

Owen Pharmacy Group  
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CLIFFORD GARDENS QLD 4350

13th September 2016

ATTN: Pharmacy Review Panel  
Department of Health  
GPO Box 9848  
Canberra ACT 2601

Dear Review Panel,

I am making a submission on behalf of the Owen Pharmacy Group. Our pharmacist group consists of 9 pharmacies, primarily based around the Darling Downs region in South-East Queensland. We have pharmacies in multiple banners group with the common theme being the ownership of Neil & Helen Owen and their son, Chris. These pharmacies are vital services for the country towns they are based. They are predominantly non-discount model stores but Three (3) stores are Discount Drug Store which is a pseudo-discount model. They are directly responsible for the employment of around 250 staff.

These pharmacies are listed below:

- John Duggan Amcal Chemist, Rose City Shopping World - Warwick Q 4370
- Warwick Discount Drug Store, Rose City Shopping World - Warwick Q 4370
- Lowood Advantage Pharmacy, Michel St - Lowood Q 4311
- Cains Pharmacy, Yandilla St - Pittsworth Q 4356
- Dalby Amcal Pharmacy, Dalby ShoppingWorld - Dalby Q 4405
- Terry White Chemist Highfields, Highfields Village S/C - Highfields Q 4352
- The Valley Discount Drug Store, Brunswick St - Fortitude Valley Q 4006
- Rainbow Beach Pharmacy, Rainbow Beach Rd, Rainbow Beach Q 4581
- Taree Discount Drug Store, Manning St - Taree NSW 2430

This submission is being made by the Owen Pharmacy Group's Managing Director, Christopher Owen  
- B. Pharm (Rural).

Responses:

1. Yes - I believe the ratio of Pharmacies to the population is optimal, or if anything, slightly too many pharmacies. The data I would use to support this opinion would be submission by The Pharmacy Guild of Australia, with input from Professor Henry Ergas and Professor Jonathan Pincus, to the Competition Policy Review Draft Report. It concluded, "First, pharmacies are highly accessible, both in absolute terms and relative to other services. This result holds both on a strictly geographical definition for urban and rural areas, as well as for access by elderly (less mobile) and low socio-economic communities. Moreover, the excellent accessibility of pharmacy services in regional areas does not compromise access, competition and choice in urban areas. Second, the consumer survey

data clearly shows that consumers trust their local pharmacist to deliver high quality health services and are wary of supermarkets operating pharmacies."

2. To reduce the pharmacy numbers to its optimal level, I would financially incentivise mergers or shutdowns, this would be to adequately reflect to the cost of investment to start a community pharmacy. The government has already done this in the past, funding mergers and shutdowns in the early 1990's, to reduce the funding requirements of the network. I don't believe we should be increasing pharmacy numbers, as the cost efficiency from a government point of view, is minimal service cost to outlets whilst still servicing need.

3. No other business has this restriction. So long as a pharmacy looks like a pharmacy and provides health advice. If it looks like a duck and quacks like a duck, it's probably a duck.

4. I don't believe the funding model should change dependant on the business model of pharmacy. The same requirements of dispensing a prescription are still required. If some models do have significant retail functions, that should not disadvantage them from being adequately remunerated for their technical functions.

5. The CPA process is a collaborative approach to medicines policy. Since its first iteration in 1990, it has enabled the World Leading PBS system to sustain and function whilst delivering good value for government and patients alike. The 5CPA process alone has delivered over \$1B worth of savings, which has enabled PBS listing of world first's such as Hepatitis C medications listed in March 2016. These agreements are public documents so any issues with clarity & transparency are a complete fallacy. Sustainability has been demonstrated with falling overall PBS dollars consistently since 2008 and will continue to do so (nb. this is like for like comparisons - newly Listed HIV and Hepatitis C medications have skewed FY 2016 results). Community pharmacy has never provided better value for money- for government and patients -and any further regulation in this area could have drastic consequences to this network and provide worse outcomes for patients, public health & pharmacies.

6. As above - The preferred approach would be a 7th CPA - negotiated by the Guild and Government only. The CPA process is a collaborative approach to medicines policy. Since its first iteration in 1990, it has enabled the World Leading PBS system to sustain and function whilst delivering good value for government and patients alike. The 5CPA process alone has delivered over \$1B worth of savings, which has enabled PBS listings of world first's, such as Hepatitis C medications listed in March 2016. The agreements are public documents so any issues with clarity & transparency are a complete fallacy.

7. The CPA by definition is for Community Pharmacy only. Other groups are not immune to making their own agreements. I don't believe any other stakeholders should have input into an agreement that the owners of the pharmacies providing the services (Pharmacy Guild) and the government who pay for the services (on behalf of the people). Contestability and effectiveness are proven with the resulting reports from professional programs. The administration of these programs should be tendered, providing the administrators have adequate knowledge in the field and can resolve problems specific to pharmacy practice.

8. Yes- it is entirely appropriate. The CPA by definition is for Community Pharmacy only. I don't believe any other stakeholders should have input into an agreement other than those directly impacted, (skin in the game) i.e. the owners of the community pharmacies providing the services (Pharmacy Guild) and the government who pay for the services (on behalf of the people).

9. No - I believe the current system has been very productive to both parties in terms of improving patient outcomes, providing new services, constraining costs, driving innovation and change in the sector. Since 2005, the industry has undergone radical changes and given the government in excess of \$1B in savings. I don't know how this could be a bad deal for them. One agreement for pharmaceutical services is easier to negotiate, provides more stability & doesn't drive the sector into anarchy and uncertainty. I know the bank's don't appreciate uncertainty, as the Brexit shows.

10. I believe the current system meets the needs of the NMP. Hospital pharmacies specialise in the supply of medicines and advice in a hospital pharmacy setting. They are generally big providers and policy can be implemented that is not in the good of the patient. I.e. Public hospital departments not dispensing some high cost items so it doesn't affect their budget/profitability. Public/private partnerships have always been the most cost-effective way of achieving a set of outcomes. Public institutions tend to bloat costs, i.e. Road infrastructure/IT systems. Community patients already have access to a world class system. Allowing large corporate providers into the area undermines the value of the community pharmacy model completely and is a very bad idea for sustainability of small business.

11. Yes - I believe the 6CPA achieves appropriate access to medicines as this is the primary function of the location rules. To allow every resident of our wide brown land fair and equitable access to the PBS. No clustering and over servicing. To make this even more accessible - Decrease the penalty rates on unsociable hours and constraining longer opening hours. Unlike other retailers, pharmacies have trained staff (i.e. a pharmacist) on hand at all times when open. The penalty rates are so steep compared to other markets, it is completely cost ineffective to open during these times. Raising minimum wages for pharmacists would be an adequate trade off.

12. The primary role of a pharmacist is to give the patient accurate information and advice in a timely manner. The right drug, dose & directions are critical to a patient understanding how to take their medications. Current arrangements of CMI's allow the pharmacist to give written information to follow up and confirm with the patient. There are standards in place for the provision of CMI's- when, how often, etc, Pharmacists have a professional responsibility to adhere to this. Newer technologies such as DAA's are also adding to the compliance and concordance of patients. So long as the patient gets the right drug, in the right amount at the right time, then that is all that matters.

13. Paper prescriptions still provide the best communication & best fraud protection method between doctors and pharmacist. And yes, whilst this may be inconvenient, it is the safest for medication management, and less risk of privacy & technology hacks. I believe a 'barcode only' or technology only system is fraught with danger. Privacy leaks and the issues involved with the PCEHR have already suggested that a government body, or any kind, is not ready to handle this sort of private data. The dispensing pharmacist is ultimately responsible for the correctness of the

medication. i.e. Indication, drug, dose, duration, drug form and delivery, by having an electronic only solution, you run the risk of reducing the relevance of the pharmacist in checking these parameters are correct. 'In person' consultations with paper prescriptions, with or without electronic backup, is the gold standard of patient care. Ultimately, we are advice givers not prescription factories. The risk is prescribers and large volume-driven pharmacy groups could use the introduction of digital-only prescriptions to channel patients to particular pharmacies, undermining patient choice. Australia's established system of medicine dispensing works exceptionally well and any change to this system should only be taken forward once there has been full consideration of all the of relevant issues for patients, pharmacies and the Government.

14. By NO way is pharmacy exempt from competition. Bankruptcies and receiverships are occurring in the industry at record levels, how can this mean competition isn't fierce. The cartel type chains, such as Chemist Warehouse, while great retailers, have market dominance and without a doubt, the current pharmacy market is as competitive as it ever has been. Reducing the barriers to entry will simply swell the smaller pharmacies numbers and ultimately end up in a situation like early 1990's, where governments paid for pharmacies to close down. The pharmacy industry has many business models which provide patients with price competition, choice and a high level of competitiveness. Delivery of health outcomes for the nation is what the pharmacy network should be judged on, and there is clear evidence the normal market mechanisms do not delivery a gold standard health product, in Quality or cost efficiency. A Good Quality, Fast access network is never the cheapest.



15 & 16. Ultimately, a pharmacist is responsible for the same things for every prescription. i.e. They must ensure a patient is receiving the correct drug, in the correct dose form at the right dose for the correct duration via the correct delivery route to treat the correct indication. Whether the technical function of physically dispensing the script takes less or more time is irrelevant. The appropriateness and the knowledge required for every prescription is the same. Often the counselling, concordance and follow up from a repeat prescription patient can exceed the time and technical requirements of a new patient/prescription. Also, it would be an absolute nightmare to introduce and administer a tiered approach.

17. Given the PBS reforms over the past CPA cycle and the start of this one, the income for community pharmacies I believe currently undervalues the costs associate with counselling, advice and professional services associated with dispensing. A fee for service for extensive medication counselling events, intervention counselling, primary healthcare consultation or diagnostic testing e.g. Blood pressure, etc, would more adequately reflect the work of community pharmacies. At no

point in the history of community pharmacy, have we seen so many bankruptcies and financial hardships experienced by community pharmacy. The expenses (Rent, Wages, super, etc) continue to go up while the remuneration drops and uncertainty continues (i.e. bad for banks!.)

18. Each of these add-on fees to the dispensing fee have a particular purpose. The PFDI encourages pharmacies to substitute generic medicines with the consent of the patient. The Dangerous Drug Fee and the Extemporaneous Dispensing Fee reflect the additional work entailed in dispensing these medicines. It is vitally important that any changes or rationalisation of these fees continues to recognise the additional work involved and is not used as a means to reduce the overall level of dispensing remuneration for pharmacies, which are already under severe financial pressure from PBS reforms. Further discretionary pharmacy discounting of patient co-payments would undermine the universality of the PBS and commoditise medicines, sending the wrong message to pharmacists and patients in relation to quality and price. It would mean that some patients would get a better deal than others.

19. I know firsthand the difficulty of attracting and retaining staff in rural and remote areas. The RPMA reflects the difficulties of the supply and demand cycle, on both the revenue and expenses side of the ledger. The community need argument is redundantly circular, i.e. the chicken or the egg if you will. Without community need why incentive someone to be there but the problem is geography & population is the basic premises of determining need. The RPMA is still very much relevant and required. I know you went to several rural areas on your roadshow tour. The pharmacist and pharmacies in this area care for their patients and their areas. Without the RPMA, they may simply not exist.

20. I do believe this incentive is working quite well to achieve its purpose. Anything requiring both the prescriber and dispenser to utilise technology is a good thing.

21. It is on the part of the pharmacist, but I still believe a price signal must be sent to patient. e.g. No PBS discounting could be done on originator brands. Or brands attract a \$1.50 surcharge, chargeable to the patient.

22 & 23 & 24. I don't believe government intervention into a singular issue is a great idea. The underlying issue with these drugs is there is not enough remuneration throughout the supply chain for these high cost drugs. The current remuneration regime actively discourages pharmacies from dispensing very high cost medicines because of the financial cost and risk entailed for the very low margins, which in the case of Hepatitis C are as low as 0.3% - under \$80 remuneration for a medicine without any ceiling to the cost (the most commonly prescribed Hepatitis C medicine costs the pharmacy over \$22,000). As a result, there is a real risk that pharmacies are not able to dispense these medicines, reducing patient access and diverting supply to other, potentially more expensive parts of the health system. One possible solution would be to set a cap on the amount that a pharmacy has to pay to purchase a high cost medicine based on the current ceiling for the AHL.

I have a pharmacy in Fortitude Valley in Brisbane which does 5 or 6 Hepatitis C medications a month. This is great for the local community, as the patients are not being stigmatized and have the comfort and convenience of my store to come into. The big issue for me is the cash flow implications and remuneration. I have to purchase the cost of several medium sized cars and receive then 0.3% of the total cost as gross profit. Not to mention the fact that I have to wait until the end of the month

to submit my BAS statement and claim my GST refund. This is not only stressful and cash inhibiting, but this was brought onto the community pharmacy network well after the 6CPA was negotiated. These sorts of high cost medications weren't even thought of when remuneration was being negotiated. It was a great policy but the implications and follow through weren't completely thought through.

Making matters worse, the health department actually negotiated a lower price for these medicines, but facilitated a rebate/risk share with Gilead (the makers of Harvoni) of around \$8000 per dispensing to go back into the 'General Revenue' area of the budget. Hence, the PBS looks worse as its costs are extrapolated out, but the actual costs to the government are a lot more modest. Where is the PBS modelling on actual costs!!!! This situation is an absolute joke as these rebate costs are lost to the health system, yet 'Health' bears the brunt of the political hits.

A fairer compensation (in the vicinity of 1%), minimum trading terms (>1 month) and transparent pricing system (net of rebates!!) is the only way we can continue to list this high these high cost medicines in the community system and continue the easier and fairer access to these life saving medications.

Hospital departments have many other higher priorities and believe these medicines should be fast tracked to the community system for great access by the public at large.

25. Chronic disease management such as renewing long term prescriptions, prescribing oral contraceptives, complex medication management, All vaccinations - currently provided by nurses, ordering blood tests for monitoring, simple antibiotic prescribing (i.e. Malaria prevention), A fee for service for extensive medication counselling events, intervention counselling, primary healthcare consultation or diagnostic testing e.g. Blood pressure, more adequately reflects the work in community pharmacies.

26. It is important that pharmacies recognise that they are first-and-foremost health destinations and the sale of any products that could put at risk the trust and reputation of pharmacists as health professionals is discouraged. That said, in some cases, complementary medicines can interact with prescription and OTC medicines and there are clear benefits if patients purchase complementary medicines at a location where they have ready access to expert pharmacist advice at the time and point of purchase. The onus is on the Government to have regulatory systems in place to ensure that therapeutic goods marketed in Australia are safe and efficacious.

Further, statutory registering bodies in pharmacy and Pharmacy Board of Australia guidelines provide guidance around dedicated and designated 'Professional Services Areas' to facilitate interaction with pharmacy staff and pharmacists.

27. Such 'hole in the wall' pharmacies do already exist, especially in high rent inner city areas. I believe these pharmacies are very limited in the services they can deliver due to cost and staffing constraints and as such, offer a worse health destination than community pharmacy as a whole.

28. That will be up to the market to decide whether a new model is warranted or successful.

29. It is important that the core dispensing service is appropriately remunerated as a holistic clinical service so that pharmacists are recognised for the professional review, evaluation and advice they

provide when they dispense any medicine. However there are occasions where pharmacists make clinical interventions as part of the dispensing service that entail significant additional work, which could be separately remunerated on a fee-for-service basis. For example, when a pharmacist identifies a medicine related adverse reaction or interaction requiring a conversation with the patient's doctor to modify the prescription or medicine regimen.

30 & 31. The Pharmacy Trial Program and the 6CPA cost effectiveness reviews will establish the necessary evidence base to demonstrate that services delivered through community pharmacy can result in improved clinical outcomes for consumers. Any pharmacist services remunerated through the MBS would need to demonstrate the same degree of clinical and cost-effectiveness and it would need to be recognised that MBS services are uncapped with the potential for significant funding increases unless there is appropriate targeting of service provision.

32. The Pharmacy Trial Program would be a good place to start investigations of this kind.

33. I believe the current community pharmacy model provides fair and equitable access to Australian's near and far. As showed by the Pharmacy Guild in their Geospatial analysis, community pharmacy is currently more accessible than supermarkets! The only way to improve this would alter penalty rates, or provide incentives to open longer hours.

34. For patients with chronic illness, I believe this should occur on a timeline basis, for example, HMR's for patients on more than 5 medications should be done yearly. On an acute basis, these services should be provided after the incident. Referral's should not be required for these.

35. Diagnostic testing such as simple bloods, blood pressure, pressure, cholesterol, INR and have that as either a fee for service or rebated via PBS/MBS. The reason for this is Accessibility, immediacy and reducing the burden on the bloated MBS.

37. It can be depending on an individual's personal circumstances and how they value their health. Medication co-payments have increased significantly, especially in the General patient category to a point now where most medications in that category now fall under co-payment. Although modest co-payments are considered great for rationalisation, I believe the current general threshold at \$38.30 is too high.

The above is all of my own thoughts, but I also agree with and support every response from the Pharmacy Guild of Australia's submission.

Kind Regards,

A handwritten signature in cursive script that reads "Chris Owen".

Chris Owen - B. Pharm (Rural)

**Managing Director- Owen Pharmacy Group**