The Pharmacy Council of New South Wales is the statutory body responsible, in partnership with the Health Care Complaints Commission, for managing complaints and notifications related to the conduct, performance or health of pharmacists practising in NSW and NSW pharmacy students. The Council is also responsible for the approval and registration of pharmacy premises in NSW.

The Pharmacy Council of New South Wales has considered the discussion paper and provides the following comments:

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?

Ownership rules and location rules are currently independent of each other and should remain so.

The Council is of the strong view that ownership rules should not change; however if there were to be a change in ownership rules, the Council is of the view that location rules should not change.

Location rules are designed to preserve equity of access for all Australians to the PBS. Therefore location considerations should be independent of any ownership considerations.

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?
Whilst Council does not oversee the administration of the PBS, it is important to be cognisant of the regulation of medications under the Poisons and Therapeutic Goods Regulation 2008 (NSW). Under each of the schedules, a section is in force around the supply of these medications, in that they are to be in a quantity and for a purpose that accords with the recognised therapeutic standard (namely, sections 23, 54 & 109). Currently this is in relation to how pharmacies (and thus pharmacists) practice, however there should be greater controls in other areas of the supply chain to minimise unsafe practice and unfettered access to medications. One area is around the regulation of wholesalers and manufacturers. Previous complaints against pharmacists dealt with by Council include inappropriate supply of medications due to sizeable quantities that are obviously outside of what is the recognised therapeutic standard. As wholesalers have access to purchase histories of pharmacies, mechanisms could be in place to identify and minimise access whenever a pharmacy starts placing abnormally large quantities for medications. There is a real risk to the public particularly with medications with a high potential for diversion and abuse. Wholesalers must be made more accountable for their actions. This business model, where volume and bottom line results over ride duty of care to the consumer/patient is the very reason why pharmacist only ownership should be preserved.

Compounding (in particular complex compounding) is a service that an increasing number of pharmacies provide. However this is an area which remains largely unregulated. Greater regulation is essential to ensure public safety.

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

The existing regulatory structure between federal and state based stakeholders results in administrative impracticalities. For instance, the PBS and Medicare is administered under a federal body, whereas health professional registration and regulation is overseen by AHPRA or state based councils. Lack of communication means there is no mechanism for sharing of information, with privacy reasons cited particularly when it may relate to misconduct or investigation. Removing barriers with appropriate safeguards (each on a legislated basis unless effective Memorandum of Understanding can be effective) would allow stakeholders to perform their roles more effectively and efficiently.

Regulatory arrangements for small business, including community pharmacies, have numerous compliance requirements. Recent changes have seen changes to remuneration awards which now involves for example, administration of maternity pay.

However, Community Pharmacy is one of the few industries without the ability to charge more for their service depending on the time of day, despite the employment of staff requiring pay at overtime rates under the award. The costs of providing access to the PBS after hours and at weekends is markedly more than during normal business hours and is not recompensed in the current remuneration agreements. A patient is charged the same price for a prescription dispensed at 9am on a Monday morning as the identical prescription dispensed at 10pm on a Sunday night.

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?

The feedback mechanisms for shortcomings in professional services are adequate if consumers are aware of the mechanisms. Online complaint systems already exist but are
probably underutilised due to lack of awareness. In NSW, complaints can be made online via AHPRA, HCCC, or the Pharmacy Council of NSW. However complaints are often sent to Pharmacy Guild (which in some instances will be appropriate) but also to Fair Trading and other Government organisations such as the ACCC, which deal with commercial aspect of a transaction under consumer law. This suggests that consumers need educating. The use of a social media campaign to lift awareness of the avenues available, may be a possible option.

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?

One of the basic principles that underpins health delivery in Australia is patient choice. Every patient has the choice of where to have their prescription dispensed. That is a free market at work. If change is prompted by unprofessional conduct or infringement of patient safety, the problem may be solved for the individual, but not for the community as a whole.

In NSW, regulatory bodies such as the Health Care Complaints Commission and the Pharmacy Council deal with complaints and queries. But these regulators need to be notified: otherwise, the poor conduct may continue undetected and unaddressed.

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?

Yes, there are appropriate standards, both professional (via Pharmacy Board and Pharmaceutical Society of Australia (PSA) Guidelines) and practical (via QCPP or any other quality standard). On the whole these standards are upheld. In cases where the standards are not upheld, it is more about educating or raising the awareness of the pharmacist about what is acceptable practice (rather than a need to change the standards).

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

The customer should expect respect, accuracy in dispensing of their medications, up to date knowledge of medications, opportunity to speak privately with a pharmacist, and maintenance of patient/consumer privacy. This allows for provision of education to consumers and the ability to manage medicines more effectively.

The Community Pharmacy Service Charter (adopted in the 5th CPA by all S90 pharmacies) provides information on the rights of consumers and responsibilities of pharmacists, and the level of service consumers can expect to receive when visiting a community pharmacy.

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?

At minimum consumers should expect access to medicines and related information (such as consumer medicine information), the provision of receiving counselling, and be provided with time to review the information and ask questions. The above should be provided by a pharmacist or an intern under the supervision of a pharmacist. It allows consumers to understand and manage their treatment within lifestyle constraints. These services should always be available but most importantly with initial prescriptions.
Initial prescriptions – offer of printed information, or a short summary of advice (how the medicine will help, dose, advice based around cautionary and advisory labels, common side effects, follow up).
Repeat prescriptions – conversation about the medicine, how it is helping, and adverse effects, monitoring.

There are times that professional input on dispensing a repeat prescription may be more than in the original prescription, especially if the consumer has had problems with the medication.

It is likely that this is not occurring in all pharmacies due to workloads and the demands on pharmacists’ time.

107. What do consumers expect from community pharmacy in relation to their medicines?

- A professional service – however price now seems to outweigh this.
- A fair price for their medicine -
- Quick dispensing service - for one or two items.
- Advice about their medicines - if time permits, some patients like this.
- Delivery service if necessary - i.e. if a patient has access issues.
- Lastly, opening hours that better facilitate ready access to medicines.

111. To what degree do current advertising restrictions limit the ability of pharmacies to promote medicines and related services available to consumers?

No limitation at all. If pharmacists are fully informed about all current medicines, they can best recommend medicines for patients based on their symptoms, current medications and information sought from the patient by the pharmacist. Heavy product and brand based advertising drives demand from the patient based on what they have seen on television rather than from professional recommendation.

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

Generally yes, but there will always those that do not follow the guidelines or legislative requirements. Sometimes this is because of convenience and other times because of naivety.

It is not uncommon that customers will either not wish to spend much time listening to advice or they will not want advice for S2 and S3 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?

They are, if pharmacists follow the prescribed guidelines and legislation. Real time reporting on products subject to abuse and misuse would be of benefit to both consumers and pharmacists.

Community pharmacy has been proactive in the adoption of initiatives such as Project Stop for Pseudoephedrine monitoring and MedsAssist for Codeine sales monitoring. Schedules should be preserved.

The current restrictions are appropriate and ensure patient safety and appropriate usage.
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?

Anything that improves patient safety should be considered. Meeting TGA licensing requirements will improve the level of safety around compounding given that the standards that currently exist are in debate. Reaching a TGA standard would certainly be a good starting point and provide a measure to which each compounder can be assessed. If it takes PBS funding to achieve this so be it.

This additional remuneration should be as an additional amount to what was the agreed remuneration. By simply taking $20 off the remuneration for those facilities not TGA approved risks denying access to all chemo patients to some treatments, particularly those infusions with a shelf life of less than 24 hours.

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, any type of compounding requires regulation and minimum standards, particularly complex compounding where special facilities are necessary eg sterile or cytotoxic.

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