of our pharmacies has a dispensing robot to help reduce the time taken to dispense a prescription whilst the other pharmacy has gravity shelves to help reduce the time taken to stock and retrieve medicines from the shelves and also save on space.

The current remuneration model relies on trying to obtain a greater volume or market share of prescriptions (and that the cost of such patient programs or fixtures and fittings is justified through that business case).

REGULATION

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

The current ratio of pharmacies to population is approximately 1 pharmacy to 4000 headcount population, which is in line with OECD averages and seems to be an appropriate balance.

In its submission to the Competition Policy Review (aka the 'Harper Review') the Pharmacy Guild of Australia conducted a geo-spatial analysis comparing the proximity of the Australian population of pharmacies to various major services including; banks, supermarkets and medical centres. It was found that 87% of the Australian population live within 2.5km of a community pharmacy across Australia – and this was more accessible than; banks, medical centres and supermarkets.

This was despite having less sites in number than medical centres (of any type) demonstrating a far greater efficiency in distribution and delivery of national medicines policy.

It makes sense that the Federal government have influence on the location of PBS approved pharmacies in order to therefore exert an influence on the distribution of PBS medicines in accordance with national medicines policy and its own policy objectives.

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?

The Victorian Pharmacy Authority (VPA) is a statutory authority that administers the *Pharmacy Regulation Act* (or relevant Act) on behalf of the Victorian government in relation to the registration and licensing of pharmacies. Within their guidelines, they stipulate a minimum dispensary size in relation to the total size of the pharmacy, and the number of counselling points in proportion to the number of dispensing stations.

The VPA has guidelines that are some of the more descriptive in nature compared to their state and territory counterparts (where there is an equivalent) – but they do not stipulate a 'retail space to professional area ratio'. There is a requirement that non-health related goods should not be stored or displayed within the professional services area.

Enforcing such a ratio could be simplistic and have unintended consequences. For example, in some regional and rural areas a pharmacy could be considered one of the few outlets that the local community could purchase such items from. As mentioned earlier, pharmacies have the greatest accessibility of any other major service across Australia. This is in part due to location rules, and also the fact that pharmacies have positioned themselves in high traffic, destination areas.

Such locations may attract greater rents and expenses to operate. To restrict the goods or services that a pharmacy can provide (within reason that are not detrimental to health) may compromise their ability to meet their immediate financial commitments.

Unless there is a viable, accessible, well-funded mechanism to remunerate pharmacies for the range of advice and services they currently provide – prohibiting certain goods from being sold and restricting the space from which they can be sold can undermine their sustainability.

On the other hand, many pharmacies particularly in shopping centres are looking to downsize their tenancy footprint and can experience resistance from their lessor. We have personally experienced this recently when our lessor as part of a redevelopment wanted out pharmacy to occupy approximately 420 sq. m and we negotiated our way down to 300 sq. m.

A restriction on how much space can be dedicated to supplying such items and services could help tenants in shopping centres more easily negotiate lower footprints, however, this could be offset by higher rents per square meter in any case negating any benefit for the lessee.

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?

Yes it is.

Community Pharmacy Agreements are a procurement of services by the Commonwealth government to distribute PBS medicines to the Australian public at an agreed price, in an agreed manner and timeframe. The agreements have grown in scope to also include medication management services associated with the quality use of medicines.

It makes sense that if the government was to procure such services that there would be a negotiation with a body or association that is representative of the network who delivers these services that help achieve equity of access and national medicines policy.

The Pharmacy Guild is the body that represents the vast majority of community pharmacies who are responsible for delivering PBS medicines to the Australian public and helping deliver our national medicines policy.

Through the most recent 6CPA there was an extensive consultative process with other stakeholders in the lead up to the formal negotiations between the Pharmacy Guild and the Commonwealth, which the Commonwealth would have considered through its negotiation process.

Other groups and parties, including consumer groups, had a significant involvement and participation during what the Minister herself referred to as a 'bilateral' and 'multilateral' consultation process.

It has been encouraging to hear Minister Ley at her recent address at the APP conference in March 2016 refer to her support of pharmacy ownership by pharmacists as having 'skin in the game'. Indeed, pharmacists who own pharmacies have skin in the game in their investment in the infrastructure and network that delivers national medicines policy, and does such a good job of it.

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 it shouldn't.

Just one look at the system in the United States and South Africa can see the discrepancy that occurs with the price paid for medicines depending on the pharmacy, or chain of pharmacies you visit with an equivalent level of health insurance cover.

Whilst there can be variances in the prices paid for prescriptions that are either not covered by the PBS, or are for a general patient that are under the co-payment level, (until the optional \$1 discount was introduced) there is not a variability in the pricing paid by consumers.

A 'standard contracting or licensing approach' would probably prove to more cumbersome for government, more expensive and inefficient and not provide any superior outcomes to the current process and system.

There has not been any purported benefits for an alternative system despite the significant successes and benefits of the current system.

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?

The tenets of the 6CPA are achieving access to medicines for consumers with the location rules, administration handling and infrastructure fee replacing % mark-up and the continuation of the Community Service Obligation (though not being indexed is something of concern to wholesalers).

What has compromised access to medicines have been recent significant medication shortages of chronic therapies, with a notable and current live example being metformin – a treatment for non-insulin dependent diabetes and polycystic ovarian syndrome. There is a strong sentiment within the community pharmacy sector that price reductions due to PBS reform may have reached a point for some molecules that some manufacturers may opt to direct their resourcing to other markets in preference to Australia.

The TGA has established a website to monitor the shortages of prescription medicines, and the fact that such a website has been established with the significant amount of recent activity is suggestive that there could be concerns from the manufacturing side of the sector in promoting ongoing availability and access.

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 pharmacies are not protected.

The regulation that exists with regards to pharmacy location rules and pharmacist ownership of pharmacies are matters of good public policy that provide a public benefit.

It has previously been noted about the efficiency and distribution of the pharmacy network providing superior consumer accessibility to pharmacies thanks in large part to location rules. Underpinned by a Community Service Obligation that helps distribute and give access to medicines for Australians regardless of their location – what could be superior to this?

A question for the panel, is National Medicines Policy not being achieved now? If not how? If not how would removal of location rules and ownership regulation (outside the terms of reference of this review) achieve this?

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?

It must be noted that ownership is not part of the Terms of Reference of this review, as has been stated a number of times by the panel chair, Professor Stephen King during the public consultation forums.

In its submission to the Competition Policy Review, the Pharmacy Guild undertook a cost benefit analysis of various scenarios looking at alteration of ownership and/or location rules.

Below is a link to the summary of submission to the Competition Policy review which modelled as a scenario the retention of pharmacy ownership laws, with the removal of location rules ('Scenario A' in the Cost Benefit Analysis section);

<https://www.guild.org.au/docs/default-source/public-documents/issues-and-resources/Policy-and-Position-Statements/summary-of-submission-re-competition-policy-review-draft-report.pdf?sfvrsn=2>

It was determined that consumers would be \$115 million **worse off** with such a scenario compared to the current baseline of pharmacist ownership laws and location rules. The removal of location rules would inevitably lead to clustering of pharmacies in areas perceived to be desirable in metropolitan areas with fewer services in rural and regional areas.

In a keynote address at the recent *Pharmacy Connect* conference hosted by the Pharmacy Guild in Sydney during September 2016, esteemed and respected economist, Professor Henry Ergas gave a keynote address on pharmacy regulation pertaining to location rules and ownership.

On ownership regulations, Professor Ergas said the requirement that only a pharmacist can own a pharmacy contributed to the trust consumers have in community pharmacy, which in turn helped achieve the Commonwealth's health goals.

Below are some quotes attributable to Professor Ergas, and are shared and fully supported by our pharmacy partnership;

"To begin with, a key feature of the ownership rules is that they ensure a dispersed ownership structure, with very low levels of ownership concentration. That provides crucial benefits to the Commonwealth, as it prevents a situation emerging where the Commonwealth, to meet its objectives, would have to purchase dispensing services from suppliers with substantial market power,".

Professor Ergas said the rules ensure owner-pharmacists have considerable 'skin in the game'.

"That gives them strong incentives to maximise the goodwill in their asset, not least by providing excellent customer service; this 'skin in the game' aspect also enhances owners' incentives to conduct themselves and their pharmacies ethically and professionally, and not risk loss of registration and, therefore, loss of value in the pharmacy,".

"It is inconsistent with the evidence to claim that the location and ownership rules reduce access or undermine efficiency—on the contrary, that evidence suggests they result in a high level of community access while underpinning a dispersed ownership structure which serves the interests of the Commonwealth, of individual proprietors and of consumers. Whatever claims might be made in theory, these practical outcomes demand and deserve substantial respect."

"In short, one needs to be extremely cautious in altering a framework that is well grounded in economic analysis, compellingly supported by evidence and—most importantly— works,".

A paper that the review panel should take note of is *Competition issues in distribution of pharmaceuticals* by Dr. Sabine Vogler to the Global forum on competition.

It is available from:

[http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=DAF/COMP/GF\(2014\)6&docLanguage=En](http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=DAF/COMP/GF(2014)6&docLanguage=En)

The paper looked at the effects on 'liberalization of pharmacy' in Europe in terms of; ownership and location rules, and what impacts these had on accessibility and pricing.

Key commentary from the conclusions include;

"A consistent decrease in the prices of OTC medicines (in countries with liberalization) was not confirmed. A reduction in overall pharmaceutical expenditure in these countries is thus also unlikely since pharmaceutical expenditure is largely influenced by prescription-only medicines that are publicly funded and whose prices continue to be regulated in liberalized markets; furthermore, factors such as increased medical need due to an ageing population, high-priced new medicines and consumption volume impact expenditure." And

*"Accessibility of medicines was observed to increase in countries whose pharmacy sector had been subject to liberalization because several new pharmacies and further dispensaries, usually OTC retailers, tended to be established and opening hours of pharmacies were extended. **The positive overall effect suffers, however, from some limitations since the new pharmacies and OTC dispensaries are usually established in urban areas, which already had a good presence of pharmacies before the reform. Accessibility of medicines in rural areas was not found to have improved; however, in the surveyed countries it had not decreased either, due to 'safeguard' policies to ensure provision with medicines in the remote.**" (emphasis added)*

And lastly;

"Another unintended effect of liberalization which limits a successful increase in accessibility of medicines and distorts competition, is the possible establishment of oligopolies of a few vertically integrated pharmacy chains which might be incentivized to align the product range to their suppliers and focus on offering more frequently asked medicines."

There have been cases in the past where supporters of deregulation of location rules have referenced this paper selectively citing the statement of 'accessibility of medicines was observed to increase in countries....' But without the qualifying statement about the 'overall effect suffering' as the new pharmacies were established in urban areas.

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?

Following on from the response the previous question, it would be simplistic to think that deregulation of location rules in urban areas but retention in rural and remote areas will automatically produce the best system to deliver national medicines policy.

How would a rural be defined?

The location rules as a framework and system must be considered as a whole, not cherry picked from out of convenience. The superior and efficient accessibility of community pharmacies that is currently enjoyed is thanks to the whole framework of location rules, not just their existence in certain instances.

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?

Given ownership is not within the terms of reference of this review, and given the panel cannot make recommendations pertaining to state and territory matters, our pharmacy is not sure why this question is being asked.

In any case, as answered in a previous question, pharmacy is not protected there are regulations in place that have a public benefit both pharmacist ownership and location rules and should not and cannot be traded off for another. Removal of either or both will cause a net public detriment.

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?

Our pharmacy will try and answer these questions concurrently.

In principle, we feel the short distance relocation rule is appropriate as there are instances where a pharmacy may need to relocate a short distance due to expiration of an existing lease, redevelopment works or other reasons.

We have had experience with the short distance relocation rule from a small shopping centre, as we had to relocate on two occasions within twelve months as part of a shopping centre redevelopment. For the most part and overall, the rules did not preclude us from continuing our trade and achieving our objectives but there was a process that needed to be undertaken which we made known to our lessors.

We have also been in the situation where a lease negotiation has been very challenging in a shopping centre environment and the lessor seemed to exert an influence with knowledge of the pharmacy location rules. We agree there could be potential unintended consequences with the shopping centre environment, but this is not cause to throw out the location rules all together.

A limitation of the location rules in these types of instances involving shopping centres is that the Australian Community Pharmacy Authority (ACPA) does not have any ability to exercise discretion when considering recommendations for approval to the Department of Human Services (Medicare) for issuing a PBS approval number. Each requirement must be met and if not met, it cannot be recommended for approval.

Some of the conditions and requirements on the short distance relocation rule (when involving shopping centres) was to potentially prevent the practice of 'backfilling' whereby an applicant can apply for the short distance relocation out of a shopping centre facility and then immediately after apply for a 'new pharmacy' within the shopping centre.

The net effect was a new additional pharmacy just outside the shopping centre. This happened to our pharmacy partnership back approximately 10 years ago in another location near Fountain Gate shopping centre, Narre Warren Victoria on two separate occasions within 12 months. The practice of 'backfilling' is not within the spirit or purpose of the location rules.

If there was an ability for the ACPA to be given discretion to provide considered judgement on; a) clear attempts to backfill at a shopping centre and b) enable a pharmacy to relocate out of a shopping centre should there a breakdown in lease negotiations (or the lessor is being unreasonable to the tenant) then this could be worth exploration.

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.

We put to the panel that pharmacy is very competitive, so competitive in that in some areas it is actually more competitive with supermarkets.

A study undertaken by consumer group *Choice* in mid 2015 titled ‘*A better deal on drugs*’ comparing the price of non-scheduled over-the-counter medicines with pharmacies and supermarkets found that ‘in general, pharmacies equalled or beat supermarkets on price when comparing brand for brand, and with larger pack sizes available in pharmacies, the price per dose was even cheaper.’

The full report can be access from;

<https://www.choice.com.au/health-and-body/medicines-and-supplements/prescription-medicines/articles/supermarkets-vs-pharmacies-for-otc-medicine>

The biggest impact on pharmacy profitability in the past decade has been from PBS reform and price disclosure (rather than pharmacy location rules) and this has not been in a positive way. The reports published by the Pharmacy Guild with their ‘*Guild Digests*’ give indications of the economic impacts and pressures placed on pharmacies from the effects of price disclosure.

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?

Undesirable, very undesirable.

Referring to earlier discussion around the superior accessibility that pharmacies across Australia offer compared to all other major services (including supermarkets) there is not even a compelling convenience argument in terms of accessibility that can be considered.

Given the supermarket duopoly of Coles and Woolworths that operates in Australia have as their selling lines tobacco products, and most of their top 20 products tobacco products or soft drinks – one cannot take their place in primary care with any sort of seriousness.

Colocation of pharmacies within supermarkets would put at risk the sustainability and viability of existing pharmacies, particularly in regional areas and this would not be to the benefit of the community.

58. Should hospitals be able to open dispensing pharmacies in the community? Should hospitals be able to contract with specific community pharmacies? Under these arrangements, should community pharmacies be able to access medicines through hospital supply arrangements?

If the hospital was a private hospital group, and that private hospital group was publicly listed – then the operation of that dispensary would be answerable to shareholders and profit driven. It would not be accountable to the public as is the case with pharmacist owned community pharmacists who are accountable with their registration to a National regulatory board whose remit is to protect the public.

WHOLESALE, LOGISTICS AND DISTRIBUTION ARRANGEMENTS

74. Are there alternatives to the current CSO rules that would enable wholesalers to improve the efficiencies of their services without detracting from the consumer experience and access?

For the most part, the CSO has worked well as an important piece of public policy to ensure access of medicines to the Australian public. Given that the wholesalers are still linked to the cost of goods with their remuneration (with a % mark-up) – should they be afforded a mark-up floor (akin to the AHI fee that pharmacy receives for dispensary remuneration) this would make their operations more sustainable.

Changes to the CSO rules have had to be sought by the wholesalers, as from their perspective, they have felt that being linked to the cost of goods created pressures for them to meet their CSO requirements and caused them to seek amendments to the CSO deed in July 2015. If these were enacted, there would be a flow on detrimental effect to consumers in terms of; delayed access and additional cost to the pharmacy which may have to reduce other services to compensate. Pharmacies would not be able to pass on the cost (even additional delivery charges) as it is not allowed under the *National Health Act 1953*.

According to sources from the wholesaling sector, they believe that due to the current remuneration structure and the ongoing price reduction of PBS medicines due to price disclosure – the CSO funding pool may not even be fully expended over the course of the 6CPA. This may cause financial strain on the CSO wholesaling network, and potentially move towards enacting allowed adjusted service provisions in the altered CSO deed. The allocated CSO pool within the 6CPA should at least be expended in accordance to the 6CPA providing the CSO wholesalers meet their requirements to access the pool.

The above can be taken to help address responses to questions 81 and 82 as to the potential impacts on pharmacies should wholesalers enforce terms that are consistent with their alterations to the CSO deed.

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?

Yes all PBS medicines should be available through the CSO. The whole purpose of the CSO is to enable access of PBS medicines to the Australian public as part of national medicines policy.

There can be a model where a manufacturer supplies direct to pharmacy, but not at the exclusion of CSO wholesalers. CSO wholesalers should have the opportunity to stock the product and at least compete in this space. There may be instances where a pharmacy will pay a higher price in a certain minimal quantity to obtain the product the next day for a patient if the need arises.

Consumers would ultimately benefit as there is greater flexibility and options for the pharmacy to procure the product.

As wholesaling in Australia has a long tail (that is only a small minority of products generate profit for the wholesaler) should another major manufacturer exit the CSO wholesaling distribution network and choose to supply only direct – this could have a devastating impact on the CSO wholesaling network and ultimately accessibility of medicines by consumers.

76. Should s100 and RPBS items be included in normal wholesale arrangements and in the CSO? If so, why? If not, how do the current arrangements support consumer access to all PBS and RPBS items?

Most definitely.

The current situation whereby they are not included creates uncertainty on ease of gaining access to the product on behalf of the consumer. Not all CSO wholesalers may necessarily stock a particular S100 product, and should a pharmacy not have an account with that wholesaler – then be forced to open an account with that wholesaler (and possibly have to order a minimum amount of stock per month) just to obtain a particular item.

There is also uncertainty on pricing and pharmacies can be faced with the ludicrous situation of dispensing a S100 at a financial loss. This could particularly be the case if the item is only available from a particular wholesaler which is not their first line wholesaler.

As there is not an ‘approved ex manufacturer price’ or ‘approved price to pharmacy’ that is then underpinned by the CSO – different products get treated on a ‘case by case’ basis it seems depending on a particular wholesaler’s ability to negotiate terms with a manufacturer.

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?

Yes there should be.

Previously we have encountered instances where a patient has presented a prescription endorsed as Regulation 24 (with all repeats to be supplied at once due to an overseas trip the patient was taking), and it was for an anti-hypertensive (blood pressure lowering pill) of six months’ supply.

Our pharmacy did not have sufficient stock of the item and had to order it in from the wholesaler and found that some of the stock would expire by the time the patient took it with them on their trip. Eventually our pharmacy was able to obtain a credit for return of the stock but it was not a straightforward process. Where there is the potential to impact a consumer in such a way, minimum dating through the system should be supported.

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.

As mentioned earlier, wholesalers have sought a mark-up floor like the pharmacy's 'AHI' mark-up floor for their remuneration. This has merit if it provides greater predictability and sustainability to the wholesalers (with CPI indexation) as their logistics and delivery costs don't reduce just because the PBS price paid may reduce.

The current situation of linking to a % mark-up is resulting in wholesalers reducing their settlement discount trading terms with pharmacies with each price reduction cycle on April 1st and October 1st. This is creating additional financial pressures on top of the economic impacts of the price reductions. Whilst the AHI agreed to in the 6CPA helps shield pharmacies from and address some of the price reduction impact, reduction in trading terms from suppliers is a direct and additional impact.

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?

Generally speaking, no they're not.

From our experience, when offering a funded medication management service such as a MedsCheck or a Home Medicines Review, some consumers can be suspicious and feel as though they're being 'sold' a service.

In some instances when a patient has been telephoned to arrange a Home Medicines Review following receipt of a referral from a GP – if the patient hasn't been fully explained or not fully understood what the service involves, they can feel that it is a telemarketer contacting them trying to sell them a service!

It should never be underestimated the importance of health literacy and consumer awareness of programs available and preferably through mass media channels to promote awareness or at least targeted to the appropriate demographic and their carers should be considered.

98. Are there appropriate standards for the dispensing of medicines and delivery of services by community pharmacy? If so, are these standards being upheld? If not, how could the current standards be improved?

For the most part there is and this is demonstrated by the strong consumer support for community pharmacy in terms of; overall satisfaction, willingness to use the support again, appreciation for the advice received and trustworthiness in the pharmacist. This has been demonstrated repeatedly in a number of consumer surveys and research studies.

There is always room for improvement.

During the 5th Community Pharmacy Agreement there were concerns of potential unscrupulous behaviour by certain service providers in the delivery of MedsChecks and Home Medicine Review services due to the significantly higher than industry average volumes that were being delivered.

The high volumes led to the imposition of funding caps on the number of services per month (mentioned earlier). This answer is to not suggest that there definitely was unscrupulous behaviour, but there was significant concern by the industry at the time which continues today.

The profession (and the public) would take greater comfort if there was an appropriate auditing and surveillance process in place to ensure that funded programs were being administered and delivered in accordance with the program specific rules. Any audit should be undertaken on outcomes (potential interviewing of patients or consumers who received the service) not just a review of documentation. A poor quality (or non-delivery of a) service can still have documentation produced.

Our pharmacy ensures that it has a sufficiently staffed roster to be well within the Pharmacy Board dispensary workload guidelines. On any inspection that our pharmacies have received from the Victorian Pharmacy Authority (or the predecessor Pharmacy Board of Victoria), workload or staff resourcing has never been cited as a matter for concern.

Our pharmacy has noted the concerns raised publicly by the *Professional Pharmacists Australia* of the workload concerns that some of their members have with their places of employ.

We feel that the panel should meet with *Professional Pharmacists Australia* (if they have not already) and understand whether these concerns are isolated to a particular pharmacy group or model of pharmacy – or whether they are not isolated in such a way.

The Victorian Pharmacy Authority undertakes a cyclical inspection process of pharmacies in Victoria to ensure they are compliant with the relevant legislation and their guidelines. There is a reference to dispensary workload in these guidelines (and the requirements of the dispensary, references and other resources required). Such inspections occur at least every two years for each licensed premises. We are not aware whether this is the case in other states and territories, and furthermore we note that the Pharmacy Board themselves do not seem to have jurisdiction or resources to undertake inspections themselves of pharmacies – and tend to operate in a notification system that is responsive towards an individual rather than a group or a pharmacy proprietorship.

CONSUMER EXPERIENCE

99. What services should a consumer expect to receive from a community pharmacist who dispenses their medicines? Why should the consumer expect these services?

The Pharmacy Board of Australia operates under the national scheme of Health Professional registration and regulation administered by AHPRA.

The Pharmacy Board's remit is to 'protect the public' and does this through managing the registrations of pharmacists as health professionals, providing guidance on what is considered to be good pharmacy practice amongst other measures.

The Pharmacy Board has produced and updates from time to time guideline documents such as '*Guidelines for Dispensing Medicines*', latest version; September 2015. These guidelines documents are available from; www.pharmacyboard.gov.au

Consumers should expect these services to ensure; appropriateness of the dispensed medicine, accuracy of the dispensed prescription in accordance with the prescriber's intentions, documentation and recording of the prescription dispensed, appropriate opportunity to impart information to the consumer regarding the medicine dispensed – specifically at least the pharmacist offering to counsel the patient or their agent.

102. In your experience, are community pharmacies generally delivering these services?

A range of recent consumer surveys have demonstrated their satisfaction with pharmacists as health professionals and pharmacies as healthcare destinations, some of which are quoted below for the panel's reference.

According to the *Roy Morgan's annual Image of Professions survey*, pharmacists are one of the most trusted professions in Australia, ranked 2nd, only behind nurses, for the last 3 consecutive years, and community's trust in pharmacists had increased over the previous 12 months¹.

According to the *Governance Institute Ethic Index 2016*, pharmacists are one of the most ethical professions, ranked 2nd (74 Ethical Net Score) amongst all other health care destinations across Australia².

According to the *Menzies-Nous Australian Health Survey*, pharmacy has the highest consumer satisfaction rating of all health care destinations. 89% of the Australians expressed the highest level of satisfaction with pharmacy as compared to General Practitioners (78%), Nurses (85%)³.

¹ Source: *Roy Morgan's annual Image of Professions survey (2014- 2016)*

² Source: *Governance Institute Ethic Index 2016*

³ Source: *The Menzies-Nous Australian Health Survey (2012)*

According to the *CFEP Patient Experience Survey*, pharmacy has the highest consumer satisfaction rating of all health care destinations. Community Pharmacy scored an average satisfaction rating of 4.62 as compared to other health care destinations like GP 4.37 and Physiotherapists 4.56⁴.

A vast majority of customers (approximately 90%) are overall satisfied with the interaction they had with their pharmacist and other pharmacy staff. Respondents indicated pharmacist knowledge and good service are the primary reasons for consumer satisfaction⁵.

Consumers responding to the CFEP patient experience survey rated their overall satisfaction with their pharmacy between “very good” and “excellent” on a 5 point rating scale. The overall patient experience continues to improve from 4.60 in 2011 to 4.63 in 2016⁶.

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

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

There are a range of different sources of consumer surveys, some of which have been quoted above.

Another consumer feedback source that may be of interest to the panel is the consumer website; ‘Product Review’ – which can be found at: www.productreview.com.au

Below is an excerpt from the ‘About Us’ section of the website;

ProductReview.com.au is Australia's first and most comprehensive consumer opinion site, online since May 2003. We provide a platform where people can rate and review services and products and the shops that sell them. It is consumer response - satisfied or not!

On this site you will find real-life experiences and opinions voiced by Australians. We provide our users with the tools to easily find the items they are interested in, read what others have said about them and share their own experiences.

There is the ability to search by franchise or pharmacy brand (amongst many other businesses or retailers). There is extensive feedback offered by consumers who have shopped at a prominent discount pharmacy brand that may be of interest to the panel.

It is important to note that whilst a pharmacy may identify as a ‘discounter’ – as a range of pharmacy brands do, the actual service standard experienced by the consumer may not be purely determined by whether the pharmacy is a ‘discounter’ or not. In saying that, there may be discernible differences between the service standards of some discounters compared to others.

⁴ Source: *CFEP Patient Experience Survey - Benchmarking*

⁵ Source: *Consumer needs full final report- National community survey (PWC 2014)*

⁶ Source: *Source: CFEP Patient Experience Survey (2011 to 2016)*

In a recent announcement on their website in April, the organisation representing employee pharmacists in an industrial relations sense, *Professional Pharmacists Australia* announced they had written to the Pharmacy Board of Australia regarding safe dispensing workloads in community pharmacy. Some of their members had expressed concern in certain instances of dispensary workload.

Our pharmacies have always been very mindful of the dispensary workload guidelines that are set out by the Pharmacy Board of Australia, and have staffed our pharmacies accordingly. Essentially, a pharmacist is suggested to be rostered on for every 150 prescriptions dispensed during a 9am-5pm period (if there is also a dispensary assistant who is assisting the pharmacist, then the guideline is; one pharmacist + one dispensary assistant for every 200 prescriptions).

There was no detail within the release whether there were certain environments or practices consistent with a particular model of pharmacy (or pharmacy brand) and this answer is not drawing any conclusions in that way. If the panel has not already approached *Professional Pharmacists Australia* on this matter, they may consider doing so.

Each year *Professional Pharmacists Australia* produce a pharmacy remuneration survey based on feedback from their members and other employee pharmacists regarding their remuneration.

The results for the 2015 Pharmacy Remuneration Survey by *Professional Pharmacists Australia* can be accessed from;

<http://www.professionalpharmacists.com.au/2015-remuneration-survey-results/>

Below is an excerpt from the results:

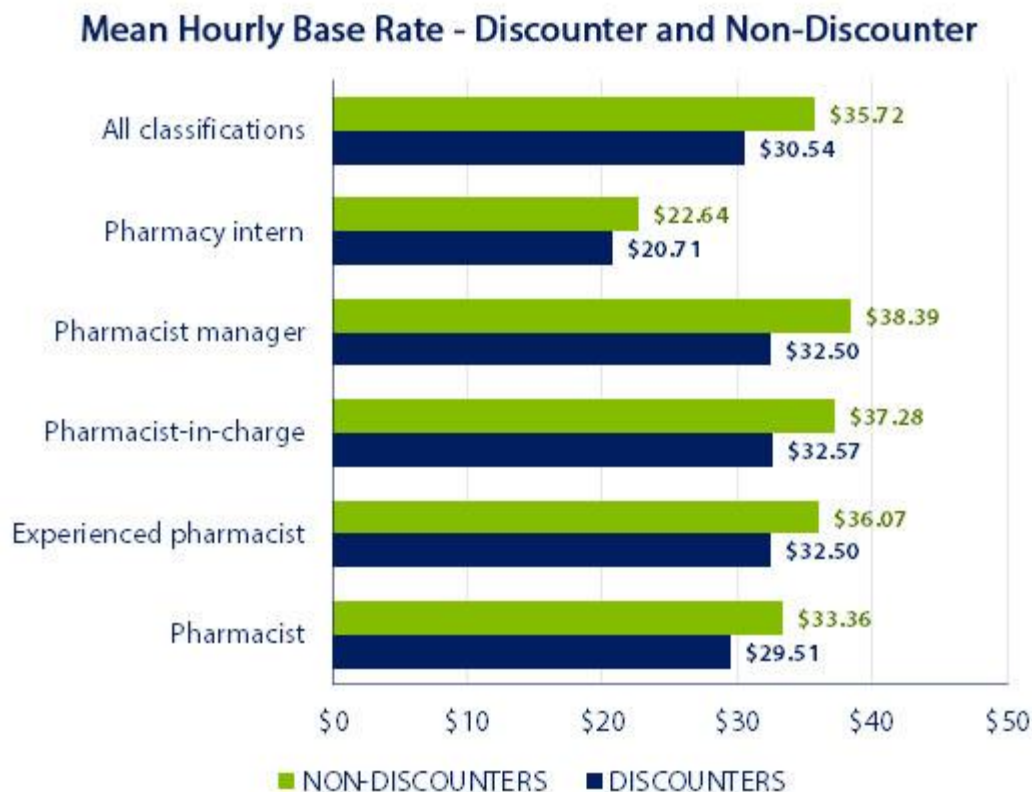
Community pharmacists that participated in the 2015 Pharmacy Remuneration Survey were asked to identify which pharmacy banner group the pharmacy they were employed by fell under.

Submissions show that the mean hourly earnings for an employee pharmacist working for the majority of banner groups was between \$33.01 – \$33.99 per hour.

Employers nominated in the survey as an 'independent pharmacy' paid an average of \$33.32 per hour.

The mean hourly rate across all classifications (the overall remuneration conditions for all positions) was above \$35 in five banner groups. None of these were discounters.

Below is a bar graph comparing mean hourly base rate for 'discounter' vs. 'non-discounter' pharmacies.



Employees from pharmacies they identified as 'discounter pharmacies' reported lower mean hourly base rates across all classifications than those that identified with 'non-discounter' pharmacies. The remuneration levels for our employee pharmacists are largely consistent with those reported for 'non-discounter' pharmacies in this survey.

Whilst this does not directly or obviously correlate with the service level from a consumer experience perspective – it may be of interest to the panel.

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?

123. Should pharmacists be able to discount the co-payment by more than one dollar if they choose to do so? Would such competition benefit or harm consumers? If competitive discounting is expanded for the co-payment, should any limits be placed on the potential discounts?

Our pharmacy feels that this policy undermines the equity of access of the PBS in national medicines policy. As explained earlier in the submission, pharmacy is a highly competitive sector in some instances offering greater value than supermarkets with non-scheduled medicines.

It also does not benefit those patients and consumers who take the most medicines, as those that reach the Safety Net are only delayed in reaching the Safety Net threshold should they choose to receive the \$1 discount.

Pharmacies and pharmacists have promoted affordability of medicines for the consumers, being an active participant in promoting generic medicines and also through PBS reform and price disclosure which is anticipated to save the Commonwealth government \$20 billion by 2020.

The \$1 discount policy has essentially been a tax on small business – in a pursuit by government to save on costs themselves, by creating further financial pressures for pharmacies to compete, especially with larger pharmacy groups or discounter groups who have chosen to lead with and offer the \$1 discount in all instances. Our pharmacy to date, has not offered the \$1 discount in all instances and done so on a discretionary basis to mitigate its financial impact.

The impacts of this policy along with other financial pressures in the community pharmacy sector have led our pharmacy to rationalise services such as; trading hours on weekdays, home delivery services and staffing levels during the week.

Cadence Economics, in conjunction with Green Square Associates, undertook a detailed fiscal and cost benefit analysis for the Pharmacy Guild of Australia. Their cost benefit analysis showed that the \$1 discount policy was likely to increase the costs of PBS outlays for the Commonwealth, as opposed to the savings it was expecting.

Their analysis also showed that the losses from the policy change were likely to outweigh the benefits (where most of the benefits were, indeed, simply transfers from pharmacists in terms of gross margins to consumers and taxpayers). This was due to declining service standards for key consumer groups such as the elderly and chronically ill as well as the increase in demand for medicines requiring higher levels of government subsidisation.

The full report is available from the below link;

<https://www.guild.org.au/docs/default-source/public-documents/issues-and-resources/pbs-copayment-discount---a-cost-benefit-appraisal.pdf?sfvrsn=0>

Below is an excerpt from the executive summary of this report:

“The losses, which are far larger, arise for two reasons.

First, even assuming demand were unchanged (and so the number of prescriptions was constant), we show that very small declines in service quality – due, for example, to a reduction in the number of pharmacies – would be sufficient to outweigh the fiscal savings (and associated reduction in the deadweight cost of taxation) that any discounting of the co-payment would yield. Both experience and economic analysis suggest such falls in service quality are likely, with the greatest adverse effects on those consumer groups – the elderly and the chronically ill – that have traditionally been at the heart of the Commonwealth’s concerns.....

Second, the reduction in the co-payment will increase demand for PBS medicines. Using conservative estimates of the extent of discounting and of the responsiveness of demand to the fall in price, we estimate that this increase in demand will eliminate any fiscal savings to the Commonwealth, instead PBS outlays will rise by somewhere between \$125 million to \$405 million over the duration of the 6CPA. While this increase in outlays is not itself a social cost, the distortion to economic activity induced by the additional taxes that are required to finance it is. Again using conservative parameters, we estimate that deadweight loss to be in the order of \$50 million to \$162 million, which is far greater than any gain in consumer surplus from the added consumption.

In short, the social costs of the policy change are likely to significantly exceed the benefits.”

Our pharmacy does not believe the \$1 discount is good policy, particularly in a backdrop (and as an offset) of potentially significant co-payment increases by the Federal government that they have been unable to have passed through the senate. We do not feel it should continue beyond 2020, and certainly should not be extended beyond \$1.

113. Are the current restrictions on the sale of schedule 2 and 3 medicines an appropriate balance between access and health and safety for consumers? If not, how could this balance be improved?

Our pharmacy supports the current medicines scheduling framework, including the classifications for *Pharmacy Medicine* and *Pharmacist Only Medicine*.

This is underpinned by appropriate oversight by the *Therapeutic Goods Administration* who as a unit of the Australian Government and Department of Health and Ageing, are responsible for administering the *Therapeutic Goods Act (1989)*. The objectives of this act is to provide a national framework for the regulation of therapeutic goods in Australia to “ensure the quality, safety and efficacy of medicines and ensure the quality, safety and performance of medical devices.”

The scheduling classifications help determine the level of public access to medicines, with the scheduling determined according to the degree of risk and the level of restriction applied to availability in order to protect public health (including acknowledging the level of professional support and intervention across the various schedules).

In other jurisdictions such as the United States that only have essentially two classifications; prescription only and non-prescription, there is no appropriate advice and support given for the sale of non-prescription medicines in outlets such as supermarkets or 'gas stations'.

Such outlets in Australia, or any jurisdiction, are not equipped, trained or appropriate to be handling medicines. One could question whether they should even be allowed to sell currently non-scheduled preparations of non-steroidal anti-inflammatory medicines such as ibuprofen which have known risks associated with cardiac or renal failure in certain instances.

Pharmacists are highly trained medicine experts, supported by pharmacy assistants who in the case of *Quality Care Pharmacy Program* accredited pharmacies have undergone specific training (and refresher training) on handling pharmacy and pharmacist only medicines.

115. Does the availability and promotion of vitamins and complementary medicines in community pharmacies influence consumer buying habits?

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

Our pharmacy believes that complementary medicine should continue to be made available at a community pharmacy.

The inference that they 'undermine health care' disregards that there are cases of evidence to support improved patient outcomes such as; Vitamin D supplementation, probiotics in digestive health, cranberry for the urinary system, St. John's Wort in mild depression, fish oil and CoEnzyme Q10 in associated high blood pressure and secondary cardiac disease. We could go on.

It would lack logic to not allow the sale of therapeutic substances (or substances that could be potentially harmful when used inappropriately or with certain medicines) from a pharmacy with a trained medicines expert being a pharmacist on duty, but allow the sale of such products from a supermarket or a health food store where a pharmacist was not available to consult the consumer.

Thank you for the opportunity in lodging a submission to the Pharmacy Remuneration and Regulation review.

Proprietors of; Casey Central Pharmacy and Pharmacy on Clyde; Carolyn Wynen, Lynette Calabrese, Chris Kelly, Zoltan Toskov and Anthony Tassone