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

Yes, the ratio is optimal. We have a similar number of “Persons per Pharmacy” to other international markets such as Canada and the United Kingdom (and a better ratio than countries with more deregulated markets such as the United States and New Zealand), and the spread of pharmacies by state roughly matches the population. This data is sourced from the Review paper.

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?

No. The retail space still has value to the consumer and forms a core part of community pharmacy. Pharmacists are available for consult on a number of categories within their area of expertise including vitamins. Having said that, we see no problem with limiting retail space for certain categories unrelated to health (e.g. household items); in fact we firmly believe that a pharmacy should be a health and wellbeing destination and should only retail products that reflect that vision.

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?

No. However if the retail activities are unrelated to health, then we are open to a reduced funding model on that basis.

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?

We believe the CPA process is good value for money for the patients and taxpayers. Pharmacists typically deliver a lot more services than they are paid to deliver. Sustainability is less certain as price disclosure erodes dispensary margins, so we rely on the CPA to deliver income in other areas to keep pharmacies viable.

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?

We believe this is the best approach.

7. Should the CPA be limited to dispensing and professional programs provided by community pharmacy only? If so, how can contestability and effectiveness be ensured in professional programs? If not, why not?

The CPA should limit to dispensing by community pharmacy, but we are open to professional programs being available outside of community pharmacy.

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 the best available body to represent our industry’s interests, and the government is the best body to represent the patient’s interest.
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. This would place too much power in the hands of too few (big pharmacy groups) and erode patient confidence that they will receive a high standard of care regardless of which pharmacy they choose.

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 arrangements? If so, what could these alternative approaches look like?

Yes – this is the best system. Community pharmacists are consistently considered the most accessible healthcare professional available to the public and our view is that this is due to the small business model. Hospitals are few and far between, making them far less accessible than your local pharmacy. A general practitioner being involved (such as in a shared GP/pharmacist dispensing model) raises the question of conflict of interest between prescribing and dispensing.

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?

Yes – we are not aware of any issues around patient access to medicines.

12. Do current arrangements under the 6CPA lead to the appropriate creation and distribution of information relating to the use of medicines? If so, how and why? If not, why not and how could the distribution of this information be improved?

Yes, however there needs to be more incentive financially for pharmacists to focus more on information delivery instead of dispensing activities. Right now there is no incentive (beyond our good intentions) of going into in-depth counselling with a patient.

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?

We would need more information on how another system might work. We would need to be certain of the legitimacy of the prescription, however it arrives to us. Online ordering is a tricky subject as it has the potential to make the pharmacist less accessible for advice. There is also an issue of patient safety when considering online ordering of drugs— the WHO estimates that “50% of the drugs for sale on the internet are fake... even though the online dispensaries might look legitimate”

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?

Pharmacy is unlike a standard retail business in many ways, and we form an integral part of the community. The competition in the pharmacy market is already extremely fierce, and without certain protective factors we risk slipping into a monopoly or duopoly controlling the pharmacy

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TagsDrug therapy

2 Rise in online pharmacies sees counterfeit drugs go global. Clark, Fiona.The Lancet , Volume 386 , Issue 10001 , 1327 - 1328
sector, which we believe would result in worse outcomes for patients. Any change to this legislation also needs to consider the fact that many proprietors have borrowed significant amounts from lending institutions and rely on these location rules to ensure they have enough business to meet their repayments. If this were to change, significant compensation would need to be paid to existing owners. In contrast to disruptions occurring in other industries (e.g. Uber in the taxi industry) in which market forces lead to a better deal for consumers, we fear that disruption and deregulation would deterioration of patient care as outlined above.

15. Is the ‘swings and roundabouts’ approach to remunerating pharmacists for dispensing appropriate? Does it lead to undesirable incentives?
It is not ideal, as pharmacists are forced to focus on processing as many scripts as possible under the flat-rate system “churning out scripts”. Ideally remuneration should be linked to other aspects of patient care including counselling and professional services. We would be open to another system being developed.

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?
Yes. The first dispensing of a new script presents the greatest risk of error (possibilities of different dose, different strength, new medication, transcribing errors, need to review contraindications) and as such is more demanding of the pharmacist’s time to ensure the medication is safe and appropriate for the patient. There is also a much higher chance the patient will need counselling on how to take the medication appropriately. Repeat scripts are often much faster to dispense and process and patients often have fewer questions.

17. Are the current fees and charges associated with the dispensing of medicine appropriate? In particular, do they provide appropriate remuneration for community pharmacists? Do they provide appropriate incentives for community pharmacists to provide the professional services, such as the provision of medicine advice, associated with dispensing?
If they remain at this level, it is manageable, however if they drop much further it will be unviable.

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?
Community pharmacists should not be involved in discounting PBS pricing – this commoditises our services and devalues our products, while at the same time creating inequity in access to PBS medicines between demographics.

19. Is the RPMA the best way to encourage pharmacies in locations where they would not otherwise be viable? Is community need a more appropriate measure than geographical location?
The RPMA is the most suitable way we can think of to reimburse rural pharmacies.

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?
The Premium Free Dispensing Fee does not really achieve its aim – there are enough other reasons to use generic medications.
22. Should the timeframes for payment settlements for very high cost medicines be lengthened throughout the supply chain and mandated by Government?
We believe the timeframes have now been adjusted and are happy with them at present.

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?
Services pharmacists can offer include screening for conditions (e.g. iron deficiency), testing and reviewing of chronic disease (e.g. HbA1c for diabetes) and medication reviews. The restrictions around HMRs being conducted by accredited pharmacies are overly burdensome – it is too costly and time consuming to become registered.

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?
We are open to the idea of certain products being restricted (non-medicinal) however we think community pharmacy is a great place to get advice on all medicinal products and should therefore offer them for sale. Judging products by the amount of evidence available can be a slippery slope; the gold standard of a double-blind randomised controlled trial does not exist for a large number of complementary products yet that does not rule out their benefit either. If consumers are going to take these products, we feel that pharmacy is the best place to ensure they do so in the most informed manner possible. Whilst products such as toilet paper or detergent may have no place in a pharmacy, general wellbeing items such as hair and skin care products, gastrointestinal products, wound care items and other similar therapeutic goods should be readily available.

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?
We believe removing retail items would shift the burden onto another retailer to provide these items – however this other retailer will not necessarily have the level of skill and expertise to ensure the products are taken safely.

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?
Yes – there is a need for a new pharmacy business model. The current trend of discounting and price wars is a race to the bottom. The newer model must focus on patient care first and foremost, not a volume of sales model.

29. Is it appropriate that the PBS links the remuneration for the provisions of professional advice to the sale of medicines?
It would be better to shift the focus of remuneration towards services rather than for dispensing. We could separate the pharmacy payments into PBS payments and an MBS payment for time spent with the patient giving advice/performing services.

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?
Yes – currently pharmacists are incentivised to spend more time dispensing and time with patients often comes at a financial loss.

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?
Strict standards and auditing should be considered to ensure pharmacists won’t take advantage of the system. Payment should be related to the complexity of the medication and advice given.

32. What are appropriate ways for pharmacies to identify and supply the health services most needed by their local communities?
We believe there should be a minimum standard of health services provided by pharmacies in a demographic, to cover the most common needs. Other services provided are best left to consumer demand; as conditions rise in prominence (e.g. sleep apnoea awareness) then the business side of pharmacy develops to mirror it. If the government considers one condition a priority in a certain demographic, then the government can make a case to the pharmacies to support a particular health initiative, on a case-by-case basis.

33. Are pharmacy services accessible for all consumers under the current community pharmacy model? If not, how could pharmacy services be made more accessible?
Perhaps a government website could be set up (in conjunction with pharmacies) with a searchable function to determine the nearest access point is various services based on a postcode.

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?
Services should be evidence based. All patients should be entitled to an annual HMR (with less restrictions on who can perform a HMR – the current restrictions are overly restrictive and burdensome). Extra HMR’s could then be allocated based on health events as mentioned. They should not require a medical practitioner.

35. Are there non-medicine-related services that pharmacists can or should provide to consumers due to their expertise as pharmacists or for other reasons (e.g. consumer ease of access to community pharmacies)? If so, why are these services best provided by community pharmacy?
Yes – “mini clinics” and minor ailment schemes have been run in overseas countries and are a great way for pharmacists to take the load off general practice. Pharmacists should have prescribing rights for common low-risk items.

36. Is cost a barrier to accessing worthwhile health services offered by pharmacy?
Yes – patients seem unwilling to pay for services out of their own pocket.

37. If particular health services were deemed to be of clinical value and delivered good patient outcomes, what other mechanisms could allow these programs to be disseminated around the country to relevant communities and groups on an affordable basis?
Government funding would make pharmacy services much more attractive and cost-effective for patients.

38. Should both direct consumer remuneration and government-based remuneration be applied for particular services or access arrangements?
Sometimes – it depends on the program and whether it is evidence based and rigorous enough to attract government funding.

39. What pharmacy services should be fully or partially PBS funded and what is best left to market or jurisdiction demands?
We believe services that use pharmacists’ skills and training that reduce hospitalisations and improve patient quality of life should be funded (as long as they make a significant impact). These include MedsChecks and HMRs, as well as other disease state management programs we could be running. Other more trivial tests and services could be on a patient funded basis.
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?

There is very little innovation in pharmacy – perhaps due to it being a highly regulated industry and having an elderly clientele. We believe that the industry should be moving towards innovative improvements and that there should be greater scope to reward experimenting.

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?

We see the location rules as non-negotiable. The pharmacists have paid a premium to buy into these pharmacies due to government regulation, and as a result have loan commitments they must meet based on this. To open the market up to competition would destroy many pharmacies and cause widespread inability to meet bank loan repayments. Patients would initially have greater access to medicines but once these countless pharmacies go bankrupt, the market would consolidate into a few large chains who will then have an oligopoly and market prices would rise again. There would be no net gain to the patient. We would consider sacrificing the ownership rules if necessary but we feel the location rules are absolutely necessary.

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?

As above.

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

As above.

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?

As above.

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

The short distance rule needs to be adjusted to prevent pharmacies from creeping into a different area. Smaller relocations are fine in our view. It has been our experience that pharmacies have been deliberately purchased in an undesirable location, and gradually relocated several times into a neighbouring community with a “better” location. This can lead to clumping of pharmacies in certain areas and is against the spirit of the location rules.

49. It has been suggested to the Review that pharmacies should be allowed to enter new locations subject to the payment of an appropriate approval fee to Government to prevent excessive entry to the pharmacy market. Any pharmacy then having been competitively impacted by a new entrant, or who would prefer to exit the market, would be able to receive compensation for surrender of its own approval number. Would such an approach be desirable or undesirable?

This is very undesirable – pharmacy locations should not be determined by whether their competitors can afford to pay government fees in order to ‘get around’ regulations.

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.
It is correct that location rules increase the profitability of pharmacies – however this is the deal that many pharmacies have entered into with the government in the first place, and now rely on. Removing this now would cause considerable hardship as outlined in point 42.

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

52. **The current pharmacy location rules do not preclude a pharmacist from operating more than one pharmacy within a particular area. To the extent that this may allow an approved pharmacist to restrict local competition by opening a second pharmacy in the same area, should the rules be amended to restrict choice and value for money for consumers?**
   
   The rules should be amended – this is undesirable.

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?**
   
   This is undesirable – do you want your health looked after by a corporation that also retails cigarettes and liquor? There are certainly issues around conflict of interest and oligopolies. Supermarkets cannot deliver the patient care that pharmacies are known for.

54. **Could hospital pharmacies complement medicine dispensing and related services currently provided through community pharmacy or other public and private hospital pharmacies?**
   
   No they cannot. Hospital pharmacists do not build up the same rapport that community pharmacists often build up with their patients over many years, and thus do not have the same ability to impart change on the patient’s behaviour. In addition, a patient’s medication often fluctuates and changes whilst in hospital, and is only stabilised upon release. Thus conducting a medication review or similar service with the patient during their stay would have limited benefit as the patient might feel overwhelmed with the changes and uncomfortable in a foreign and often stressful environment.

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?**
   
   This could be a valuable service however we are unable to say if it is viable.

56. **How might broadening the services provided by hospital pharmacies improve consumer access in rural and regional Australia?**
   
   This is possibly an option to increase consumer access for rural and remote areas.

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?**
   
   Hospitals should not be able to form partnerships with individual pharmacies – this leaves too much power in too few hands.

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?**
   
   No – unless the area is determined to be under-serviced. Patients are better off liaising with their community pharmacist.

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

90. Are there any other regulatory arrangements that should be introduced to promote high standards of delivery and accountability amongst pharmacies, wholesalers, manufacturers and other entities receiving funding under the PBS?

Pharmacist’s minimum wage must be increased to promote higher standards of delivery and accountability. The presentation and pharmacist involvement should be assessed for each pharmacy to determine their eligibility for payment. There should be much stronger expectations on minimum service requirements for each community pharmacy.

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

Accreditation for pharmacists to perform HMRs

92. What data is already available in pharmacy and other parts of the health system that could be used to inform the monitoring and assessment of standards of delivery and health outcomes? How might a patient’s existing My Health Record be used to support this?

Dispensary Data should automatically upload to the myHealth record. More data needs to be captured to support the increase of pharmacy services.

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?

No, consumers are not aware.

96. If they are not receiving the relevant service, do consumers know the avenues for feedback or complaint? Are these feedback mechanisms adequate or should they be improved? If so, are there ways of using technology to provide better feedback?

There are not adequate avenues of feedback that we know of.

97. Is the ability for the consumer to choose their pharmacist, and change pharmacists if they are dissatisfied, the appropriate or best mechanism to provide feedback?

This is important for the patient to be able to change pharmacists however that pharmacist is often not given that feedback that they caused a patient to leave their pharmacy, which is unfortunate.

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?

Dispensing of Medications – Yes. Delivery of services – No. Whilst there are standards for the services they are not widely followed.

100. What are the minimum services that consumers expect (and should receive) at the time of dispensing? Do these differ between initial and repeat prescriptions? Are these services being provided by all pharmacies?

Perhaps patients should receive a mandatory medicine review every X number of months for repeat prescriptions. If we go down the line of increasing government funding for initial prescriptions, a condition could be that there is an expectation of a consultation with the pharmacist giving the patient the opportunity to seek advice.

101. What does ‘transparently cost effective’ mean for consumers in the context of remunerated pharmacy services?

Transparently cost effective means that the program should be shown to be value for money – i.e. by reducing other costs and improving the patient’s quality of life by some demonstrable mean.

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

Pharmacies are generally delivering these services but not to the higher standards that we need to be – in many cases the dispensary workload (processing scripts) is high and there is not enough investment (and reimbursement) to perform these other services.
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?
Compulsory medicine reviews as per point 100.

104. Is there a variation in service standards between different pharmacy models?
Yes. Pharmacies that work to a ‘discount’ model rely heavily on a lower labour cost that the market average, and this could reasonably be expected to produce a less satisfied workforce (and less discretionary effort on behalf of the pharmacists, from our experience in the industry and discussions with former employees at discount stores), resulting in a lower standard of patient care.

105. Do community pharmacies that offer discount medicines provide lower levels of service? If so, what evidence is there available to support this?
Yes. You can wander the aisles of a discount chemist and because they are so focused on lower wage expenditure, you will be hard-pressed to find staff to advise you on medication and supplements. This leads to people self-selecting and making more medication errors. You also have a much longer waiting time for a script (up to 40 minutes) as opposed to a professional services pharmacy having a lower waiting time (around 10 minutes). Staff are also paid a lower rate and this translates to a poor work ethic/morale and less discretionary effort in regard to patient care. Patients are also conditioned to look for the lowest price instead of the best result for their health, and it encourages wasteful and unnecessary consumption of retail products to drive sales volume (with less regard to whether the patient needs the product). The evidence is only from first-hand and second-hand experience but it should not be hard to confirm with a survey performed.

106. How do we measure the level of service provided by the pharmacy?
At the moment there is no measure of the quality of health services provided.

107. What do consumers expect from community pharmacy in relation to their medicines?
Patients expect their medications to be accurately dispensed in a timely manner, at a fair price, and they want advice if necessary.

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?
No, and no. It is mandatory to accept the $1 discount if you want to remain competitive in the market with discounters, and all it has done is cost all pharmacies involved a lot of money. Patients do not understand the complexity of the PBS safety net and what it means to take the discount. If the government wants to control the PBS cost, they should go about it in a non-discriminatory manner. All the $1 discount has done is create confusion for patients, and wasted time and money for pharmacists.

109. What examples can you provide of variation in prices for regular PBS prescriptions?
Many items have a government determined price of around $15-20 if you follow the recommended mark-ups – however discounters sell these same medications for $6 in many cases. There is a wide variation in PBS pricing and therefore the perception that the ‘regular’ PBS price is ripping off consumers, when in fact it has been determined that this is the fair price for the work involved in dispensing the medication safely and effectively.

110. How informed are consumers of the scope of medicines and related services that can be provided by pharmacists without referral to a General Practitioner?
Consumers are not at all informed.
Review of Pharmacy Remuneration and Regulation
Submission #113; 20-Sep-2016; Small Pharmacy Group

111. To what degree do current advertising restrictions limit the ability of pharmacies to promote medicines and related services available to consumers?
The current regulations could be relaxed a little bit. As an example, our pharmacies have wished to advertise on TV a number of health services that would have had a widespread positive impact on the community by screening for diseases such as diabetes, stroke risk, and COPD. The goal was to help diagnose these patients earlier and reduce the burden of late-stage disease. We had many setbacks in getting this TV commercial to market due to concerns that we were breaching government regulations around “encouraging a potentially unnecessary health service” – that eventually we gave up.

112. In your experience, do community pharmacists provide appropriate advice for schedule 2 and 3 medicines?
This varies greatly depending on the pharmacy. We support a model of pharmacy where pharmacists are not tied down to the dispensary with financial burdens to dispense scripts and are encouraged to roam the aisles of the stores giving advice and recommending schedule 2 products. Schedule 3 products sales need greater involvement with a pharmacist. It is far too common that pharmacists are simply flashed a product box by an assistant, and the pharmacist will nod his approval that the customer can take the medication without raising any questions about it. However the current burden of dispensing often puts the pharmacist in a position where they feel they don’t have time in their workload to give proper advice regarding Schedule 3 products – we believe this needs to change.

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?
Yes, this is a safe balance.

114. Is the sale of schedule 2 and 3 medicines an important contributor to the income of community pharmacies?
Yes, they are important to pharmacy.

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

116. Should complementary products be available at a community pharmacy, or does this create a conflict of interest for pharmacists and undermine health care?
They should be sold in pharmacy – this gives the patient the ability to seek advice on the product, which we are more trained for than any other retailer.

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?
Consumers appreciate the convenience and the advice.

118. Does the ‘retail environment’ within which community pharmacy operates detract from health care objectives?
Only if the retail side of the pharmacy expands too greatly at the expense of the dispensary. Both are necessary components of pharmacy.

119. Are the current consumer payments for the supply and dispensing of PBS listed medicines transparent? Are they appropriate?
Consumers do not understand the pricing and value for money provided to them.
120. Is the PBS Safety Net adequate to address the needs of low income consumers who face high pharmaceutical costs and other medical-related costs? If not, what other strategies can be employed to ensure access to cost-effective health care is protected and promoted?
The safety net is adequate but probably unappreciated by many patients.

121. What do consumers expect for the value of the PBS co-payment, noting it is intended to contribute to the price of the medicine, supply to pharmacy, a pharmacy handling fee and a professional dispensing fee?
The consumers do not understand the co-payment and often complain about it, not realising how much value they get for money.

122. What is the objective of the co-payment? Is it to ensure patients use PBS medicines appropriately, by setting a price signal? If so, is this objective enhanced or undermined by allowing co-payment discounts?
Yes it sets a price signal, and it is undermined by discounting co-payments.

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?
No. It sends the wrong message to customers and commoditizes the whole process. Patients already have limited understanding of the costs and subsidies associated with providing them with a medication at the co-payment price, and this would only worsen if the co-payment varied between pharmacies. It is important that the customer pays a fair price for the medication in order for the patient to understand the value of our system; otherwise it can encourage wasteful purchasing of medication that the patient may never use (and increase PBS costs in that way). The pharmacies that choose to discount the co-payment will naturally have to increase their script volume to compensate for this loss, and this high volume approach leads to the issues outlined in our answers to questions 104 and 105. We reiterate our position that if the government wishes to save on PBS expenditure, it needs to do so in a fair and equitable way that affects all pharmacies equally.

124. Is it reasonable for consumers to expect access to medicines outside of standard business hours? If so, why? What arrangements could be made to improve consumer access?
Yes it is reasonable to expect access outside of hours. However staff should be rewarded with higher rates for working unusual hours, and if this is unfeasible and it is deemed to be in the public interest, the government should subsidise these higher rates.

125. What services do consumers expect and value from pharmacists outside of standard business hours? Are there other settings or mechanisms that could deliver these services after hours?
A set of essential services could be developed for minimum standards after hours - at least one pharmacy in each local area should offer these services up to a predetermined opening hour. Access to prescription medication and important “on demand” over the counter medication for temporary conditions like nausea and pain would be essentials. The exact nature of what is deemed necessary can be formulated based on a triage system – non-urgent products and services should not be mandated to be performed after-hours. The other system would be to ensure that there is a local hospital pharmacy that can provide these services.