Pharmacy Remuneration for Dispensing

Q4. No, while difference business models exist, the PBS supply function of different pharmacies models remains the same thus should be remunerated the same way.

Q15. No, it doesn't distinguish time spend by pharmacist in a simple dispensing and a more complex dispensing.

Q16. Yes, basically it should follow a time spend basis, please draw parallel to difference level of consultations in MBS. My gut feeling is $2 per minute, or say initial dispensing fee can be a combination of now dispensing fee and a clinical intervention ( say $16 = 8 minutes), a repeat script (say $6 = 3 minutes). A time and motion study would have yield more information on the time spent of pharmacist with different scripts scenario.

Q17. No, fees and charges on dispensing now doesn't reflect enough on time spend per script. In my opinion, it's too low. However, that may be I tend to spend "too much" time in counselling patient. I once commented in a pharmacy magazine, that I spend up to 8 minutes "selling" a Chlorsig eyedrop, follow the recommended protocol in APF, down to giving the customer a business card of the nearest optometrist. The reason I can do this is (1) My price is $15.95 for Chlorsig whereas some discounter sell it for $6.25 (2) I don't have 20 scripts waiting in my dispensary for me to do. You see, I think our time and expertise needs to be properly remunerated.

Q18. I think the only way for a pharmacist to alter the dispensed price is to dispense as NON-PBS item. Then, the price can be adjusted higher or lower.

Q19. Seems working for now. Can be always more flexible in individual cases.

Q20. Need data from prescriber.

Q21. I largely agreed. Please review generic uptake data since 1 August 2008.

Q22, Q23 Say made them exempted from GST.

Q24. Somewhere between hospital pharmacy and community pharmacy would lies our answer to dispense very high cost drugs. My pharmacy, for one, does not dispense these very high cost drugs as I don't have enough cashflow coverage.

Q25. Let the individual community pharmac(ies) decide for themselves. They should varies from one communities to the next.

Q26. No. Limitations on retail would suppress individuality of difference community pharmacies. I sell (used to sell, anyways) a lot of gifts and jewelleries as quite a few of our customers travels from rural areas to see a City-based specialist. They often browse in our pharmacy while waiting for their appointments (which can be hours) thus I want to excite them with somethings glamorous as well as a good retail therapy. I also take a lot of
passport photos as I am situated among 5 to 6 different foreign consulates who all have different passport & visa photos requirements.

About so called non-evidence based therapies, some of them are simply not enough evidences e.g. I personally take a supplement which made from Conifer Green Needle Complex as an immune booster. I have talked to the scientists in production and I have seen the company research papers and I am convinced. However, this product remains as one of not enough evidence based product. In any case, worst case scenario, would it be better that a pharmacist sells them who the customer can ask and will be given genuine health advice than an unsolicited snake-oil salesman?

Q27. As a community pharmacy business owner, I can say for most of us, apart from dispensing fees collection, the most profitable sections are S2 and S3 anyway. If that's what the local community want, a community pharmacy can certainly solely focused on dispensing. But... better health environment? That's up to local communities to decide and it often fall back on an individual pharmacist. As for viable? It's a business decision.

Q28. There are always a need for new business model in any industries. I once had discussions with some of pharmacy & medical students on the subject of difference type and models of pharmacies in Australia drawing parallel from supermarket industries. We talked about Coles, Woolworth, IGA, Costco and Aldi, we come to conclusion that there are at presence no Aldi & Costco type pharmacies yet. May be there will be in future.

Q29, Q30 One really cannot separate the professional advice to the sale of medicines if a pharmacist is allowed to intervene the dispensing process. However, in other countries system such as Hong Kong where dispensing is performed almost solely by dispenser (who are more advanced than our dispensing assistant) then pharmacist involvements can and should be remunerated separately either as MBS or separate PBS payment.

Q31. The easiest step is to change HMR payment into a MBS payment. The payment system can then expand from there.

Q32. The community pharmacists should be more alerted to the needs of local communities. Certainly more collaboration with PHNs is desirable.

Q33. Best answered by a consumer representative than myself.

Q34. Please ask each and every HMR pharmacists for their individual opinions, there can't be that many of them.

Q35. I sign statutory declaration at no charge. I do charge for signing certified copies. I provide passport photos, photocopying and fax service. In my opinion, a community pharmacy also acts as a hub in a local community. One can also draw parallel to the local pub, except hopefully we give advice not gossips.

Q36. I said this to my customer "... If you sign a statutory declaration for a sick leave, the responsibility is on YOU. If I (as pharmacist) sign your medical certificate,
the responsibility is on ME. If you go next door to the doctor and ask for a medical certificate, who can give you more than one days depends on your needs, the responsibility is on your Doctor.... hence $20 for my time, responsibility and expertise." Remuneration models are largely based on these 3 elements, pharmacists or not. (On reflection, I might have left out creative industries such as artists and advertisers which are paid by creativity)

Q37. Cost is always a barrier in any system. It is the awareness of cost that led to assessment of potential benefits.

Q38. There are network of doctors in general practices, nurses in maternity & health centres who can run a particular health services if so desired. However, none are as accessible as the community pharmacy network.

Q39. Yes, this is in line with most health services offered in Australia with both consumer and government co-contribution.

Q40. Dispensing PBS medicines and Pharmacotherapy program should be fully PBS funded. (The latter is not for now)

Q41. Not in the current remuneration model. There is certainly no reward for R&D. I once tried to claim a receipt for a box of Godiva chocolate as a R&D expenses for a new range of antioxidant from my accountant. Unfortunately, I failed.

Q133 to Q140. I suggest the committee directly ask the pharmacies involved in Chemotherapy for individual comments. There are only fifty invitations to send?!

**Regulation**

Q1. What is "optimal"? This is best answer by an economist.

Q2. The best way to "encourage" any outcome is always Government intervention.

Q3. No. However, a standard for a minimum PBS services should and can be set.

Q5. Once a treasurer of a certain country said " Tax matters are not design to be understand by general public...." The responsibility of ensuring sustainability and affordability of the PBS are now equally shared by Health minister, PBD and Pharmacy Guild through the CPA negotiation. I hardly think it is a good idea to drag treasury, consumer council...etc into this.

Q6. I still prefer the CPA process.

Q7. Yes, CPA should be limited to community pharmacy only. HMR services should be incorporated into MBS if HMR pharmacists are to be treated as individual operators. If HMR services are to be included into PBS, then certain restrictions needs to be imposed onto
HMR pharmacists to ensure they are each assigned a "community area" (e.g. Each is given a few postcode to practice, says 3000 to 3006 for Melbourne CBD)

Q8. There had been a lot of talks about the monopoly of Pharmacy Guild in the negotiation of CPA and the lack of transparency. In my opinion, until such time as Pharmacy Guild failed to represent the majority of community pharmacies, it should be the only body involve in the CPA process. However, as a certain retail pharmacy group choose not to be Guild member, there might be interesting development in few years’ time. More in Q104 & Q105.

Q9. The more parties involved in any negotiations, the more the confusion. Existing arrangements seems to work fine with community pharmacies with Pharmacy Guild as their collective representative.

Q10. In my opinion, Yes. The current system of GP and Community Pharmacy as 2 main pillars of community healthcare is a sound system. More can be done to improve the collaboration of the GPs and Community pharmacists to better the system.

Q11. Are there areas in Australia that access to medicines is significantly beyond the rest of the countries? If so, why?

Q13. Pharmacist can dispense on a doctor’s order by phone or fax/email or even sms. The paper prescription is a confirmation of the doctor’s intention and authority. Provided there is enough recording such as recorded voice messages and/or video images as confirmation. I don’t see why they can’t be used to replace paper prescription. Parallels can be drawn from writing paper cheque to E cheque and EFT.

Q14. If we view the individual community pharmacies as an office set up by PBS where a civil servant has to be on duty 5 to 7 days to provide a service (medicines in this case) to the public then the picture become clearer. Parallels can again be drawn from all civil services.

Say, post offices. Would you like all the post offices serving 10 suburbs to sit next to each other in City CBD? Or you would rather have one post office per suburb with all 10 scattered evenly?

Q42. Not enough data to speculate.

Q43. With few exceptions, access and affordability of any services, pharmacy included, are more difficult in rural and remote areas than urban. The question is would the removal of pharmacy location rules increase or decrease urban access. My “gut feeling” is it will increase access to some suburbs while decrease in other. Pharmacies will “rush” to set up in an area where there are most demands, simple supply & demand relationship.

Q44. What is the average travel time for a consumer in difference suburbs, urban, rural and remote, to travel to the nearest pharmacies? Surely we need this data to determine whether consumers in difference areas are adequate service or not. Does the committee now in possession of such data?
Q45. Relaxing ownership rules can lead to the following ownership structures spring up overnight. Wholesaler owned pharmacies (API, Sigma, Symbion & a whole lot of small buying groups); Coles, Woolworths, IGA owned pharmacies; Drug Companies owned pharmacies; Overseas Pharmacy Chains owned pharmacies e.g. USA, UK, Singapore ownerships; ASX listed pharmacies...etc

I think by then the pharmacy location rules would be the least of Government problems.

Q46. It is reasonable to have some flexibility built in for community pharmacies to move within their community. But, how short is short distance?

Q47. Any statement with “unintended consequences” attached to it sound to me like a mistake. Mistakes are to be rectified. May be best to talk to individual pharmacies which claimed to have been affected.

Q48. If the existing medical centre relocated to 1.3km from the old site, should the existing pharmacy relocated together or the pharmacy can only move as far as 1km and patients have to walk the remaining 300m? Again depends on individual circumstance.

Q49. I seem to recall there are similar arrangements of compensation schemes back in 1990. However I was still working in Hong Kong at the time. Someone would know. I personally known of a community pharmacist chose to sell his approval number within 2 years after a big box discounter move next door 100m from him.

Q50. The pharmacy location rules are there to ensure consumers have a reasonable access to PBS medicines. From time to time on numerous occasions pharmacists were told that the rules are not there to improve or reduce profitability of community pharmacies. Why are we considering the matter of profitability again?

Q51. A minimum level of services should be maintained in any industry, which is called quality assurance. I think with community pharmacies, it is called QCPP

Q52. If the local community needs 2 or more pharmacies within a particular area, then there are unmet demands for PBS services. With ref to Q51, if all the pharmacies owned by the same owner(s) meet the minimum level of services then I personally don’t see a problem.

Q53. Supermarket is at present not allowed to sell scheduled medicines nor pharmacies be allowed to sell fresh groceries. I think it is better things stay this way. The funny things is I have always considered if the three most popular drugs in the world, alcohol, caffeine as in tea & coffee and nicotinic acid as in tobacco, were sold in pharmacies only then people can received more advice on their usage. If I am allowed to sell an orange per day to a customer as a fruit laxative, the customer may benefit more.

Q54. Best answered by the hospital pharmacists who work in hospital pharmacies themselves.

Q55. I think currently in Victoria, there are some pilot projects which involve pharmacies to open 24 hours. May be the results from the pilot can provide us with some insight into this matter.

Q56. To answer this question, one needs certain localised knowledge of rural and regional Australia. I’ll pass this one.
Q57 to Q61 Although I don’t claim to have the knowledge nor the experience of hospital pharmacies and Section 94, I think the co-existing of two different price structure for the same medicine automatically create a pricing issue.

Moreover, if the hospital pharmacies are allowed to dispense directly to the community general public, then would it further worsen the “fragmented care”, a situation our esteemed GPs are so fondly pointed out?

Q62 to Q72 I don’t have sufficient knowledge to comment. Suggest consult directly with pharmacies (and/or pharmacists) and other field workers who work directly with Aboriginal and Torres Strait Islander communities.

**Wholesaling, Logistics and Distribution Arrangements**

Q73. Please ask CSO wholesalers, there are not that many.

Q74. There are always alternatives to any situation.

Q75. It is appropriate as long as consumer accesses to medicines are not compromised.

Q76. Is there a need for s100 and RPBS items be included?

Q77. Insufficient knowledge to answer. Don’t have any personal experience of such.

Q78. Please ask the consumers and pharmacies in those areas.

Q79. How much resources needed to ensure 24 hour rule? Are the use of resources economically viable? Are there alternatives?

Q80. As a former small pharmacy owner manager, I can confirm that lots of so called 1000 highest volume medicines that I kept in my pharmacy are only 1 to 2 days stock. If I be forced to keep a 72 hour (3 days or more) stock, it would impose a great burden on cashflow.

Furthermore, with the mechanism of price disclosure, pharmacies are forced to minimise their stock level to reduce loss of value of their stock with each price disclosure exercise.

Q81 to Q84. Whatever happen between wholesalers and community pharmacies cannot be allowed to affect the welfare of general public as in term of short dated stocks, shortage of supplies, delay in obtaining medicines, inconvenience in obtaining medicines..etc.

However, community pharmacies are one step closer to the general public as a retailer compare to a wholesaler. Anything which increases their cost of doing business would usually lead to decrease in their services. Some offset mechanisms may needs to be set up between wholesalers and pharmacies.

Q85. What alternative systems? Direct supplies from manufactures?

Q86. May be if we demolish the wholesaler system.
Q87. Would another manufacturer be willing to have a 5000 or more individual contracts with pharmacies? Another Pfizer? Or since Pharmacy Guild represent community pharmacies; a manufacturer can just negotiate with the Guild?

Q88. Insufficient knowledge to answer.

Q89. Drawing from my experience in HK Government procurement pharmacist for 2 years, It is not the tender progress but the writing of the tender specifications that is crucial to the success of the process.

The choices of the Australian consumers are can also be limited by the tender process. E.g. During 1st quarter of 2016 we have a pink colour Amoxycillin 500mg capsule only to be replaced by a yellow colour Amoxycillin 500mg capsule in the 2nd quarter, a green one for the 3rd quarter then back to yellow again the same as 2nd quarter tender winner in the 4th quarter.

Accountability and Regulation

Q90 to Q91. I am unaware of any shortfall in the existing regulatory systems.

Q92 to Q93. Data already exist under 6CPA Clinical Intervention, Medscheck and RPBS dosette administration aid reviews that could be used to assess and monitor standards of delivery and health outcomes.

Data collected from MedsASSIST can also use to analyse the health outcome of use of pain killers in both general public and in particular patients who suffer from chronic pain.

Q94. Well someone has to pay for the extra work!

Q95 to Q97. May be the Government can set up a Review your Community Pharmacists Website? While we are at it, how about your local GP? Your local restaurants? Or your local MP?

Q98. QCPP alone is not enough? Let’s have a 5 Stars rating for community pharmacies? May be a Google review?

Consumer Experience

Q12. Studies show that consumers tend to get their health information from the following sources. Their doctor; their community pharmacist; their friends and relatives; Internet websites and chat sites.

My experience with my customers suggest to me that a lot of works are still yet to be done to improve the health literacy of general public especially when it comes to correctly process the information they received from Internet.

Q99. Pharmacists who dispense medicines to patients must satisfy themselves that The right drug to the right patient in the right dose and the right manner.

Q100. At initial dispensing, pharmacist must make sure the patient understand fully the intention of the doctor and be able to use/take their medicines in the right manner. During repeat prescriptions dispensing, pharmacist needs to make sure the patient is indeed using/taking the medicine in the
right manner as instructed before and any side effects developed along the ways and/or other issues which needs attention.

A more specific example is when the GP next door prescribed my patient an antidepressant for the first time (initial dispensing). The advice and service I would offered are

1) Dispense the script.
2) Advice on dosage and manner to take the medicine e.g. time of day, with/without food.
3) Possible side effects – usually give out a copy of CMI at this point with side effects highlighted.
4) Advise it usually take 2 or more weeks for the full effects of medicines be felted (i.e. may be a brighter outlooks for the patient)
5) Suggest if any issues can talk to us or doctor ASAP

When 3 months later, I dispense a repeat script of the same medicine to this patient again. The advice and service I would offered are

1) Dispense the script
2) Advise on dosage and manner to take the medicine (assume no change from initial dispensing)
3) Ask is everything goes according to plan? Any side effects experienced? Are feeling the full effects of the medicines?
4) Any things else the patient think can improve his/her outlook? Sometime this is time to give out Self Care information (PSA, Beyond blue, The Black Dog Institute..etc)

Generally speaking, I do tend to spend on initial dispensing than repeat dispensing. May be 5-10 minutes on initial and 2-5 minutes on repeats.

Are these services being provided by all pharmacies? Well, in theory Yes. They should be provided by all pharmacists regardless of where they practised. The reality is in my pharmacy, I dispense average of 85 scripts items in a 11 hours day. I can afford the time to spend with my customers. If I were dispensing 150-200 scripts in the same 11 hours day (well within the Pharmacy Board guideline without helps by a single pharmacist) I won’t and can’t spend that much time with each customer.

Q101. I wonder how many member of general public can tell me that PBS dispensing fee for a single drug item?

Q102. My pharmacy, small as it is, (T/O less than 1.5M and yearly script dispensed less than 35,000) does provide all listed DDA, Staged Supply, CI, HMR (out sourced), MedsCheck and eHealth. Not RMMR as I don’t service nursing home and the others are not relevance.

In fact, the trouble is working as a Sole pharmacy owner manager (for over 12 years), I feel that I have become more and more of a song and dance man with a one-man band. All I need now is a monkey to accomplish me to the show.

Q103. Never make a professional service program compulsory, you’ll kill it. Professional service should be delivered on a as needed basis.
Q104 to Q106. There are now exist in our industries, a different pharmacy model which emphasis on the needs of customers beyond local community. I named them Retail pharmacy model as opposed to Community pharmacy model.

My own observations are as follows:

1) Retail pharmacies are larger in area than Community pharmacies. So that they can accommodate as much customers as possible, not such the customers from a local community.

2) Retail pharmacies are better stocked both in range and quantities of pharmacy goods and medicines. So that their customers can browse the widest range of products and have the best choices, as opposed to keep specific drugs for one or two particular community customers.

3) Retail pharmacies complete on lowest possible prices among each other, even within their own group. In best price, best service and best speed, they choose the price factor.

4) Retail pharmacies want their customers to stay browsing in their store as long as possible. Luckily I have as yet seen one adopt a store layout as IKEA, that would be the day.

5) Retail pharmacies have a lesser staff to customer ratio. I think this is true in any discount model to keep the overhead at a minimum. Although I’ve mentioned before a pharmacy service is only as good as it’s pharmacists allow to be, a higher workload with less staff make things very difficult.

6) Retail pharmacies are often situated in out of traffic location. The rent needs to be lower and the car park needs to be bigger than that of a community pharmacy. However, bargain hunting customers will go out of their ways (and out of their suburb) to go to a discounter.

In short, community pharmacy is about best serving the local community, while retail pharmacy is about best choices (both price and range) for every possible customer.


Q108. For the last 14 years, I run my pharmacy I DO NOT discount. Enough said. The $1 discount is not in accordance to fairness principle of NMP in my opinion.

Q109. Strictly speaking apart from the $1 discount, there should be no difference in what pharmacies charging for PBS prescriptions. Any variation in price should be that one script is dispensed as PBS item, another script of the same item is dispensed as NON-PBS item.

Q110. A better question is “How informed are the GP?”

Q111. I don’t have the advertising budget to place an ad on National newspaper, let alone TV.

Q112. Of course YES, do you seriously expect me to say anything else?
Q113. The essence here is to minimise risks to consumers thorough uneducated usage of medicines.

Q114. I am a pharmacy operator. What do you expect me to sell? S5 Caution, S6 Poison, S7 Dangerous Poison, S9 Prohibited Substance?

Of course I would sell S2, S3 S4 & S8. I also need to make money out of the sale of these 4 schedule items, it’s my job!

Q115. Yes of course. All promotion advertising are designed to influence consumer buying habits.

Q116. Of course Complementary products should be available for sale together with pharmacy products. Please look up dictionary meaning of the word “Complementary”.

Q117. Does your average customer know St John’s Wart interact with an antidepressants? Garlic and Ginko tablets can interact with someone INR level if the customer is taking warfarin? Of course, it is better if a pharmacist talk to the customer.

Q118. I have operated for many years a retail environment inside my pharmacy. If that’s what your community want then it is the right operating environment.

Q119. I printed my dispensed price of each medicine on its label. However, I don’t think every pharmacy follow the same practice as I do.

Q120. What about a low income consumer who is also taking Methadone/Suboxone? These services are not now subsidised by the Government. Yet, I think it would be the most cost-effective health care the Government can provided.

Q121. From various management studies, it seem that a co-payment system between consumers and Government had the most effectiveness. In Japan, if one does not dispense his/her prescription within 3 days of prescribing, one loses some or the entire Government subsidy on that prescription.

Q122. I said again $1 co-payment discount is wrong.

Q123. Wrong, wrong, wrong.

Q124. Pharmacy Standard Hour is 9am to 9pm if you ask most people. But then again, I was called seven-eleven in my early pharmacy career which refers to the time I left home and time I return home.

Q125. I mentioned before there is this project in Victoria, where they are trying some 24 hours pharmacy model.

Q126. Not enough knowledge to answer.

Q127. A customer with common sense would not expect ALL community pharmacies which vary in size and layout to provide EVERY service. Would you go to your local Chinese restaurant and demand to be serve Peking Duck?

Q128. Thorough the Department of Health PHNs of course, who else?
Q129 to Q132. I think these questions are better answered by the PHNs then community pharmacies. May be advertising and marketing experts can be consulted in improving the current situations.