

- 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?*
- 4. Should Government funding take into account the business model of the pharmacy when determining remuneration, recognising that some businesses receive significant revenue from retail activities?*

If we were to go down the aforementioned path, I feel that as many pharmacies now receive a large portion of their revenue from the front of store, there would need to be sufficient funding provided through new clinical services that would take place in the newly allocated space. The number and variety of services would need to be increased, and funding available more readily (rather than the current setup of quarterly submissions through 6CPA), with some form of appointment structure established, rather than the current walk-in-for-free-advice setup that currently applies in community pharmacy.

- 5. Is the CPA process consistent with the National Medicines Policy? Is it consistent with the long term sustainability and affordability of the PBS? Is it consistent with good government practice in terms of value for money (for both patients and taxpayers), clarity, transparency and sustainability?*
- 6. What would be a preferable approach? Why would this be preferable? In particular why would this lead to better value for money and better meet the objectives of the NMP?*

The CPA process is consistent with the National Medicines Policy, and is sustainable in line with PBS Price disclosure, as long as payments and amounts are made more readily available to both pharmacies and the public. Currently funding is distributed based on the number of services carried out in a particular LHD as well as the number of services carried out. This amount can vary quarter to quarter, making it difficult for businesses to manage their cash flow.

With the increased amount of services required to adequately counteract PBS Price disclosure, and potential removal of sales floor space, the breakdown of provision of funds based on services needs to be more descript, and more readily accessible by community pharmacies.

- 10. Is the current system of dispensing of medicines in Australia, that focuses predominantly on community pharmacies operating as small businesses, the best way to achieve the objectives of the NMP? Should there be alternative approaches for the dispensing of PBS medicines beyond a community pharmacy, such as through hospitals or different pharmacy*

The current system is well entrenched in our culture, so any drastic changes would undoubtedly have an impact on both patients and pharmacies as a small business. Patients require continued supply of many medications, so having a hospital supply these, even initially, would be both cumbersome for hospital pharmacy staff, taking them away from other clinical services required of them on the ward, and would leave a great gap in the link to community pharmacies. Thorough discharge clinic and follow up style appointments, similar to a GP consult would need to be implemented in order to ensure ongoing patient care.

13. Is this requirement a significant impediment to online ordering and remote dispensing? If so, should this impediment be removed? In this scenario, what compensating arrangements would need to be implemented to ensure that there is appropriate oversight and control over dispensing and patient choice of pharmacy?

Yes I believe that it is. Pharmacy as an industry that sometimes struggle to keep up with advancing technology. While online ordering is something else, I feel that having the ability to provide medications via some form of secured email form from say a GP or a hospital would hasten the speed and ability for patients access medications. Funding would be allocated according to dispensed medications similar to how it is done at the moment with paper prescriptions.

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?

A tiered structure could well be beneficial, as more information and counselling is usually required on the first dispensing of a product, ergo more time is spent with the patient. Again though, I feel this requires an appointment, similar to a GP appointment, as some patients may be in a rush and not willing to go through all the required information that needs to be conveyed.

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?

Disparity in pricing implies that corners can be cut and that not all patients are receiving the counselling and information required as per the pharmacists' code of conduct. I feel that an even playing field should exist, so as to not place pressure on independent pharmacies that may not be able to burden the cost that some larger chains may choose to sacrifice in their margins, and use this as a promotional tool for their business. Similar circumstances have presented themselves with the \$1 discount structure.

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

23. Are there better ways of achieving patient access to very high cost medicines through community pharmacy that reduce the financial risks to the supply chain and facilitate consumer choice?

This must change, and soon. The turnaround time can be as little as 25 days until payment is due. A small business cannot afford to put out so much money in such a short period of time, and with very little to gain out of it. The GST claiming alone is enough to disrupt a pharmacy's cashflow significantly. I believe an extended period for payment of such items as well as a higher payment fee may help this process.

--

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?

28. More generally, is there a need for new business models in pharmacy? If so, what would such a model look like and how would it lead to better health outcomes?

There are many areas that pharmacists could provide services for including: wound care and dressing; INR dose adjustments and counselling services: Heart health reviews incl BP and cholesterol checks. These are all clinics that could be set up in the pharmacy through an appointment like structure, and remunerated appropriately for the time and service provided.

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?

This is similar to how the 6CPA currently funds Medschecks and Diabetes MedsChecks. the review with more work required is paid at a higher rate. Such a system seems to work well at this stage and could be expanded to incorporate other professional services.

32. What are appropriate ways for pharmacies to identify and supply the health services most needed by their local communities?

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

I feel that a closer link is required between hospital discharges and the community pharmacy, hence having pharmacists in GP surgeries and in close contact with hospital pharmacists. Such relationships will aid the identification of patients whom are high risk and could benefit from our clinical services.

From a location sense, I think access to community pharmacy services is more than adequate. The problem lies in (a) identifying the patients that could most benefit from services more readily and (b) changing people's perceptions in the community of what we as pharmacists can offer for their healthcare and overall wellbeing.

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?

I feel that rather than restriction of HMR numbers due to funding, the service should be opened up to more candidates, as posed in the aforementioned question. If funding is being cut from PBS Ethicals, can it not be redirected into services that we will structure our new models around? Appointments can be made, and services could be paid through swiping the patients' medicare card. Depending on the service, perhaps there is also a patient contribution.

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?

In short, no. Innovation is purely driven by individual owners and their employees. Large chains will only develop processes for their stores for the firmly established 6CPA programs, and to my knowledge, the current model does not allow for any funding or grants for individually developed service models.

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? Why and for what reasons?

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?

Access to medicines in suburban areas is already readily available, with extended opening hours prevalent. Furthermore, the PBS cuts have ensured that prices remain as competitive as possible, and increased supplier numbers would not really affect prices for consumers. In terms of rural locations, as stated in the review, access to pharmacies is already greater than that of many other services in these areas. Furthermore, rural pharmacies often have allocated services and charters to ensure isolated communities also have access to vital medicines. These are services provided by individuals in (rightly) protected industry who know the importance of being able to provide these medicines for their patients; a quality that may well be lost should the location rules and ownership laws be altered.

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

While I understand its purpose, the short distance location rule has been manipulated to the benefit of some. Eg) Chemist Warehouse in Toowong Brisbane has moved its location multiple times over the past few years, now finally moving in directly adjacent to Discount Drug Stores Toowong (also the head office location of the franchise), in the building which they have purchased (one can only speculate as to the intent of the new landlords). This blatant bullying is the result of such manipulation of said regulations.

51. Should an approved pharmacy operating in an area for which the pharmacy location rules preclude the operation of a second pharmacy be required to provide a minimum level of services in addition to the dispensing of PBS medicines? Should such pharmacies also be required to maintain minimum opening hours in addition to those typically offered by community pharmacy?

If the purpose of changing the locations rules is to increase access to medicines and services, and this is a proposed method to maintain those location and exclusivity rules, then I support such measures.

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?

Due to the clinical nature of pharmacy, and the focus on services that the industry seems to be heading towards, I feel access to pharmacies via a supermarket only diminishes the image that we should be working so hard to create. Patients would quite obviously drop scripts off, and head to do their shopping, with little or no desire/time to enlist in the services we are offering.

54. Could hospital pharmacies complement medicine dispensing and related services currently provided through community pharmacy or other public and private hospital pharmacies?

Having an integrated system to allow a hospital d/c medication order become a valid script for community pharmacy so it is ready when pt goes to their community pharmacy - very helpful for Webster Pack patients

55. If pharmacies operating out of private hospitals were required to operate 24-hours a day, would this be beneficial for consumer access? Would it be viable or economical for private hospitals to provide this service?

Only be viable if it had an ED department. Private hosp have scheduled procedures and planned d/c. Would only be viable for 24/7 access to medication in the public system for meds such as antibiotics where therapy cannot be delayed.

57. If hospital pharmacies were able to complement the services provided by community pharmacy, should all pharmacies be able to access similar purchasing arrangements?

No, public hospitals are not for profit and making a loss on certain medications that are eg: SAS or non PBS but hosp funded are not issues a hosp pharmacy would raise as long as it is in the best interest of the pt.

Pharmacy chains and independent pharmacies should be responsible for their own purchasing arrangements,

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?

No, seems unethical to favour certain pharmacies as part of a contract.

There's already plenty of competition in the community for pharmacies, I don't believe private hosp pharmacy operating outside of their hosp premise would be advantageous for the pt.

59. Should hospital pharmacies be able to establish limited dispensing arrangements, either in-pharmacy or through a delivery or mail order service, to enable post-discharge services and continuity of care to patients in the community setting?

Yes, especially for rural locations. Also be helpful for elderly or disabled pt until community can be formally arranged

60. Could dispensing arrangements by hospital pharmacies to patients be extended to the broader community to complement access to medicines through community pharmacy?

Yes, mainly higher costs SAS drugs. Hosp pharmacy should be able to send stock to the pts nominated pharmacy for them to supply as per script rather than coming to the hosp pharmacy where issues such as parking and distance from home can be an issues.

89. The Review Panel notes that state and territory governments already tender for the supply of medicines to public hospitals, should the Commonwealth and state and territory governments work together for a single tendering model for relevant public

hospitals and community pharmacy in the relevant state? If so, should it be for all medicines or specific medicines (e.g. biosimilar or generic medicines)?

Having worked in hospital, the tendering system has always worked well there, with guaranteed supply, and compensation should the manufacturer go OOS. With pressure building on CSOs, perhaps this route would provide better, more sustained and direct access to medicines for community pharmacies and patients alike.

91. Are there any existing regulatory arrangements that are unnecessary or overly burdensome?

Currently, the process of receiving and filing paper prescriptions is outdated in our modern world. New legislation surround eScripts needs to be mandated and regulated in order to bring pharmacy up with other professions.

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?

While pharmacies can individually advertise what services they provide, I feel that the overall image of what pharmacy as an industry provides needs to change. With this perception shift, consumers will actively seek the services that we offer, and we will be in a better position to promote these services.

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

Overall, I would say yes they are. Not all locations will, but any bannered pharmacies will, and any independents who wish to remain relevant and competitive should also be actively participating.

103. Are there currently some programs that are viewed as additional to dispensing which should be included as part of the service provided by a pharmacist when a prescription medicine is dispensed (for example, a medicines check or review)? If so, how should pharmacists be remunerated for providing these services? Should such services be included each time a prescription is filled or should 'initial' and 'repeat' prescription dispensing involve different services?

If we were include programs such as a basic meds check into dispensing, I feel that the fee provided to us would have to be appropriately calculated. Doing MedsCheck on all scripts would also increase customer wait time, and a meds check is not something that every person wants or needs. I do feel that there should be extra consultation on initial prescriptions , and therefore a higher fee paid. This financial incentive would also ensure that the customer is receiving quality medical advice each time they commence a new medication.

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

There is a difference in standards between different pharmacies, not necessarily different models. In fact, I believe the strict procedural nature of some chains make them a more accessible platform for a variety of services, compared to some stand alone stores.

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

I believe that discount pharmacies are often busier than non discount pharmacies, and unfortunately, pressures placed upon staff mean a lower level of service. However, speaking as an owner of a discount model pharmacy (recently converted from an independent), I believe that we offer the same, if not an increased level of service to our customers since the change

106. How do we measure the quality of services provided by the pharmacy?

Customer experience, number of available services, counselling and time taken on provision of new medications

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?

In short, no, It does not increase accessibility to medicines at all in urban based areas. I cannot speak for rural pharmacies, although looking at the CTG scheme, which has significant discounts for those patients, the program has failed to increase patient outcomes.

I feel the implementation has not been successful, as it has only further divided the pharmacy industry, with some places offering the discount and others not. This does not encourage further services within the industry, nor does it create uniformity. Consumers are unsure what to expect when they go from pharmacy to pharmacy, and small business are worried about how to protect their margins. I feel if the \$1 discount was to be implemented, it should be done across the board, therefore ensuring uniformity across the industry.

112. In your experience, do community pharmacists provide appropriate advice for schedule 2 and 3 medicines?

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?

114. Is the sale of schedule 2 and 3 medicines an important contributor to the income of community pharmacies?

Speaking as a supplier, I can say that we do provide appropriate advice and service. I can also say, travelling across the country and venturing into other pharmacies, this is largely the case everywhere. I believe that with the extended opening hours that many pharmacies provide, the level of accessibility is more than adequate. I also feel that professional advice is required on many of these products so yes the balance is adequate. Finally, with the professional advice provided, I think (rightly so) that S2 and S3 medicines make up a significant portion of income for community pharmacies.

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?

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

In short, yes the availability of these products undoubtedly will influence buying habits. And yes, many do not have substantiated clinical evidence. However, vitamin sales are a huge aspect of the retail sector, and consumers have the right to choice. The issue with many of these vitamins is that they can interact with other medications that the patient is taking. Having these vitamin in store allows the pharmacist to assess the patient and determine if there may be any clinical reason why the consumers' choice of vitamins may be inappropriate for their conditions. Consumers will definitely benefit from a pharmacist's intervention at this point. Restricting the availability of these items will only encourage consumers to make their purchases elsewhere, increasing the potential for drug interactions and misadventures.

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?

Opening up the co-payment discount further will not only increase the disparity between pharmacies, it will also simply encourage people to go to big discounters who can afford to absorb the cost of such discounts. Service and professional health care will be reduced in such settings due to extremely high volumes of scripts, ergo not providing any health benefit to the consumer, and placing increased pressure on smaller independent pharmacies.

131. What can be done to increase public awareness of available pharmacy programs and services, particularly specialist services?

The Guild has done well in the promotion "Ask Your Pharmacist," in promoting our extended value. However, I feel a more specific campaign focussing on our professional services, detailing some of the things that we can do, would be of great benefit in changing the public's perception of our role.

133. It is the Panel's understanding that the additional \$20 payable for infusions compounded by TGA licensed compounders is remuneration for the cost of gaining and holding the TGA licence. Should the PBS provide additional remuneration for compounders that meet TGA licensing requirements?

134. It is unclear to the Panel that there is any therapeutic difference between chemotherapy medicines provided by TGA licenced compounders and non-TGA licensed compounders. Is there any therapeutic difference, if so, what are they? If there are no therapeutic differences, should the payment of chemotherapy compounding be the same regardless of whether the provider is TGA licensed? If there are therapeutic differences, why should the Government continue to subsidise sub-optimal medicine?

Chemotherapy is considered a high risk drug with specific handling and storage requirements. It would also be mostly compounded IV therefore it's imperative that the product is made under sterile conditions. If a facility is non TGA licenced, what standard are they following? Its in the best interest for pts and the gov to support and only endorse TGA facilities to ensure a standard is maintained. This can affect product stability, bioavailability etc

135. Are the two compounding fees (\$60 for TGA licensed, \$40 for non-TGA licensed) reflecting a supply guarantee?

No, the chemo drug itself is still purchased through a wholesaler

136. If it is appropriate to have differential payments for chemotherapy compounders, what is the best way for those payments to be made? What should form the basis of the difference of the payment?

Hard to say how the payments should be made as compounded chemo may include non PBS. Maybe PBS for most drugs and a separate form for non PBS?

138. Should non-TGA licensed public hospitals be allowed to provide chemotherapy compounding services to other public and private hospitals?

Yes, as maybe the only exception to the rule. Cases of chemo may be urgent and waiting for next business hours may result in adverse outcomes for the pt.

139. Chemotherapy patients benefit from the ability of local chemotherapy manufacturing facilities to provide more timely medications to patients locally. These facilities generally do not hold a TGA licence. Is there a need for additional standards for non-TGA licensed compounders?

Yes, as also mentioned above. Chemo being a high risk drug should have stricter licencing rules.

140. Are there other issues with the production and delivery of chemotherapy medicines which the Panel should be aware of?

Personally no. Working in a cancer therapy centre, we've never had an issue with pt access to therapy with the exception to public holidays as we do not have a compounding facility. In these instances, oral chemo would be an option to replace IV if possible, or the pt gets referred to a larger hosp for chemo as an inpatient rather than an outpatient.

Scott Walters