Review of *Pharmacy Remuneration and Regulation*
Discussion Paper

July 2016

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MESSAGE FROM THE PANEL

This Review is an important opportunity to strengthen the role of community pharmacy and pharmacists in the delivery of primary health care to the Australian community, both now and into the future. Since the Review commenced in November 2015, we have heard much about the importance of pharmacy in the health care system and the care pharmacists provide to their communities. This has included numerous examples of community pharmacists going above and beyond in providing additional services that are in the patient’s best interest, even though they may not be compensated for these valuable services.

While the sustainability and viability of an effective community pharmacy sector is a key consideration of this Review, this is primarily a consumer-focused review that aims to identify which services and programs consumers value from community pharmacy. In developing our recommendations, the Panel will seek to ensure that future arrangements will support reliable and affordable access to medicines by the Australian community and will promote the quality use of medicines. The Panel will also consider any future arrangements in the context of the long-term sustainability and equitable distribution of the PBS as a government funded ‘community resource’.

The Panel has met with a broad range of stakeholders and representative bodies from the consumer, pharmacy, wholesaling and hospital sectors in order to prepare this Discussion Paper (see Appendix C). This Paper aims to stimulate debate on both the current arrangements for pharmacy remuneration and regulation, and on how these arrangements can be improved in the interests of the Australian community.

This Paper presents a series of questions for the public and other stakeholders. Many of these questions were raised by stakeholders in our discussions with them and are presented in this Paper to capture key elements of those discussions. Some questions consider how to modify and improve current arrangements while others ask stakeholders to re-imagine the community pharmacy and wholesaling landscape in Australia.

Some stakeholders will see parts of this Paper as contentious and provocative. That is deliberate. In order to properly analyse the current system of pharmacy remuneration and regulation, existing approaches must be critically examined. While many parts of the system will stand up to such close scrutiny, other parts may be revealed as inadequate and in need of reform.

We have heard about the excellence of parts of the current system of community pharmacy. However, we have also heard from those who are not satisfied with the current direction of community pharmacy. We consider that this review, as a commitment of the Sixth Community Pharmacy Agreement, is a platform for improvement and, where needed, transformation within the community pharmacy sector.

While comprehensive, the Terms of Reference for this Review have limits. Community pharmacy operates as part of a broader health care system with state and territory regulation as well as Commonwealth. For example, state-based ownership rules among other things determine who can own a community pharmacy.

It is clearly beyond the scope of this Review to make recommendations relating to broader state-based issues that are beyond the Terms of Reference. However, these broader issues form the context of pharmacy in Australia and cannot be ignored by this Review. Our recommendations will be cognisant of broader regulations and constraints. In general, these constraints will be taken ‘as given’ for our recommendations. At the same time, the Review will recognise that some of these broader regulations and constraints may themselves change. To ensure that our recommendations are not rendered obsolete by such changes, some of our recommendations may have multiple parts: first taking outside constraints as given, but then, secondly, considering alternatives that may be relevant if outside constraints were to change. Of course, we will not
recommend or comment on such change where it is outside our Terms of Reference.

This Review represents the first independent, comprehensive review of pharmacy remuneration and regulation in over two decades. We are privileged to be able to conduct this Review. We acknowledge the significant responsibility that has been given to us to ensure that community pharmacy continues to deliver quality health outcomes and promote access and the quality use of medicines. We encourage you to engage with the Discussion Paper and participate in the national consultation process commencing in July 2016. This is your opportunity to shape the vision for community pharmacy in the future and to share your thoughts on how we can achieve that vision.

We look forward to your responses and meeting with you in the coming months.

Professor Stephen King
Mr Bill Scott
Ms Jo Watson
HOW YOU CAN CONTRIBUTE

The Review Panel is committed to consulting broadly to gain an extensive view of the pharmacy sector in Australia and the factors contributing to patient health outcomes and the quality use of medicines. We are keen to engage with all interested stakeholders, including consumers, pharmacists, health professionals, hospitals, wholesalers and medicine companies. This is your opportunity to contribute to our understanding of the current and future expectations of the community pharmacy sector, so we may provide informed and pragmatic recommendations for Government to consider.

This Discussion Paper presents a range of questions for stakeholders to consider, which reflect both evolutionary and more transformative options to strengthen community pharmacy in Australia. This is intended to challenge respondents to re-think the role of community pharmacy and provide new and innovative ideas on what community pharmacy should look like in the future.

The Panel also invites interested parties to highlight examples of valuable services and programs offered by community pharmacy that could potentially be expanded to improve the consumer experience. Conversely, the Panel is also interested in understanding areas where stakeholders feel that there has been a degradation of pharmacy services which has impacted on consumer access or affordability.

Your thoughts and perspectives on the Discussion Paper can be provided through the public submission process. Formal submissions may be lodged to pharmacy.review@health.gov.au, or forwarded to:

Pharmacy Review (MDP 900)
Department of Health
GPO Box 9848
Canberra ACT 2601

Written submissions in response to the Discussion Paper may be made from the release of the Discussion Paper through to 23 September 2016. All comments and submissions received by this closing date will be reviewed and considered by the Panel.

In addition, a short online questionnaire – targeted at both consumers and pharmacists – will be available to collect responses to the Discussion Paper from these key stakeholders. The questionnaire will be available from the Review website and will be open until 18 September 2016. Respondents are invited to complete the surveys in addition to, or in lieu of, a formal written submission in response to the Discussion Paper.

Extensive consultation will be held following the release of the Discussion Paper, including public forums in each state and territory (including metro and regional centres), briefings at industry conferences and a public interactive live webcast. Further advice on the Review and its progress, including details of all public consultations, will be posted regularly on the Pharmacy Review Website.

Confidentiality of Submissions

The Panel intends for this Review to be as transparent as possible to encourage public trust in the process being followed by the Review. Therefore, all submissions will be treated as public and published on the Review website following the closing date for submissions (23 September 2016). Authors of submissions who would like part of their submission to remain in confidence should provide justification for this at the time of submission. Should the Panel not agree with an author’s request for confidentiality, the author will be given the option to withdraw their submission without public disclosure.

If you have any questions about the public submission process or the Review in general, please contact pharmacy.review@health.gov.au.
INTRODUCTION

The Review of Pharmacy Remuneration and Regulation (the Review) forms a key component of the Sixth Community Pharmacy Agreement (6CPA) made between the Commonwealth and the Pharmacy Guild of Australia (the Guild). As outlined in the 6CPA, the Review is based on specific Terms of Reference determined by the Minister for Health following consultation with the Guild. The Review will provide recommendations on future remuneration, regulation including pharmacy location rules, and other arrangements that apply to pharmacies and wholesalers for the dispensing of medicines and other services provided under the Pharmaceutical Benefits Scheme (PBS), to ensure consumers have reliable and affordable access to medicines.

The National Medicines Policy and the Pharmaceutical Benefits Scheme

Australia’s National Medicines Policy (NMP) represents an ongoing cooperative partnership between Commonwealth, state and territory governments, health educators, health practitioners, other health care providers and suppliers, the medicines industry and health care consumers. The NMP is aimed at bringing better health outcomes for all Australians, with a focus on supporting timely access to the medicines that Australians need, at a cost individuals and the community can afford.

The NMP recognises that cost should not constitute a substantial barrier to people’s access to the medicines they need and explicitly recognises the role of subsidies for medicines, within a framework of cost-effectiveness and rational use of medicines.

The Commonwealth aims to ensure affordable and reliable access to a wide range of necessary medicines for all Australians through supporting the continued access and sustainability of the PBS. As a Commonwealth program the PBS primarily assumes responsibility for the cost of drugs to patients in the community setting. In contrast, the cost of medicines for patients in hospital is primarily the responsibility of each state and territory.

The cost of providing the PBS has always been a concern to Government and the very high cost of new medications has increased the scrutiny on the efficiency of the PBS.

The Role of Pharmacy

Community pharmacy and pharmacists play a key role in primary health care in Australia through the delivery of PBS medicines and other medicines related services to the community. Community pharmacies are often considered the most accessible of all health care destinations in Australia. It is estimated that on average Australians visit a pharmacy 14 times a year.

Key pharmacy settings include independent community pharmacies, banner groups (both wholesaler-owned and independent), friendly societies, buying groups and discount pharmacies. The range of services offered by community pharmacies varies depending largely upon the location or local market in which the pharmacy operates. For example, pharmacies located in shopping strips or medical centres traditionally tend to derive a greater proportion of their income from the dispensing of medicines, while pharmacies located in shopping centres may have a greater emphasis on front-of-store retail sales.

The level and range of professional services offered by community pharmacy can similarly vary, from a customer-oriented approach concentrating on high volume medicines dispensing and front-of-house (non-medicine) sales, to a more patient-centred approach offering specialised medicines management and adherence services, advice and consulting, including medicines reconciliation and health checks, wound management and vaccination programs.

More broadly, pharmacists themselves may work beyond the community pharmacy setting, including as consultant pharmacists in providing medicines reviews or other medication-related cognitive services; hospital pharmacists involved in providing medicines information and advice to
health professionals conducting clinical trials and preparing medicines for patient use; and industrial pharmacists involved in the research and development of pharmaceutical products to market. Each of these roles play a part in supporting key objectives of the NMP and PBS by promoting timely access to and quality use of medicines within the Australian community.

Key representative groups in the pharmacy sector include:

The Pharmacy Guild of Australia: the national peak body representing the business and professional interests of community pharmacy in Australia. Membership is limited to the owners of community pharmacies, with the Guild representing 75-80% of all pharmacy owners - being approximately 4,000 pharmacies, which employ 20,000 registered pharmacists and 60,000 staff in total. While seeking to serve the interests of its members, the Guild also seeks to support the role of community pharmacy in delivering quality health outcomes for all Australians.

The Pharmaceutical Society of Australia (PSA): a professional society representing all of the pharmacy profession in Australia. The PSA has approximately 18,000 members nationally and is a major provider of continuing professional development (CPD) programs for pharmacists in Australia.

The Society of Hospital Pharmacists of Australia (SHPA): a professional association whose membership mostly comprises hospital pharmacists, but is also open to pharmacy technicians and pharmacy students. SHPA aims to support and provide professional development to its members and be an advocate for improved medicines management in policy and practice.

The Australian College of Pharmacy (ACP): a member-based professional organisation providing CPD programs for pharmacists in Australia. A key objective of the ACP is to develop and deliver quality educational, training and research programs and to contribute to the advancement of the pharmacy profession.

Community Pharmacy Agreements

In response to the requirements of section 98BAA of the National Health Act 1953 the Commonwealth has, since 1990, entered into successive five-year agreements with the Guild, as an organisation representing the majority of pharmacists approved to supply PBS subsidised medicines in Australia. While the main purpose of the Community Pharmacy Agreements have been to set out remuneration arrangements for pharmacists that dispense PBS medicines, their scope has been expanded to encompass a range of government funded professional programs and a funding pool for pharmaceutical wholesalers.

The objectives of these Agreements have also evolved over time, with the current Agreement seeking to ensure that pharmacists receive fair and adequate remuneration for the supply of pharmaceutical benefits and that a stable network of accessible and viable community pharmacies and related services is maintained throughout Australia, including in rural and remote areas. Importantly, all Agreements since the third agreement have also sought to ensure positive health outcomes for the Australian community through the efficient delivery of patient-focused professional programs and services.

The five-year 6CPA between the Commonwealth of Australia and the Guild commenced on 1 July 2015. The 6CPA provides for an estimated $18.9 billion in remuneration for dispensing PBS medicines, providing pharmacy programs and services and to support the pharmaceutical supply chain. The 6CPA was developed following consultations with key stakeholders in the community pharmacy sector, including industry, pharmacy and pharmacists, consumers, peak groups, and other organisations.

As part of the wider package of PBS reforms supporting delivery of the 6CPA, this Review will provide recommendations to support future Government decisions on the remuneration and regulation of community pharmacy (including wholesalers) in subsequent Community Pharmacy Agreements.
REVIEW TERMS OF REFERENCE

Pharmacy and pharmacists play an important role in the delivery of primary health care in the Australian community. As successive Community Pharmacy Agreements have seen increasing investment by Government in supporting pharmacy, the Review of Pharmacy Remuneration and Regulation will provide recommendations on future remuneration, regulation including pharmacy location rules, and other arrangements that apply to pharmacy and wholesalers for the dispensing of medicines and other services, including the preparation of infusions or injections for chemotherapy, provided under the PBS, to ensure consumers have reliable and affordable access to medicines.

In consideration of the Commonwealth’s roles and responsibilities in health, in the context of the Australian Government’s Reform of Federation White Paper, the Review’s recommendations will be directed toward achieving arrangements which are transparently cost-effective for Government and consumers, financially sustainable, considerate of current and future expectations for the community pharmacy sector, and effective in delivering quality health outcomes and promoting access and quality use of medicines, in the context of Australia’s NMP and the broader Australian health sector.

The Review will provide a report to the Minister for Health by 1 March 2017.

In making its recommendations, the Review will consider:

Pharmacy Remuneration for Dispensing

1. The appropriate level and structure of remuneration for community pharmacy for the dispensing of medicines under the PBS consistent with the NMP and its role in delivering health outcomes for patients, including consideration of:
   a) the costs and cost drivers associated with dispensing;
   b) market considerations, including likely growth and distribution of demand and community need, based on medicines listing projections, and population and health care trends (in Australia and overseas);
   c) funding models that could be used, including comparable overseas examples; and
   d) different funding structures that may be appropriate for different business models for delivery of pharmaceutical services (including the preparation of chemotherapy infusions or injections) in different settings and how any new structures improve access to, affordability and quality use of medicines.

Regulation

2. The appropriate regulation of pharmacy and pharmacy distribution, including the role of Pharmacy Location Rules in supporting access to medicines in Australia, including consideration of:
   a) the costs and benefits of such structures, their consistency with current thinking for effective competition in a pharmacy environment and impacts on access and affordability for consumers and communities;
   b) key components of such structures that are necessary to support access and quality use of medicines, in the context of Australia’s NMP and the broader Australian health sector;
   c) the role of government in the regulation of pharmacy and wholesalers; and
   d) the impact of any recommendations for change on the community pharmacy sector and transitional arrangements that may be necessary to sustainably manage those impacts and how those recommendations improve access to, affordability and quality use of medicines.

Wholesaling, Logistics and Distribution Arrangements

3. The appropriate level and structure of remuneration for wholesalers and pharmacies for wholesaling, logistics and distribution of medicines from manufacturer to community pharmacy, including consideration of:
a) regulatory requirements, standards and quality control to provide assurance of timely and reliable access and delivery;
b) the costs and cost drivers associated with timely supply consistent with the NMP, wholesaling, logistics and delivery;
c) the adequacy of funding to promote investment in supply chain infrastructure to meet future PBS supply and security needs; and
d) the relationships between manufacturer, wholesaler, distributor, delivery partner, pharmacy and government and how these impact consumer and community need.

**Accountability and Regulation**

4. What regulatory arrangements are necessary to promote high standards of delivery and accountability amongst pharmacies, wholesalers, manufacturers and other entities receiving funding under the PBS, and the data required to monitor and assess these standards of delivery and community outcomes.

**Consumer Experience**

5. The consumer experience, including:
a) consumer attitudes to the services expected from community pharmacy;
b) consumer expectations regarding access to and affordability of medicines; and
c) consumer priorities regarding access to and quality use of medicines.
PHARMACY AND PHARMACEUTICAL SERVICES IN AUSTRALIA

Over the last five years, the increase in PBS expenditure has slowed as changes to generic medicine prices under PBS Reform have increasingly reflected their market price (see Figure 1). This decreased the remuneration to pharmacy over the Fifth Community Pharmacy Agreement (5CPA) from ‘mark-ups’ as these were calculated as a percentage of the wholesale price. With the 6CPA, however, a new flat fee called the administration, handling and infrastructure fee (AHI) was introduced.

Figure 1 – Government Pharmaceutical Benefits Scheme Expenditure ($ billions)

As at 30 June 2015, there were 5,511 pharmacies in Australia (There is one approved pharmacy (section 90) on Christmas Island an external territory of Australia, which is why the total number of pharmacies in Australia is one more than the total number in each state and territory). Figure 2 shows that the distribution of pharmacies across the country in each state and territory was largely proportionate to the distribution of the population in each state and territory.

Figure 2 – Proportion of Community Pharmacies and Population by state and territory

Source: Department of Health PBS Data and Estimated Resident Population, States and Territories (Number) 3101.0 Australian Demographic Statistics, ABS
Despite the proportionality of pharmacy and population distribution seen in Figure 2, Table 1 demonstrates significant variation in the average PBS expenditure by Government per capita between states and territories.\(^1\) The PBS and Repatriation Pharmaceutical Benefits Scheme (RPBS) are demand driven programs, and benefits paid reflect the underlying demand for medicines in each state and territory, the causes of which can be demographically driven. For instance, Tasmania, with the oldest median age also has the highest per capita expenditure on the PBS and RPBS, compared to the Northern Territory which has the youngest.

Table 1 also illustrates that the number of people per community pharmacy varies greatly by state and territory, and those jurisdictions with fewer community pharmacies per capita also tend to have the lowest PBS expenditure per capita. It is unclear if this per capita distribution of community pharmacies reflects actual demand for pharmaceutical services, as suggested by the younger median age in jurisdictions with fewer pharmacies per capita; or whether it demonstrates that some jurisdictions may be experiencing a lack of community pharmacies that is affecting access to medicines and other pharmacy programs.

Access to PBS medicines from section 100 approved Aboriginal Health Services and dispensing medical practitioners is also a relevant factor in accessing PBS medicines in many rural and remote communities, but this is not included in Table 1 as this is not PBS expenditure that passes through (section 90) community pharmacies.

From an international perspective, the number of pharmacies per capita in Australia is comparable to the United Kingdom, South Africa and New Zealand, based on 2012-2014 figures.

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\(^1\) This expenditure consists of the volume of scripts dispensed multiplied by the price of the medicine (i.e. the ex-manufacturer price + the wholesale and pharmacy mark-ups + the dispensing fee, all for the quantity of medicine supplied) minus the relevant patient co-payment.
1. In your opinion, is the ratio of community pharmacies to population optimal? What data would you use to support this opinion?

2. If it is desirable for the ratio of community pharmacies to population to increase or decrease in some areas, what in your opinion is the best way to encourage this?

Distribution Arrangements under the *National Health Act 1953*

Most medicines on the PBS are available under section 85 (s85) of the *National Health Act 1953* (the Act). In addition to this, some medicines are distributed under alternative arrangements where these are considered more appropriate, which are provided for under section 100 (s100) of the Act. Several programs exist for the provision of medicines as pharmaceutical benefits in this way, including the Highly Specialised Drugs Program and the Efficient Funding of Chemotherapy (EFC) Program, both available in private and public hospitals.

Due to the increase in expensive new PBS medicines provided under the s100 program, expenditure has increased greatly on s100 relative to s85 over the last ten years, as noted in Table 2.\(^2\)

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\(^2\) Note, however that part of this expenditure is due to the movement of chemotherapy from s85 to s100 in 2012.

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**Table 2 – s100 and s85 Benefits**

<table>
<thead>
<tr>
<th>Total Benefits by Program</th>
<th>2005-06</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 100</td>
<td>$208,067,908</td>
<td>$2,106,800,000</td>
</tr>
<tr>
<td>Section 85</td>
<td>$5,826,451,884</td>
<td>$7,119,087,606</td>
</tr>
</tbody>
</table>

Most of the expenditure on s100 programs occurs in public hospitals (Figure 3), a reversal of ten years ago when most occurred in community pharmacy. However, this growth could be attributed to the introduction of chemotherapy and other highly specialised drugs into s100.
However, s85 medicines are predominantly distributed in community pharmacy and this has not changed, as illustrated in Figure 4.

**Pharmacy Industry**

The business model for the pharmacy sector in Australia is both retail and health care. Selected data from the April 2016 IBISWorld report on the pharmacy sector in Australia illustrates the proportion of income pharmacy received from prescriptions as opposed to non-prescription business (Figure 5). Note that it is not possible to distinguish PBS versus private prescriptions from this data.

It has been put to the Panel that the ratio of revenue from ‘front of shop’ and prescription
medicines varies greatly across pharmacy business models.

Figure 5 – Products and Services Segmentation

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?

Table 3 – Pharmacy Groups

Guild Digest data indicates that the average turnover for community pharmacies in Australia is $2.8 million and the average net profit is $107,000 (excluding proprietors’ salaries), noting these figures have fluctuated in recent years.

The IBISWorld report quotes ABS data suggesting that the average pharmacist-employee earned $55,400 in 2012, not including any profit share. However, the employment of lower paid pharmacy assistants and other retail staff, means that the average wage for the industry is lower.

IBISWorld also noted the significant expense of rental and lease costs, particularly for pharmacies in shopping centres or medical centres, where it may rise to 6.5% of revenue compared to the industry average of 5.1%, and much higher than the 3.5% for pharmacies located in a shopping strip.

There is a significant degree of vertical integration in the pharmacy and wholesaling sectors in Australia, and five pharmacy groups account for around 65% of the total market revenue. Notably there has been a rise of the ‘big box’ discounter model, with their price competition appearing to increase pressure on traditional, smaller pharmacies.
REGULATORY LANDSCAPE

Community Pharmacy Agreement

The approach to community pharmacy remuneration taken by Community Pharmacy Agreements is unusual, both in terms of general regulated industries and other parts of the health system available to patients.

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?

If the CPA process is not the best way to organise medicine distribution and remuneration then:

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?

Community pharmacy programs within the CPA include some professional services that could be delivered by non-dispensing pharmacists.

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 National Medicines Policy

The NMP notes the importance of partnerships with a range of parties including health practitioners, health care providers and suppliers. However the Government has entered into successive Community Pharmacy Agreements with the Pharmacy Guild alone. It has been put to the Review that the Guild is not representative of the whole of community pharmacy and only represents a subset of community pharmacy owners. It is of note that for the first time, the 6CPA included significant consultation with other stakeholder organisations regarding what they would like to see in the new agreement. However, the current Agreement is signed with only the Guild. Arguably, this is because the Guild represents those community pharmacy owners ‘with skin in the game’ and who carry the business risks.

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?

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?

The CPAs focus on remunerating community pharmacy for the dispensing of medicines and other services under the PBS. However, medicines are dispensed through a range of mechanisms, of which community pharmacy is currently the primary setting. Other avenues for the dispensing of medicines include private and public hospitals.

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?

A key objective of the NMP is ‘access to medicines’. The NMP discusses a number of aspects to providing access to medicines.

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?

The NMP notes the importance of information on medicines for both health practitioners and consumers for quality assurance and quality use of 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?

Community Pharmacy

Community pharmacies generally operate as privately-owned small businesses, with state and territory rules limiting ownership to practising registered pharmacists. However, medicines are also dispensed by other public and private (including not-for-profit) organisations including hospitals and, in some states, friendly societies.

The Panel has been informed that while the paper prescription remains the legal record, this presents a significant impediment to more technologically-enabled dispensing, such as online ordering by the patient and remote dispensing. This means that pharmacists must sight the paper script when dispensing.

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?

Regulations such as pharmacy location rules were designed to promote efficient and equitable access to pharmacy. At the same time they protect community pharmacies from some aspects of competition that face other small business owners in Australia.

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?
The PBS model funds the purchase cost, distribution and dispensing of medicines listed on the PBS to ensure access for all Australians. Community pharmacy, at the end of this supply chain, is the link connecting the PBS medicine with the consumer. The Government pays pharmacy an agreed mark-up price for their costs in acquiring medicines, and additional fees, such as the dangerous drug fee. The dispensing fee also incorporates payment for advice to patients on the use of the medicine.

6CPA Arrangements

The 6CPA is estimated to provide approximately $18.9 billion, to over 5,500 community pharmacies (being of the order of $690,000 per pharmacy per annum) across Australia, to dispense prescriptions and assist in the provision of programs and services over the life of the Agreement (to 30 June 2020), comprising:

- Commonwealth contributions of $15.5 billion
- Patient contributions of $3.4 billion.

The Commonwealth contributions include payments to pharmacists and wholesalers for medicines dispensed under the PBS.

The Commonwealth will also make available up to $1.26 billion in funding for patient-focused professional programs and services over the term of the 6CPA. Funding is expected to:

i. be at a level of $613 million over the term, as continued investment in a range of community pharmacy programs subject to an evaluation of their cost effectiveness
ii. be at a level of $50 million over the term as funding for a Pharmacy Trial Program relating to community pharmacy programs
iii. include access to additional funding of up to $600 million over the term to implement new and expanded community pharmacy programs, and which are successfully trialled for delivery through community pharmacies (excluding unapproved pharmacies). It is intended that a particular focus of these programs will be those which benefit Aboriginal and Torres Strait Islander peoples and consumers in rural and remote areas.

Components of Pharmacy Remuneration

Actual Government expenditure on supply chain remuneration under the 5CPA averaged $2.7 billion per year of the agreement. Dispensing fees made up the majority of payments to pharmacy (51%), followed by pharmacy mark-ups (25%), the Premium Free Dispensing Incentive (PFDI) (7%), dangerous drug fee (1%) and other fees such as wastage fee, container fees, and electronic prescription fees accounting for less than 1% of remuneration (Figure 6).
Figure 6 – Proportion of Expenditure on Supply Chain Remuneration under 5CPA

Figure 7 – Estimated Proportion of Expenditure on Supply Chain Remuneration under 6CPA
In the 6CPA, the percentage based mark-up that applied to the majority of medicines has been replaced by a flat rate AHI. This is to counter the effects of PBS reform savings measures that have reduced the price of many PBS medicines and consequently eroded the value of mark-ups to pharmacy. The PFDI, which pays an additional fee to pharmacists in certain circumstances to support the uptake of generic medicines, has been retained but is applicable to a reduced number of drugs compared to the 5CPA.

The relative proportions of the $13.2 billion of Government expenditure on pharmacy and wholesaler fees and mark-ups over the 6CPA is shown in below.

Dispensing is a highly skilled process involving varying requirements for delivering advice to patients. However as a flat fee, it reflects a ‘swings and roundabouts’ approach, where those transactions that involve little interaction between the pharmacist and the consumer and, in this sense are relatively low cost to the pharmacist, are balanced by the transactions that require a considerable amount of time spent by the pharmacist with the consumer.

15. Is the ‘swings and roundabouts’ approach to remunerating pharmacists for dispensing appropriate? Does it lead to undesirable incentives?

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?

It is noteworthy that the proportion of PBS expenditure that goes to community pharmacy represents almost 30% of total expenditure on the PBS, even without including pharmacy programs and the wholesalers Community Service Obligation (CSO) payments (Figure 8).

**Figure 8 – Supply Chain Proportions of PBS and RPBS Expenditure Claimed by Community Pharmacies and Friendly Societies 2014-15 (Government and Patient Contribution)**

- **Pharmacy & Wholesaler Component** of expenditure DPMQ:
  - dispensing fee
  - pharmacy mark-up
  - wholesaler mark-up
  - dangerous drug fee
  - wastage amount
  - container fee

- **Other:**
  - premium free dispensing incentive
  - electronic prescription fee

- **Manufacturer Component**
Case study – Pricing of PBS medicines

Figures 9 and 10 show the different remuneration components that make up the dispensed price of a PBS medicine, with examples both above, and below, the General Co-payment ($38.30). They also demonstrate the relative contribution made by consumers and Government to the cost of the medicines.

Figure 9 – Pharmacy Remuneration (over co-payment) - 200mg Quetiapine (post 1 April 2016 Price Disclosure Reduction)\(^3\)


1. The $0.15 Electronic Prescription Fee only applies for each prescription dispensed electronically.
2. The $1.72 Premium Free Dispensing Incentive only applies for each substitutable brand:
   a. dispensed without a premium; and
   b. attracting a government subsidy (ie. priced above relevant patient co-payment).

\(^3\) This remuneration example does not include payments made to CSO wholesalers by Government.
Figure 10 – Pharmacy Remuneration (under co-payment) - 40mg Atorvastatin (post 1 April 2016 Price Disclosure Reduction)⁴


1. The $0.15 Electronic Prescription Fee only applies for each prescription dispensed electronically.

2. The $1.72 Premium Free Dispensing Incentive only applies for each substitutable brand:
   a. dispensed without a premium; and
   b. attracting a government subsidy (i.e. priced above relevant patient co-payment).

3. The Safety Net Recording Fee of $1.17 and the allowable extra fee of $4.33 is a discretionary charge and pharmacists are only permitted to apply these fees where the PBS dispensed price is below the general patient contribution of $38.30. The allowable extra fee is not a Government initiated fee.

⁴ This remuneration example does not include payments made to CSO wholesalers by Government.
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?

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?

19. Is the RPMA the best way to encourage pharmacies to operate in locations where they would not otherwise be viable? Is community need a more appropriate measure than geographical location?

20. Is the Electronic Prescription Fee achieving its intended purpose of increasing the uptake of electronic prescribing and dispensing?

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?

Other Fees Payable Under the 6CPA

Rural Pharmacy Maintenance Allowance

The Rural Pharmacy Maintenance Allowance (RPMA) is a support allowance designed to support rural pharmacies which are otherwise uneconomic, which leads to improved access to PBS medicines and pharmacy services for people in rural and remote regions. It is a monthly allowance paid to eligible proprietors of section 90 approved pharmacies.

Electronic Prescription Fee

Funding is provided under the 6CPA to support payment of an Electronic Prescription Fee per claimable electronic prescription transaction to approved suppliers for eligible electronic prescriptions.

Premium-Free Dispensing Incentive

An incentive payment of $1.50 to dispense a substitutable, premium-free brand was introduced on 1 August 2008. The incentive is paid to all community pharmacies and other approved suppliers, for each substitutable brand they dispense where a premium does not apply. The incentive applies only to PBS subsidised medicines which attract a PBS subsidy. Therefore, under-co-payment medicines and private scripts are not eligible for the PFDI (which is currently $1.72). Its purpose is to support pharmacists to increase the uptake of generic medicines by consumers, and reflects the time taken in the provision of advice by the pharmacist on their safety and efficacy.

High cost medicines

Increasingly expensive medicines are being listed on the PBS, creating supply cost issues for both wholesalers and pharmacy. New hepatitis C medicines, in particular have presented challenges to current arrangements with significant cash flow issues through the supply chain. For example one hepatitis C medicine, Sovaldi, is $19,367 (plus GST). The mark-up for wholesalers is $69.94 to distribute this drug and the mark-up for pharmacy is $70 plus the dispensing fee.

Additionally, payment timeframes from the wholesalers can be shorter than the reimbursement timeframe from the Commonwealth Department of Human Services back to the pharmacy. It has been put to the Panel that these pressures make pharmacists reluctant to stock these very high cost medicines and this in turn affects patient access.
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?

Hepatitis C medicines are dual listed as available under s100 and under s85 (general schedule) of the PBS. This allows patients to access these medicines in hospital as well as the community. However the remuneration structures are quite different, and remuneration for community pharmacies dispensing an s100 Highly Specialised Drug (HSD) is less than that for the equivalent s85 general schedule item. In the case of hepatitis C drugs, this means that hospitals are in effect paid an additional mark-up of around $2,000 by the PBS when compared to being dispensed through a community pharmacy.

Table 4 – Public and private hospital pharmacy mark-ups\(^1\) for section 85 and section 100\(^3\) medicines

<table>
<thead>
<tr>
<th>Section 85 medicines</th>
<th>Public Hospitals(^2) (dispensed price(^3))</th>
<th>Private Hospitals (dispensed price(^2))</th>
<th>Community Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ex-manufacturer price + 11.1% wholesale mark-up</td>
<td>Ex-manufacturer price + 11.1% whole-sale mark-up + 1.4% pharmacy mark-up + Dispensing Fee</td>
<td>Ex-manufacturer price + 7.52% whole-sale mark-up + AHF fee + Dispensing Fee</td>
</tr>
<tr>
<td>Section 100 medicines (where applicable)</td>
<td>Ex-manufacturer price</td>
<td>Ex-manufacturer price + 4-tier s100 pharmacy mark-up + Dispensing Fee</td>
<td>Ex-manufacturer price + 4-tier s100 pharmacy mark-up + Dispensing Fee</td>
</tr>
</tbody>
</table>

Notes:

1. Adjustments for broken packs are not accounted for here.
2. Adjustments required for calculating the dispensed price where the pack quantity and maximum quantity are different are not accounted for here.
3. These are the mark-up structures that apply now. In the past this may have been different.
4. The arrangements outlined above do not include s100 EFC remuneration. S100 EFC remuneration arrangements are significantly different.
5. s85 medicines (and s100 EFC medicines) cannot be dispensed under the PBS in public hospitals in NSW and ACT as they do not participate in the PBS Pharmaceutical Reforms.
6. Smaller fees such as the container fee and dangerous drug fee are not included here.
7. Section 100 medicines include the Highly Specialised Drugs, IVF medicines, Growth Hormone and Botulinum Toxin.

24. Given that very high cost drugs are likely to become more common on the PBS, should this remuneration structure for hospitals change to more closely reflect the remuneration structure of community pharmacy?

The Role of Pharmacists

It has been put to the Review that the skills, knowledge and expertise of pharmacists are under-utilised and any future reform should better support the integration of community pharmacy within the health system to help address increasing workloads in primary health care (e.g. in general practice).
This aligns with the views of professional organisations, who say that integrating pharmacists into general practice clinics and better utilising the role of pharmacists in primary health care are cost-effective solutions the Government should consider.

It has been put to the Panel that Government should be investing in and utilising the skills of pharmacists in co-located general practice, aged care, and other clinical settings.

Additionally, it has been put to the Panel that while some pharmacies and pharmacists are preparing to meet and make the most of future challenges and opportunities, others are not.

For example, some pharmacies are ‘value-adding’ to services and embracing a new role while others are simply not ready, or unwilling, to take up new responsibilities in an expanded primary health care role. Others could not find a satisfactory economic model. However, on the whole, it has been argued to the Review that the profession’s appetite to embrace change has never been stronger. This Review is seen as an opportunity for transformation in the sector.

Some groups also believe that this potential is being ‘hi-jacked’ by the political debate rather than the health care debate.

Currently, the 6CPA funds pharmacists to deliver a range of professional programs and services subject to evaluation of their cost-effectiveness.

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?

Moreover, the retail/health care hybrid creates cross-subsidies allowing some health care activities in pharmacy to be subsidised by the ‘front of shop’. This obscures the true costs, which need to be transparent to understand how Government investment is contributing to improved patient health outcomes. It is also important that pharmacists receive a fair price for the professional work that they do, and that cross-subsidies do not act to distort incentives.

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?

It has been put to the Panel that a non-retail environment may improve the health outcomes for patients. For instance, some hospital pharmacies have their service area resemble a clinic rather than just a counter, providing a private environment without distraction, which maximises the professionalism of patient-pharmacist interaction.

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?

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?

Alternative Arrangements to Remunerate Pharmacists for Services

It has been put to the Panel that to strengthen the consumer focus on programs and services, and reduce the possible conflict of interest between the ‘retail’ and ‘health care’ environment, it is necessary to strengthen the focus on ‘evidence-based’ health services and remuneration systems.
and fund community pharmacy services outside of current 6CPA arrangements.

To ensure pharmacists are in a better position to help improve consumer health outcomes and the quality use of medicines some groups have suggested (for example) that the Medicare Benefits Schedule (MBS) could be expanded.

It has been put to the Review that there is an opportunity to improve outcomes in the care of patients with chronic diseases and complex care needs by optimising the contribution of pharmacists in multidisciplinary care teams and primary health care settings – areas of the MBS which may be better utilised to reduce the impact of medication misadventure.

One organisation highlighted the Chronic Disease Management Service as an example of a service funded through the MBS which represents high value care for patients with chronic disease and complex care needs. However, this service is currently underutilised due to the exclusion of pharmacists as eligible allied health providers.

Other changes that have been proposed include:

- establishing a Pharmacists in General Practice Incentive Payment, analogous to the Practice Nurse Incentive Payment. It has been contended that pharmacists should be eligible to provide services, where appropriate, in the same way as services under the MBS are provided by practice nurses
- supporting after-hours services through the introduction of an after-hours pharmacy payment through the MBS.

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?

Alternatively, pharmacy could become more closely aligned with reforms occurring in primary care. This could take the form of collaboration with Primary Health Networks (PHNs) to identify local health service needs and PHNs could contract certain pharmacies to deliver services of particular value to that community. It has also been put to the Panel that closer integration of pharmacists and medical centres would be desirable, including clinical pharmacists being employed by the medical practice to deliver advice, with or without dispensing.

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?

Additional medicine related programs offered through community pharmacies have been funded both in the Sixth and previous CPAs. Further, some community pharmacies have shown innovation by designing and implementing new programs for their customers, sometimes on a user-pays basis.

However, there have been some issues with previous government funded programs. For example, in the case of the Home Medicines Reviews (HMR) program funded under the 5CPA, it became apparent during the Agreement, that the five-year funding allocation for this program would be exceeded. Additional funds were transferred from another area of the Agreement and a cap was introduced on the number of HMRs that a pharmacy could undertake each year.
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?

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?

36. Would any of these remuneration models be generalizable to other medicine services offered by pharmacies? Why or why not?

There are a number of programs and services available in community pharmacy which consumers may be charged for, such as dose administration aids, or blood pressure monitoring. Some pharmacies also offer weight loss or quit smoking services.

37. Is cost a barrier to accessing worthwhile health services offered by pharmacy?

38. 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?

39. Should both direct consumer remuneration and government-based remuneration be applied for particular services or access arrangements?

40. What pharmacy services should be fully or partially Government funded and what is best left to market or jurisdiction demands?

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?
REGULATION

The Commonwealth and the states and territories each have responsibility for different aspects of the regulation of pharmacy and pharmaceutical supply in Australia. Whereas the Commonwealth regulates pharmaceuticals and where pharmacies that dispense medicines subsidised under the PBS can be located, the states and territories regulate the ownership of pharmacies, as well as the licensing of pharmacists and pharmacy premises. In addition to Commonwealth regulations which govern the advertising of different categories of medicines (non-scheduled, pharmacy only, pharmacist only, and prescription only), differing legislation in each state and territory determine the specific control, supply and reporting arrangements applied to pharmaceuticals across Australia.

Also of relevance to the delivery of pharmacy, the states and territories regulate public and private hospitals, including private hospital ownership and standards for quality of care. As for pharmacy and pharmaceutical supply, the regulation of hospitals differs across states and territories.

Pharmacy Location Rules

The locations of pharmacies in Australia that are approved to supply medicines subsidised under the PBS, are determined through the application of pharmacy location rules that restrict where an approved pharmacy can either be established or re-located. The pharmacy location rules, setting out location-based criteria which must be met for a pharmacist to be approved to supply PBS medicines, aim to ensure a well distributed network of community pharmacies to provide reasonable access to PBS medicines to all Australians regardless of where they live.

It is important to understand that while the location rules determine where a pharmacy operated by an approved pharmacist can be located, they do not impose restrictions on who can own a pharmacy.

History of the Pharmacy Location Rules

In 1988, an enquiry conducted by the Pharmaceutical Benefits Remuneration Tribunal found that there was marked inconsistency in the location of pharmacies and the national network of pharmacies supplying PBS medicines. It found that many pharmacies in urban areas were clustered together with rural and remote areas having significantly poorer access. In some cases pharmacies were located within 10 m of each other, 25% of pharmacies were within 100 m of another pharmacy and 62% were within 1 km of another pharmacy, while other areas struggled to attract even one.

The overall pharmacy to population ratio in Australia was, at that time, considered high compared to other developed countries. There were 5,609 pharmacies, with a pharmacy to population ratio of 1:2,974.

In July 1990, the Commonwealth and the Guild agreed to set out a new remuneration framework for community pharmacy which was reflected in the First CPA. This was coupled with the introduction of pharmacy location rules in 1991, resulting in industry restructuring that would lower pharmacy numbers and encourage greater efficiency, profitability and economies of scale in individual pharmacy businesses.

A program of pharmacy closures and amalgamations was implemented, funded in partnership between pharmacists and the Commonwealth, and controls were imposed on the establishment of new pharmacies.

The pharmacy location rules have been a key component of successive five-year CPAs between the Commonwealth and the Guild.

In the First Agreement, the pharmacy location rules introduced specific requirements for the relocation of existing pharmacies and the establishment of new pharmacies approved to supply PBS medicines. This included a requirement for a new pharmacy to be located at least 5 km from the nearest approved pharmacy. In the short term the First Agreement enabled two major
policy objectives to be met: winding back what was then considered unsustainable growth in PBS remuneration, and, via the introduction of the pharmacy location rules, rationalising and reducing numbers of relatively inefficient pharmacies, in cooperation with the Guild.

The Second Community Pharmacy Agreement (1995-2000) sought to consolidate the remuneration structure and efficiency gains of the first. This agreement separately maintained pharmacy location rules, both in terms of satisfying a community need criteria to establish a new pharmacy, and to satisfy primarily distance-based criteria for relocated pharmacies.

The Third Community Pharmacy Agreement (2000-2005) reduced the emphasis on prescription based remuneration arrangements and modified the pharmacy location rules governing the location of pharmacies. The requirements for both new and relocated pharmacy approvals were relaxed, particularly in rural and remote areas. Financial incentives to support the operation of pharmacies in rural locations were also introduced through application of the RPMA which provided a monthly allowance to proprietors of approved pharmacies operating in rural and remote Australia.

The Fourth Community Pharmacy Agreement (2006-2010) introduced new provisions to facilitate the relocation of pharmacies into large medical centres, as well as small and large shopping centres (to recognise changing retail trends to smaller community shopping centres). There was also improved flexibility to allow the relocation of an existing pharmacy into single pharmacy towns and high growth single pharmacy urban areas.

The 5CPA converted the majority of previous relocation rules to new approval rules, to provide greater flexibility to establish new pharmacies in shopping centres, medical centres and private hospitals. These changes created an environment where pharmacists could realise ownership without the need to ‘buy’ an existing pharmacy.

The 6CPA continues the operation of the pharmacy location rules, as amended in October 2011. The Department of Health and the Pharmacy Guild of Australia, as signatories to the Sixth Agreement may review the location rules and advise the Minister for Health on whether an amendment is required. Minor amendments to the pharmacy location rules came into effect on 10 November 2015.

The pharmacy location rules currently comprise 11 Rules, each applicable to certain circumstances, including the relocation of an existing pharmacy within the local community (up to 1 km). The location rules also provide for the establishment of a new pharmacy where there is a demonstrable community need, for example, in a new development area, a non-urban locality or in a facility (small or large shopping centre, large private hospital or large medical centre).

Current Environment

There are differing views across the sector and in the community on the appropriateness of the current pharmacy location rules.

Those that support maintenance of the existing pharmacy location rules, argue that they provide pharmacy businesses with the certainty and capacity to allow continued investment in providing a range of high quality pharmacy and related services to the community. The Panel is aware of evidence presented to the Competition Policy Review by the Guild that supports the argument that the current community pharmacy model provides better access compared to supermarkets, banks and medical centres in regional and rural or remote areas.

Others who favour a removal of the pharmacy location rules, argue that they prevent competition in the sector and stifle innovation and consumer choice. They note that there are fewer community pharmacies in Australia today than there were in 1988, despite the considerable growth in population since that time.

The Panel invites views on the potential intended or unintended consequences or impacts from changes to the location rules on any part of the
pharmacy system and on consumer access to affordable medicines.

It has been argued that the pharmacy location rules limit both access to, and affordability of, prescription medicines. The pharmacy location rules have been the subject of numerous reports and reviews over the past 20 years, including the Wilkinson National Competition Policy Review of Pharmacy in 2005 and the 2005 Productivity Commission Review of National Competition Policy Reforms, 2010 Department of Health Post-implementation Review of Pharmacy Location Rules, 2014 National Commission of Audit and the Competition Policy (Harper) Review in 2015. These reviews reached a range of different conclusions.

Table 5 – International Regulation of Pharmacy

The Review is aware of overseas experiences with the removal of rules governing the locations in which pharmacies can operate and of the complications that this can create for community pharmacy and the overall health system. For instance, Vogler et al found that “access to pharmacies usually increases after a deregulation but this is likely to favour urban populations with already good accessibility”.

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?

As in Australia, many other countries regulate the establishment or location of community pharmacies. While the framework and extent of regulation varies between countries, the location (or ‘establishment’) of pharmacies is a common feature of pharmacy regulation. Internationally, debate over the regulation of pharmacy sector and markets has continued for some years. The varying approaches to the regulation of pharmacies in 13 countries including Australia are summarised in Table 5 below.

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?

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?

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?

The current location rules allow for the re-location of a pharmacy within a kilometre of its original location, provided that pharmacy has been at its original location for at least two years (Rule 124 - Short distance relocation).

Although intended to ensure flexibility for pharmacies to relocate within the local area, it has been put to the Review that this rule has allowed unintended and undesirable grouping of pharmacies in desirable urban areas.

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

Another feature of Location Rule 124 for short distance relocations is a requirement that a pharmacy relocating from within a shopping centre must not move to within 500 metres of any existing pharmacy not located within that shopping centre. This aims to avoid clustering of pharmacies outside shopping centres, as had previously occurred.

47. It has been suggested to the Review that this creates unintended consequences in locking pharmacies into specific shopping centres and transferring effective ownership of the pharmacy approval number to the shopping centre. Is this a reasonable assessment of the effect of the location rule regarding short distance relocation from a shopping centre? Should this rule be modified, and if so, why? If not, why not?

48. A similar requirement exists with the same rule for relocation of pharmacies from within medical centres. Is this requirement for medical centres desirable or undesirable?

It has been suggested to the Review that the current location rules create an undesirable barrier to new pharmacies wishing to compete for business in particular locations. This could provide benefits to the business viability of existing pharmacies.

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?

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.

To the extent that pharmacy location rules can benefit the viability of community pharmacy, it has been put to the Review that approved pharmacies should be required to offset this benefit by meeting an increased minimum level of services.

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?

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 support choice and value for money for consumers?

The current pharmacy location rules preclude the operation of a pharmacy from within a supermarket by specifically requiring that the premises from which an approved pharmacy operates are not directly accessible by the public from within a supermarket. The Review would like to better understand the objective of this requirement.

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?

Private hospitals include day hospitals that provide services on a day-only basis, and hospitals that provide overnight care.

Hospital pharmacists operate as part of the health care team within a hospital and are involved in providing medicines to patients, monitoring medication usage, counselling patients, providing drug information and advice to health professionals and the community, conducting clinical trials and preparing products for patient use.

Although initially developed to provide access to medicines in the community setting, the PBS provides various arrangements allowing access to PBS subsidised medicines for patients of both public and private hospitals, representing about 25% of annual PBS expenditure.

Section 90 - Community Pharmacies

Community pharmacies, approved to supply PBS medicines under section 90 of the National Health Act 1953, may supply medicines to private hospital patients through several mechanisms including:

- supplying PBS medicines to private hospital inpatients under contract to the hospital
- establishing community-based pharmacies within public and private hospital campuses.

Section 94 – Hospital Authorities

Under section 94 of the National Health Act 1953 a hospital authority may obtain approval in respect of a particular hospital to supply PBS medicines to patients being treated in or at that hospital. This allows for supply to in-patients (for private hospitals only), non-admitted patients, day admitted patients, and patients on discharge. Hospitals cannot supply PBS medicines to persons who are not patients, such as hospital staff, or members of the public.

Section 94 approvals are not restricted by the Pharmacy Location Rules but any hospital authority operating more than one hospital (or campus) is required to obtain a unique approval for each hospital. The ability to own and operate a pharmacy (or pharmacy department) is

Hospital Pharmacies

Hospital services in Australia are provided by both public and private hospitals. Public hospitals are mainly owned and managed by state and territory governments, whereas private hospitals are mainly owned and managed by private organisations; either for-profit companies, or not-for-profit non-government organisations.

Public hospitals include those providing acute care for short periods, or longer term care, such as for rehabilitation, as well as psychiatric hospitals specialising in the care of people with mental health conditions, sometimes for long periods.
determined by the relevant state or territory pharmacy legislation, and the premises to be used as a pharmacy are required (in most, but not all states) to be approved by the relevant statutory body.

A common arrangement for PBS medicines supply in private hospitals is for the hospital to obtain a section 94 approval, but engage a contracted pharmacy service provider to operate the pharmacy. In these cases the pharmacy utilises the hospital’s section 94 approval to claim payments for PBS medicines supplied to patients.

It has been put to the Panel that public and private hospital pharmacies should be able to provide broader services to the community beyond dispensing medicines to hospital patients alone.

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

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?

56. How might broadening the services provided by hospital pharmacies improve consumer access in rural and regional Australia?

Pharmacies in private and public hospitals currently gain access to medicines through tendering arrangements. It has been put to the Panel that the cost of medicines under these arrangements is quite different to PBS medicines. For example, the Panel understands that many public and private hospitals receive some medicines for significantly less than the PBS price and the price received by community pharmacy.

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

Hospitals may continue to provide medications for inpatients following their discharge from hospital.

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?

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

Section 100 Programs for specialised medicines

There are a number of PBS subsidised programs administered under s100 of the National Health Act 1953 providing access to a range of specialised medicines. These programs include the Highly Specialised Drugs (HSD), In-Vitro Fertilisation (IVF), Botulinum Toxin, Growth Hormone and Efficient Funding of Chemotherapy (EFC) programs. Each of these programs have unique eligibility and access arrangements for prescribers and patients as well as remuneration arrangements for pharmacists.

Historically, many of these medicines have been restricted to supply through public and private hospitals having access to appropriate specialist facilities because of their clinical use or other special features. Remuneration structures for these programs have been based on hospital supply. With the exception of EFC, where a
community based pharmacy is able to supply s100
listed medicines, they receive remuneration at the
private hospital rate (refer remuneration
breakdown as outlined in Table 4).

For HSDs to be supplied under the PBS, the
prescribing doctor must be affiliated with a
specialist hospital unit. HSDs may only be supplied
under s100 to patients attending a participating
hospital under the appropriate specialist medical
care, and meeting specific medical criteria. A
general practitioner or non-specialist hospital
doctor may only prescribe Highly Specialised Drugs
to provide maintenance therapy under the
guidance of the treating specialist.

An approval granted under s100 of the National
Health Act 1953 to a hospital authority, in respect
of a particular public hospital, enables a public
hospital authority that does not have a dispensary
or pharmacy at the hospital to claim for the supply
of highly specialised drugs. HSDs may be supplied
to patients receiving treatment in or at the public
hospital, where supply of those drugs is
undertaken by a third party such as a community
pharmacy, friendly society or agent.

Access to PBS subsidised medicines and
chemotherapy drugs by approved public hospital
authorities is dependent upon the hospitals
participation in the Pharmaceutical Reform
Arrangements under the National Health Care
Agreement. Currently all state and territories
with the exception of New South Wales and the
Australian Capital Territory participate in the
Pharmaceutical Reform Arrangements. Not all
public hospitals within participating state and
territories are registered to participate in these
arrangements.

All hospital authorities approved in respect of a
public hospital, irrespective of their participation
in the Pharmaceutical Reform Arrangements\(^5\) can
access s100 arrangements for highly specialised
drugs through the PBS for patients receiving
treatment in or at the hospital.

Recent changes to the HSD, IVF, Botulinum Toxin
and Growth Hormone programs have been
introduced to broaden access to medicines listed
on s100 programs within the community setting.
In particular, the HSD program has seen
community access arrangements introduced for
medicines for the treatment of Hepatitis B,
HIV/AIDS and schizophrenia (maintenance therapy
only). Prescription based supply and claiming
arrangements have also recently been introduced
for IVF, Botulinum Toxin (restricted to section 94
pharmacies only) and Growth Hormone. These
arrangements introduced remuneration for supply
for both section 90 and 94 pharmacies.

Remuneration for these medicines has been
retained at the private hospital section 100 rates
specified in Table 4.

NSW and the ACT do not currently participate in
Pharmaceutical Reform Arrangements under the
National Health Reform Agreement. It is
contended that economies of scale in these
domains has resulted in medicines being
purchased at much different prices to the PBS.

61. What other opportunities are there for
public and private hospital pharmacies in
securing supply options for greater
access to PBS subsidised medicines?

Aboriginal Health Services

Aboriginal and Torres Strait Islander people in
Australia continue to experience a higher burden
of disease and mortality than non-Indigenous
Australians. Eighty per cent of this mortality gap is
due to chronic disease – for which access to PBS
medicines is critical.

Aboriginal and Torres Strait Islanders face
significant barriers to access and effective use of
PBS medicines including financial, cultural and
geographic factors. Programs addressing access
and affordability in these populations include:

\(^5\) The Pharmaceutical Reform Arrangements form part of the National
Health Reform Agreement
s100 Remote Area Aboriginal Health Services Program (RAAHS)

This program provides access to PBS medicines under special supply arrangements for Aboriginal and Torres Strait Islander people in remote areas at no cost. Eligible remote Aboriginal Health Service (AHS) clinics may enter into an arrangement with a pharmacy to supply PBS medicines in bulk, which the AHS then stores and dispenses directly to patients under the supervision of a qualified health professional. Unlike usual PBS arrangements, patients at an AHS are provided their medicines at the time of consultation at the AHS and at no cost.

Pharmacists supplying PBS medicines under the RAAHS program are not required under the program legislation to be involved in the dispensing of medicines to individual patients and are essentially remunerated as wholesalers in recognition of this.

Whereas the s100 RAAHS program has increased access to medicines in remote areas, a question remains over whether those medicines are being used as effectively as possible to improve health outcomes. One concern is that this program currently only provides for the limited involvement of pharmacists in a wholesaling role.

62. Although s100 AHSs are able to fund the employment of a pharmacist from their primary health care budget, there are no specific funds to employ a pharmacist to conduct Quality Use of Medicines activities and manage the s100 program within the AHS. Do these arrangements impact on health outcomes?

s100 Support Program

This program supports Quality Use of Medicines within the s100 RAAHS program by providing an allowance to PBS approved pharmacies or approved hospital authorities to work with AHSs in dispensing medicines. Services supported include development and implementation of s100 supply arrangements, administrative procedures and protocols for managing supply, and development of measures to enhance Quality Use of Medicines (QUM) and provide educational services to AHS clinical staff.

63. The s100 Support Program supports increased involvement of pharmacists in the supply of PBS medicines to AHSs. Is there further scope for pharmacists to be more involved without impacting on access to medicines? Should pharmacists be able to directly claim an MBS type payment for QUM activities conducted in AHSs? Could this be a trial program under the 6CPA?

64. Could general improvements in remote dispensing improve the delivery of medicines in Aboriginal and Torres Strait Islander communities?

Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People

The Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People program (QUMAX) aims to improve health outcomes for Aboriginal and Torres Strait Islander people not living in a remote location, through a range of Quality Use of Medicines (QUM) support services provided by participating Aboriginal Community Controlled Health Organisations and community pharmacies in rural and urban Australia.

The program is intended to provide support to Aboriginal and Torres Strait Islander people who are assessed by a prescriber as being at risk of adverse health outcomes from a failure to comply with their medicine regime.

Closing the Gap Indigenous Chronic Disease Co-payment measure

This measure allows Aboriginal and Torres Strait Islander people to have their PBS co-payment reduced from the general co-payment to the concessional rate, or from the concessional rate to nil, if they:
have, or are at risk of developing, a chronic disease, and
• would experience setbacks in the prevention or ongoing management of the disease if they did not adhere to a course of treatment involving a PBS medicine for the disease
• are unlikely to adhere to the course of treatment without assistance under the Special Arrangement.

Patients must be registered prior to receiving a script under this measure. Scripts are then annotated that they are for supply under this measure. Prescribers must either be from an accredited General Practice, or from a non-remote Indigenous Health Services.

Indigenous Health services in remote communities cannot write Closing the Gap (CTG) prescriptions, and hospitals cannot write CTG prescriptions for out-patients.

AHSs that have a central clinic in a non-remote location and other clinics in remote areas cannot access the s100 RAAHS program, instead only being able to access CTG co-payment arrangements for each site. However, if they have out station clinics in remote areas, these out stations can access the s100 RAAHS program as long as they meet all the eligibility criteria. The Panel is aware that the Northern Territory is the only jurisdiction that allows an AHS to operate as a pharmacy.

65. **Should the s100 RAAHS program be extended to include non-remote AHSs?**
Similarly should the CTG Co-Payment measure and QUMAX programs be extended to include AHSs in remote areas?

66. **Should AHSs in all states and territories be able to operate a pharmacy business?**

Conversely, AHSs in remote areas that are accessing the s100 RAAHS program cannot access CTG co-payments for patients that plan to travel from the area served by their local AHS. Nor can remote AHSs access QUMAX funding for QUM activities, being able to only access the s100 Support Allowance.

67. **How could appropriate QUM activities be provided in all remote areas at a comparable level of quality to those provided in non-remote services?**

68. **Would it be desirable if remote s100 Aboriginal Health Services were also able to write CTG scripts?**

69. **Could the arrangements for s100 and CTG co-payments be merged to allow Indigenous people who travel to access both s100 while they are at home and CTG co-payments when they travel?**

70. **Should access to electronic patient health records be required for all health professionals treating Indigenous patients across all locations?**

71. **Should hospitals be allowed to write CTG co-payment scripts for out-patients?**

72. **Could there be more scope for tendering for the supply of medicines through AHSs?**
WHOLESALING, LOGISTICS AND DISTRIBUTION ARRANGEMENTS

PBS medicines are distributed to pharmacies across Australia through a number of competing channels. The competitors for distribution of PBS medicines include traditional wholesalers, who operate independently of manufacturers and supply the full range of PBS medicines within the CSO compliance requirements and standards, and pharmaceutical manufacturers who distribute their medicines directly to pharmacies.

Under CSO arrangements, payments are provided directly to eligible wholesalers (known as CSO Distributors) who supply the full range of PBS medicines to any pharmacy, usually within 24 hours, and that meet specific compliance requirements and service standards. These payments are over and above those made directly to pharmacists to cover the costs of supply from the wholesaler. The value of the CSO in each financial year during the Term of the 6CPA will be over $195 million. The CSO will not be indexed during the 6CPA.

A number of concerns about the CSO compliance standards have been raised with the Review. For example, the standards do not include the terms that are offered to community pharmacies by wholesalers. Recently, the listing of one ‘high cost’ medicine has meant that at least one wholesaler has reduced its terms of trade with community pharmacies for that medicine. This change in policy by this CSO wholesaler will reduce the wholesalers financing costs relating to the high cost medicine. However, this is achieved by simply passing on the financing costs to the community pharmacist.

Similarly, it has been noted to the Review that the broad definition of ‘rural’ used in the CSO compliance requirements leads to intense competition for deliveries to community pharmacies in rural locations that are easily serviced from metropolitan warehouses. However, competition is more subdued for more isolated rural and remote community pharmacies. It has been argued that the different level of service and pricing in these circumstances may undermine the objectives of the CSO.

Wholesale Margin

Wholesale margins for CSO distributors are set at 7.52% of the approved ex-manufacturer price of PBS medicines as part of the 6CPA. The Approved Price to Pharmacist (APP) includes the 7.52% wholesale margin and acts as a cap on the cost of distribution. Under the CSO Deed, PBS medicines must be supplied at or below the APP.

By selling below the APP (effectively losing some or all of the 7.52% wholesale margin) CSO distributors are able to offer discounts to pharmacies for any reason, including rewarding customer loyalty to increase market share or paying their account early. However, with the PBS pricing reforms reducing the cost of medicines along the supply chain, the wholesale margin available is being eroded – as the cost of the medicine falls, so too does the mark-up from which wholesalers derive their profits. Subsequently, wholesalers are left with less room to move when offering discounts to pharmacies, in some cases having to cease this practice completely.

Furthermore, the falling price of medicines and associated wholesale margin through Price Disclosure does not take into account the increasing cost of conducting the business of wholesaling (infrastructure, wages, insurance etc.). In the future, it is likely that wholesalers will be dealing with increased business costs and reduced revenue as a result of the falling wholesaler margin.
Recent changes to the CSO Distributor network

On 1 July 2015 the Efficient PBS Wholesaler Arrangements measure was implemented to continue improvements to the administration of the CSO through the simplification of reporting, regulation and compliance processes, such as:

- relaxing the reporting requirements for breakages and other specific items;
- recognising that high-volume PBS items, which are more regularly ordered, can be ordered less often and more efficiently with the timing of deliveries reflecting a 72 hour commitment for supply to pharmacies.

The Review Panel is interested in understanding how the current CSO arrangements could be further reformed to improve consumer access and affordability.

73. Is the current approach to CPA negotiations, as adopted in the 6CPA, an appropriate way to meet wholesalers’ needs? If so, why? If not, why not?

74. Are there alternatives to the current CSO rules that would enable wholesalers to improve the efficiencies of their services without detracting from the consumer experience and access?

75. Pfizer supply direct and do not provide their medicines for supply through the CSO. Should all PBS medicines be available through the CSO, or is it appropriate for a manufacturer to only supply direct to the pharmacy?

76. Should s100 and RPBS items be included in normal wholesale arrangements and in the CSO? If so, why? If not, how do the current arrangements support consumer access to all PBS and RPBS items?

77. Have recent changes to the CSO, such as the extension of the guaranteed supply period and introduction of minimum
order quantities, had an impact on consumer access or choice? If so, what evidence is available to demonstrate this?

78. Currently not all areas are covered by the 24-hours CSO obligations (such as Christmas Island, Derby (WA) and Mission River (QLD)). Are these exceptions leading to detrimental outcomes for patients? If so, why? If not, why not? If so, should they be included in the 24-hour rule? If so, how is this logistically possible? If not, are there other areas of Australia that could be excluded from the 24-hour rule without adverse patient impact?

Currently CSO wholesalers have discretion in relation to the trading terms and conditions agreed with community pharmacies, other than timeliness of delivery and price.

79. Should CSO wholesalers have such discretion, or should they as part of the CSO arrangements be required to provide minimum terms and conditions for PBS items?

80. In the 6CPA there was a change in the CSO requirements relating to 72-hour delivery for the 1000 highest volume medicines. Was this a desirable change? What impacts has this had and is there evidence available to demonstrate this?

81. CSO wholesalers can require minimum ordering amounts for specific medicines. This is likely to reduce the cost to the wholesaler while increasing inventory costs and wastage for the pharmacy. Is this desirable or undesirable? Are there other parts of the wholesaling arrangements that create or encourage cost shifting that are undesirable for community pharmacy or consumers?

The Review has heard concerns over the delivery of short-dated stock.

82. Should there be requirements on wholesalers relating to minimum usage dates of stock? Would such requirements increase or decrease wastage in the system? Would this shift costs to community pharmacy and reduce the efficiency of the system?

The CSO requires wholesalers to supply a minimum level of service to rural and remote areas, however it has been contended that wholesalers have a strong incentive to gain custom from community pharmacy in rural areas close to cities compared to genuinely rural or remote areas.

83. Does the current CSO arrangement lead to strategic variation in trading terms by wholesalers that is detrimental to some community pharmacies and patients. If so, how? How could the current system be modified to remove such undesirable strategic behaviours?

84. Is a percentage mark-up paid by the pharmacist an appropriate way to compensate wholesalers? Would an alternative compensation arrangement be preferred? If so, please provide details of preferred arrangements.

The discussion above presents the current wholesaling model, however there are other wholesaling models used in Australia and overseas, in pharmaceuticals and other industries, such as telecommunications. This set of questions deals with alternative models of wholesaling for pharmaceuticals.

85. Could the Government provide either improved wholesale medicine delivery or equivalent wholesale medicine delivery at a lower cost to consumers and taxpayers by moving from a broad CSO system to an alternative system?

86. Should the onus for the delivery of medicines to community pharmacy around Australia in a timely fashion (e.g. 24-hours) be imposed on the
manufactures as part of their listing requirements on the PBS?

Under this approach, the Commonwealth Government would not have a specific role in either regulating or remunerating pharmacy wholesaling. Rather it would be the responsibility of the manufacturers, either individually or as a group. In addition to the wholesaling requirement, there might be other conditions imposed in the PBS listing for certain wholesaling requirements (e.g. 30 day payment terms).

Conversely, the responsibility for timely delivery of medicines could be placed back on the pharmacist.

87. Should the onus to negotiate the delivery of PBS medicines from manufacturers be placed on community pharmacies, either individually or as collectives? Would this be desirable or undesirable?

An alternative model would be a tendering basis, as occurs for a number of other government services relied upon by the community.

88. Would an improved approach to wholesale medicine delivery involve the Government tendering delivery on a nation-wide basis to one or two wholesalers (with appropriate redundancies)? Should it be done on a national, state or local basis? Should tendering be limited to only Pharmacy Accessibility Remoteness Index of Australia (PhARIA) 2, 3 and 4 locations, with open competition in PhARIA 1 areas?

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)?
ACCOUNTABILITY AND REGULATION

Pharmacy Regulation

Under the Terms of Reference, it is noted the Review will consider accountability and regulation in the community pharmacy sector. We have discussed specific regulations in the sections 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?

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

Accountability

The Panel has been advised of concerns by some stakeholders over the accountability for the delivery of professional programs under the CPA. It has been noted that such programs should require adequate evidence-based evaluation to ensure that they achieve community outcomes and are not misused.

A clear issue in relation to the delivery of pharmacy services, both currently and in the future, is the lack of data regarding patient health outcomes.

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?

93. Is there a role for pharmacists to work with patients and other health professionals, possibly relating to individual medicines or specific conditions, to better create the data to analyse the health outcomes for that particular patient or group of patients, including through the use of a patient’s existing My Health Record?

It has been put to the Panel that partnerships between the pharmacist and patient could deliver opportunities for further data collection and information on the specific utilisation of medicines and health outcomes in real time.

94. If this data collection and analysis is desirable, would funding be needed from Government or from another source? If so, what would be the avenue for such funding?

The Community Pharmacy Service Charter is an accreditation requirement of the Guild’s Quality Care Pharmacy Program (QCPP) and a key eligibility requirement of the Pharmacy Practice Incentive Program (PPI) under the 6CPA. The Charter was developed to allow patients, consumers, families, carers and pharmacy staff to share an understanding of the rights of people receiving services in pharmacies and to assist consumers receive safe and effective health care through their local community pharmacy.

A Customer Service Statement (CSS) forms part of the Charter and is intended to provide customers with information about the pharmacy and what specific professional services are offered. To comply with QCPP and to be eligible to receive 6CPA PPI payments, pharmacies are required to display and comply with the CSS and uphold the Charter’s seven standards.

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?

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?
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?

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?
CONSUMER EXPERIENCE

A key part of this Review is the focus on the consumer experience, in particular consumer attitudes, expectations and priorities.

Consumer needs and expectations in relation to community pharmacy vary widely depending on the individual circumstances and requirements of the patient. An important aim of this Paper is to better understand the expectations of consumers, and encourage all interested parties to think about what type of pharmacy health care services and arrangements will best meet future consumer needs.

It has been put to the Panel that consumers expect community pharmacy medicines, programs and services to be:

Accessible and able to be offered in a convenient and timely manner

This includes:

- ensuring consumers are aware of the services that they have a right to receive as part of the dispensing process
- ensuring consumers are aware of other services available to them from different community pharmacies
- access to dispensing outside ‘normal’ trading hours
- innovative and flexible methods of engagement such as online ordering; other forms of ‘distance’ ordering, electronic repeat prescription reminders; and home delivery services.

Provided by a competent and trusted health care professional

Who:

- provides consumers with (or connects them to) relevant advice, information and services appropriate to their needs
- like other health care providers, is held accountable for patient outcomes.

Able to support specific health care needs

For people:

- with chronic illness and complex treatment regimens as part of an integrated model of health care designed to achieve better health outcomes
- who are elderly
- who are Aboriginal and Torres Strait Islanders
- who are from culturally and linguistically diverse backgrounds.

Transparently cost effective

Services subsidised by taxpayers should:

- be determined to be of value to consumers
- provide appropriate incentives in terms of required health outcomes (not inputs) by monitoring health outcomes.

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

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?

101. What does ‘transparently cost effective’ mean for consumers in the context of remunerated pharmacy services?
Figure 12 - Examples of Dispensing Services Provided by Community Pharmacists

Patient Scenario 1: Medication Complication

Mrs Jones goes to her local pharmacy to fill her new prescription.

The pharmacist notices the new medicine is likely to have a serious interaction with the medication Mrs Jones is already taking. He discusses this with Mrs Jones and gets her permission to call her doctor.

The pharmacist contacts the prescribing doctor to discuss the interaction of the two medicines. The doctor prescribes an alternative medication. The pharmacist needs to order the medication from his CSO wholesaler as it is not one he usually stocks.

The medication arrives later that afternoon. The pharmacist reviews the instructions and cautions labels.

The pharmacist calls Mrs Jones to come and collect her medication. The pharmacist explains how to use it and checks to see if she has any questions.

Patient Scenario 2: Referral Back to GP

Mr Smith takes his son John to fill his repeat prescription for Ventolin using his concession card.

The pharmacist checks the last time the script was filled. He can see that it has been filled more frequently in the last three months.

The pharmacist checks the brand and strength of the medication. Everything is in order.

The pharmacist labels the Ventolin.

The pharmacist dispenses the medication and asks how John’s asthma is going. When Mr Smith explains John’s asthma has been getting worse the pharmacist recommends going back to their GP to review John’s asthma action plan.

It has been put to the Panel that a strength of Australia’s community pharmacy network is the wide range of professional programs and services offered by pharmacists, beyond the dispensing of medicines. In addition to dispensing, community pharmacies are also remunerated to deliver the following services:

Medication Adherence Programs
- Dose Administration Aids
- Staged supply

Medication Management Programs
- Clinical interventions
- Home Medicines Reviews
- Residential Medical Management Reviews
- MedsCheck

Aboriginal and Torres Strait Islander Programs
- QUMAX
- s100 Support allowance
- Aboriginal and Torres Strait Islander Workforce Program
Rural Support Programs

- Rural Pharmacy Workforce Program
- Rural Pharmacy Maintenance Allowance

eHealth

- Electronic Prescription Fee

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

Pharmacy services and advice

Pharmacists provide consumers with important services, and many consumers view pharmacy as a convenient, accessible destination for the supply of medication, health care services and referrals to other support services (where needed).

However, some consumer experience is mixed in terms of the quality of advice on offer and having their specific health care needs met. Some individuals have suggested that, in their experience, the provision of services as part of dispensing in community pharmacy depends on how busy the pharmacy is at the time, and the nature of the consumer (initial script versus repeat, regular consumer versus once-off). It has also been suggested that some consumers face implicit or explicit discrimination in the dispensing process due to the nature of their condition and the medicines that they require.

It has been put to the Review that while consumer groups believe that the scope of pharmacy practice is expanding, the level and quality of service, guidance and advice is inconsistent.

Different Pharmacy Models

It is recognised that there is considerable differentiation among community pharmacies. This includes, but is not limited to, differences in the pricing of medicines (including prescription medicines) and differences in the range of services provided (including co-dispensing services). Some parties inferred that these factors were correlated with ‘discount’ community pharmacies providing low prices but poor service while higher priced community pharmacies were ‘full service’.

However, the Panel has also heard the opposite view, that these factors are unrelated.

As noted earlier, there are a range of different models of community pharmacy in Australia. Some consumers recognise these differences and shop accordingly. It has been put to the Panel that different models can lead to inconsistent consumer experience.

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

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

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

It has been put to the Panel that when it comes to choosing a community pharmacy, there is not a ‘one size fits all’ pharmacy model for every consumer. It depends on their personal needs and preferences, the costs versus the benefits of each model, and their comparison of the level of programs and services on offer.

Consumer Education and Awareness

It has been put to the Panel that to support consumer choice and sovereignty in the selection of community pharmacies, consumers need:
• a greater awareness of the services on offer and the obligations on the pharmacist to provide those services
• for any fees and charges to be made more transparent.

It is contended that there is generally a low level of awareness among consumers of community pharmacy services on offer and in particular where a pharmacy/pharmacist has a specialist accreditation or offers a specialist supply. It was put to the Panel that initiatives are needed to promote broader community understanding and awareness of pharmacy services, such as an online listing of where specialist services can be accessed.

It has been put to the Panel that consumers:
• expect all charges to be transparent so that they can assess ‘value for money’ and make a choice between community pharmacy programs and services on offer
• would like pharmacies to make it clear whether they do (or do not) offer a $1 discount on the PBS patient co-payment. It is claimed that consumers are concerned and confused about the variation in price for prescription medicines.

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

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?

109. What examples can you provide of variation in prices for regular PBS prescriptions?

The Panel understands that advertising restrictions limit consumer awareness of the range of medicines and related advice that pharmacists are able to initiate without a prescription. For example, conjunctivitis treatments, vaccinations and wound care management.

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?

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

There are restrictions on the availability and degree of control exercised over medicines in Australia, which correspond to Government ‘Schedule’ levels. Schedule 2 (Pharmacy Medicine) and Schedule 3 (Pharmacist-only Medicine) medicines may be dangerous to consumers in certain circumstances and consumers may require professional advice from a pharmacist. Consumers generally can only purchase these medicines from a community pharmacy, but do not need a prescription to make such purchases.

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

It has been put to the Panel that requiring consumers to purchase these medicines from a community pharmacy may limit consumers’ access to these medicines. However, broader access may create risks for some consumers.

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?

Some common non-prescription medicines are only available from a pharmacy or purchased from a pharmacist, such as schedule 3 analgesics, decongestants and certain cold-sore preparations.

114. Is the sale of schedule 2 and 3 medicines an important contributor to the income of community pharmacies?
Conflict between the retail and health care environment

It was put to the Panel that community pharmacists face conflicts of interest between their role as retailers and as health care professionals. This tension between treating consumers as customers or patients was attributed to the contrast in the remuneration from dispensing and the revenue generated from the sale of over-the-counter (OTC) medicines and complementary products. The Panel has heard that some consumers are concerned that pharmacists may compromise on the level of professional advice provided to patients on the quality use of medicines and feel financial pressure to ‘up-sell’ to consumers, for example by recommending medicines or products that may not be necessary for the patient. It was also claimed that many complementary products do not have evidence-based health benefits and as such, the sale of these products in a pharmacy setting may misinform consumers of their effectiveness and undermine the professional integrity of community pharmacists.

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?

118. Does the ‘retail environment’ within which community pharmacy operates detract from health care objectives?

Affordability of Medicines

Under the PBS, the Government subsidies the cost of a listed medicine and the patient contributes a set co-payment amount, currently $38.30 for a general patient and $6.20 for a concessional patient. However, charges can vary between brands of the same medicine, and between different pharmacies for the same medicine. It has been put to the Panel that these price differences can cause confusion for consumers, and raise concerns about valid pricing.

Figure 9 and 10 earlier in the paper illustrated the applicable co-payments and charges under different medicine prices. The patient may also pay a brand premium if they select (or their prescription requires) a specific brand where the supplier has requested an additional payment. This payment is made to the drug company.

For general patients, a pharmacist may choose to discount below the maximum allowed price. This can lead to significant variation in the price of a particular prescription medicine between different pharmacies.

From 1 January 2016, community pharmacies have been able to discount the patient co-payment by up to $1 if the individual pharmacy chooses to do so.

The PBS Safety Net protects patients and their families who require a large number of PBS or RPBS items.

There are two Safety Net thresholds. The general patient safety net threshold is currently $1,475.70. When a person and/or their family’s total applicable co-payments reach this amount, they may apply for a safety net concession card and pay the concessional co-payment amount of $6.20 plus any applicable premium for pharmaceutical benefits for the rest of that calendar year.

The concessional Safety Net threshold is $372.00 (this also applies to gold, white or orange card holders under the RPBS). When a patient and/or their family’s total applicable co-payments reach this amount, they may apply for a safety net.
entitlement card and may receive pharmaceutical benefits free of charge (except for any applicable premium) for the rest of that calendar year.

Brand premiums, therapeutic group premiums and special patient contributions do not count towards the safety net thresholds.

The Safety Net thresholds are adjusted on 1 January each year in line with inflation.

Despite the PBS Safety Net and other recent innovations, such as the potential for a $1 co-payment discount, cost can still be a barrier both to the purchasing, and quality use, of medicines. It has been put to the Panel by consumer groups that there is a need to contain out-of-pocket costs, particularly for people with chronic and complex conditions – or alternatively, spread the costs more evenly throughout the year.

Some consumer groups have told the Review that people on low incomes who do not qualify for concession cards are particularly vulnerable to the impact of any increased costs. As a result, many delay or do not proceed with appropriate care or medication, risking an aggravation of their current condition that can potentially lead to higher costs to the overall health system in the future.

119. Are the current consumer payments for the supply and dispensing of PBS listed medicines transparent? Are they appropriate?

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?

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?

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?

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?

Consumer Access

It was put to the Panel that the operating hours of community pharmacies can serve to limit consumer access to medicines and professional advice, particularly for consumers impacted by working arrangements, unpredictable nature of chronic illnesses and sudden onset or emergency conditions. In addition, pharmacy opening hours do not necessarily reflect other health professionals (for example, patients visiting a GP outside normal business hours would have an expectation of access to prescribed medicines).

While some pharmacies operate out of hours and even coordinate with local medical clinics, this is not systematic. Further, where pharmacies are open 24 hours, the Review has been informed that the additional security and operating costs threaten the viability of this service, as pharmacies are not directly remunerated for providing extended opening hours.

There appear to be few coordinated programs by local community pharmacists to ensure 24-hour access in a region or location. While such agreements are likely to require approval from the competition authorities, they exist for other medical services, such as after-hours medical clinic arrangements.

It has been put to the Panel that even where pharmacies are open longer hours this is often not well communicated, resulting in lack of consumer awareness of the service.
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?

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?

Inequity Issues Raised with the Panel

Inequities in Rural and Remote Communities

It was put to the Panel that the supply of medicines to AHSs under s100 arrangements is a valuable program assisting Aboriginal people access medicines.

However, some consumer organisations noted that while medicines are supplied in bulk to remote AHSs, under s100 arrangements, the services of a pharmacist are generally not available to then dispense medicines to patients.

Consequently, the medicines may not be labelled, nor recorded in the consumer’s health record, and the patient may not receive any advice about the medicine or ongoing review of its efficacy - all normal services available when medicines are obtained from a community pharmacist. Programs such as QUMAX, the s100 Support Allowance and CTG were noted as assisting in this regard.

It has also been suggested that current programs and services need to better integrated and respect a consumer’s right to move between locations, as well as expanded to improve access to, and the quality use of medicines in remote and marginalised service areas.

126. Does more need to be done to encourage greater access to medicines and professional services through the expansion of existing rural and remote programs?

Literacy and Cultural Sensitivity

It was put to the Panel that some segments of the community can face significant issues in both understanding their rights with respect to the delivery of pharmacy services and in gaining appropriate access to information about their medicines. It was contended that these literacy issues are more prevalent in culturally and linguistically diverse (CALD) communities. The Review Panel has seen examples of pharmacies that specifically cater for CALD consumers in their community through multi-lingual staff and pharmacists of varying ethnic backgrounds, however such initiatives are not universal or actively promoted.

The Review was also informed that better health outcomes could be achieved through more culturally sensitive services. For example, the need for programs such as the Home Medicines Reviews to be cognisant of the cultural sensitivities associated with entering the homes of Aboriginal and Torres Strait Islander people.

Need to improve awareness of specialist programs and services

It was put to the Panel that one means of reducing inequitable health care is to improve consumers awareness of specialist programs and services, such as treatments for opioid dependency, dispensing of hepatitis C drugs, and provision of fit-packs.

Although programs are in place for the delivery of certain specialist services, not all community pharmacies participate in these programs and in many instances do not promote the services. It was noted to the Panel that consumers accessing these specialist services are hesitant to openly ask about these services owing to privacy concerns and stigma associated with their condition.

Consumer groups suggested that public education and awareness of these specialist services could be improved through an online website or digital application that listed all community pharmacies that delivered specialist services. It was also noted that discreet symbols could be displayed at the front of pharmacy premises to denote participation in specialist programs.
127. Is it reasonable for consumers to expect that all community pharmacies provide these specialist services? If so, why? If not, why not?

128. Would it be desirable to align the delivery of specialist services to population need in local communities? If so, what is the best way of coordinating appropriate and relevant services for populations of need?

Need to accommodate privacy preferences

It was noted to the Panel that the provision of medicines and specialist services in an open community pharmacy setting can be discouraging for consumers who seek to maintain their privacy and avoid breaches of confidentiality. While it was acknowledged that many pharmacies provide private consultation rooms, it was also noted that entering these rooms may draw unwanted visibility, and may undermine the confidence of the affected groups to seeking health care advice and services.

It was suggested that in order to protect their confidentiality, some consumers would prefer alternative means for accessing follow-up treatment and counselling, such as through online and telephone pharmacy services.

129. How might access and service barriers identified above be resolved and consumer needs be better met? Is additional training and support within community pharmacy sites needed?

130. Are there other inequities in terms of access to and quality use of medicines? If so, how should those be addressed and what population groups could be targeted?

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

132. How can we encourage and support consumers to engage more with their local pharmacy and what specific patient groups require more general awareness about available pharmacy services?
**CHEMOTHERAPY ARRANGEMENTS**

Preparation and supply of chemotherapy infusions is a niche area of pharmacy practice requiring both capital investment and specialised knowledge. In Australia, fewer than fifty pharmacies (less than one per cent) supply 70% of chemotherapy infusions funded under the PBS. Chemotherapy infusions are administered to patients in hospital or day clinic settings, with approximately 60% of infusions administered through private hospitals and day procedure centres and 40% administered through public hospitals. In 2014-15, the PBS subsidised around 946,000 chemotherapy infusions at a cost to the Australian Government of $728 million.

Table 6 – Chemotherapy Fees

<table>
<thead>
<tr>
<th>Fee</th>
<th>s90 Community Pharmacy</th>
<th>s94 Approved Public Hospital</th>
<th>s94 Approved Private Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distribution fee ($25.59)</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>Diluent Fee ($5.07)</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>Preparation Fee ($82.67)</td>
<td>✓</td>
<td>X</td>
<td>✓ *</td>
</tr>
<tr>
<td>Ready Prepared Dispensing Fee ($6.93)</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
</tr>
</tbody>
</table>

*not payable where the drug is trastuzumab

Fees are paid for chemotherapy medicines to the supplying pharmacist in accordance with the Efficient Funding of Chemotherapy (EFC) Measure. These fees are paid to recognise the specialist nature of preparing chemotherapy medicines. These are in addition to the Ready Prepared Dispensing Fee of $6.93, and include:

- Preparation fee ($82.67)
- Distribution fee ($25.59), which replaces the wholesale mark-up
- Diluent fee ($5.07).

Public hospital pharmacies which are authorised to supply PBS subsidised chemotherapy medicines are only eligible for the preparation fee (i.e. not the distribution or diluent fees).

The Government has introduced a compound fee to recognise the additional steps required to compound each patient specific infusion. This compound fee is $40 per eligible EFC claim.

An additional $20 per eligible EFC claim is available for infusions compounded by a facility that holds a manufacturing licence from the Therapeutic Goods Administration (TGA). This fee will be paid directly to the commercial third party compounding pharmacy supplying the infusion via an external agency.

There have been representations to the Review that $40 is insufficient to support the ongoing viability of in-house compounding, particularly hospitals and pharmacies compounding infusions in rural and remote locations, or on an as needs basis. This could potentially drive hospitals to use commercial TGA licensed third party compounders, which has flow-ons resulting in higher costs to the PBS through the higher compounding fee, and increased wastage of infused chemotherapy.

There is a high level of complexity with many different models of chemotherapy pharmaceutical service provision, each with differing commercial arrangements between the hospitals, pharmacies and oncologists involved. Factors influencing these various models include:

- economies of scale and location have driven an increased use of out-sourced infusion compounding through commercial third party compounders
- some of these delivery models involve commercial or equity relationships between pharmacists, oncologists and hospitals
- chemotherapy services have shifted from the public sector to the private sector over time, transferring medicine costs to the PBS.
It has been put to the Panel that the PBS price disclosure measure has removed the excessive profit margins for multi brand medicines. The Review of Chemotherapy had otherwise provided evidence that reimbursement of chemotherapy costs were being used to support provision of related health services. Remuneration available thorough PBS mark-ups and fees under the Efficient Funding of Chemotherapy arrangements may no longer be sufficient to adequately meet the costs of compounding and supply for the average pharmacy.

Data provided to the 2013 Review of Chemotherapy Funding Arrangements by a sample of pharmacies indicated that there may be a deficit in funding. However, there are limitations in the verifiability and representativeness of the data due to the small number of data sets and inconsistencies between reported costs.

While the anecdotal evidence supporting the shortfall in funding has been provided during bilateral consultations, the Review Panel encourages stakeholders to provide robust cost data to fully assess the impact current funding levels are having on the long term provision of these vital services.

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?

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

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?

137. Are the levels of these fees sufficient to ensure long term viability of compounding services?

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

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?

140. Are there other issues with the production and delivery of chemotherapy medicines which the Panel should be aware of?
Presented below is a complete listing of the questions posed in the Discussion Paper, arranged in the context of the key areas of the Review Terms of Reference.

**Pharmacy Remuneration for Dispensing**

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?

15. Is the ‘swings and roundabouts’ approach to remunerating pharmacists for dispensing appropriate? Does it lead to undesirable incentives?

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?

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?

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?

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?

20. Is the Electronic Prescription Fee achieving its intended purpose of increasing the uptake of electronic prescribing and dispensing?

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?

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?

24. Given that very high cost drugs are likely to become more common on the PBS, should this remuneration structure for hospitals change to more closely reflect the remuneration structure of community pharmacy?

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?

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?
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?

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?

29. Is it appropriate that the PBS links the remuneration for the provisions of professional advice to the sale of medicines?

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?

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?

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?

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?

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?

36. Would any of these remuneration models be generalizable to other medicine services offered by pharmacies? Why or why not?

37. Is cost a barrier to accessing worthwhile health services offered by pharmacy?

38. 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?

39. Should both direct consumer remuneration and government-based remuneration be applied for particular services or access arrangements?

40. What pharmacy services should be fully or partially PBS funded and what is best left to market or jurisdiction demands?

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?
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?

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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?

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

**Regulation**

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

2. If it is desirable for the ratio of community pharmacies to population to increase or decrease in some areas, what in your opinion is the best way to encourage this?

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?

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?

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?

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
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?

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?

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?

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?

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?

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?

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?

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?

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?

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

47. It has been suggested to the Review that this creates unintended consequences in locking pharmacies into specific shopping centres and transferring effective ownership of the pharmacy approval number to the shopping centre. Is this a reasonable assessment of the effect of the location rule regarding short distance relocation from a shopping centre? Should this rule be modified, and if so, why? If not, why not?

48. A similar requirement exists with the same rule for relocation of pharmacies from within medical centres. Is this
requirement for medical centres desirable or undesirable?

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?

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.

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?

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 support choice and value for money for consumers?

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?

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

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?

56. How might broadening the services provided by hospital pharmacies improve consumer access in rural and regional Australia?

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

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?

60. Could dispensing arrangements by hospital pharmacies to patients be extended to the broader community to complement access to medicines through community pharmacy?
61. What other opportunities are there for public and private hospital pharmacies in securing supply options for greater access to PBS subsidised medicines?

62. Although s100 AHSs are able to fund the employment of a pharmacist from their primary health care budget, there are no specific funds to employ a pharmacist to conduct Quality Use of Medicines activities and manage the s100 program within the AHS. Do these arrangements impact on health outcomes?

63. The s100 Support Program supports increased involvement of pharmacists in the supply of PBS medicines to AHSs. Is there further scope for pharmacists to be more involved without impacting on access to medicines? Should pharmacists be able to directly claim an MBS type payment for QUM activities conducted in AHSs? Could this be a trial program under the 6CPA?

64. Could general improvements in remote dispensing improve the delivery of medicines in Aboriginal and Torres Strait Islander communities?

65. Should the s100 RAAHS program be extended to include non-remote AHSs? Similarly should the CTG Co-Payment measure and QUMAX programs be extended to include AHSs in remote areas?

66. Should AHSs in all states and territories be able to operate a pharmacy business?

67. How could appropriate QUM activities be provided in all remote areas at a comparable level of quality to those provided in non-remote services?

68. Would it be desirable if remote s100 Aboriginal Health Services were also able to write CTG scripts?

69. Could the arrangements for s100 and CTG co-payments be merged to allow Indigenous people who travel to access both s100 while they are at home and CTG co-payments when they travel?

70. Should access to electronic patient health records be required for all health professionals treating Indigenous patients across all locations?

71. Should hospitals be allowed to write CTG co-payment scripts for out-patients?

72. Could there be more scope for tendering for the supply of medicines through AHSs?

Wholesaling, Logistics and Distribution Arrangements

73. Is the current approach to CPA negotiations, as adopted in the 6CPA, an appropriate way to meet wholesalers’ needs? If so, why? If not, why not?

74. Are there alternatives to the current CSO rules that would enable wholesalers to improve the efficiencies of their services without detracting from the consumer experience and access?

75. Pfizer supply direct and do not provide their medicines for supply through the CSO. Should all PBS medicines be available through the CSO, or is it appropriate for a manufacturer to only supply direct to the pharmacy?

76. Should s100 and RPBS items be included in normal wholesale arrangements and in the CSO? If so, why? If not, how do the current arrangements support consumer access to all PBS and RPBS items?

77. Have recent changes to the CSO, such as the extension of the guaranteed supply period and introduction of minimum order quantities, had an impact on consumer access or choice? If so, what evidence is available to demonstrate this?
78. Currently not all areas are covered by the 24-hours CSO obligations (such as Christmas Island, Derby (WA) and Mission River (QLD)). Are these exceptions leading to detrimental outcomes for patients? If so, why? If not, why not? If so, should they be included in the 24-hour rule? If so, how is this logistically possible? If not, are there other areas of Australia that could be excluded from the 24-hour rule without adverse patient impact?

79. Should CSO wholesalers have such discretion, or should they as part of the CSO arrangements be required to provide minimum terms and conditions for PBS items?

80. In the 6CPA there was a change in the CSO requirements relating to 72-hour delivery for the 1000 highest volume medicines. Was this a desirable change? What impacts has this had and is there evidence available to demonstrate this?

81. CSO wholesalers can require minimum ordering amounts for specific medicines. This is likely to reduce the cost to the wholesaler while increasing inventory costs and wastage for the pharmacy. Is this desirable or undesirable? Are there other parts of the wholesaling arrangements that create or encourage cost shifting that are undesirable for community pharmacy or consumers?

82. Should there be requirements on wholesalers relating to minimum usage dates of stock? Would such requirements increase or decrease wastage in the system? Would this shift costs to community pharmacy and reduce the efficiency of the system?

83. Does the current CSO arrangement lead to strategic variation in trading terms by wholesalers that is detrimental to some community pharmacies and patients. If so, how? How could the current system be modified to remove such undesirable strategic behaviours?

84. Is a percentage mark-up paid by the pharmacist an appropriate way to compensate wholesalers? Would an alternative compensation arrangement be preferred? If so, please provide details of preferred arrangements.

85. Could the Government provide either improved wholesale medicine delivery or equivalent wholesale medicine delivery at a lower cost to consumers and taxpayers by moving from a broad CSO system to an alternative system?

86. Should the onus for the delivery of medicines to community pharmacy around Australia in a timely fashion (e.g. 24-hours) be imposed on the manufactures as part of their listing requirements on the PBS?

87. Should the onus to negotiate the delivery of PBS medicines from manufacturers be placed on community pharmacies, either individually or as collectives? Would this be desirable or undesirable?

88. Would an improved approach to wholesale medicine delivery involve the Government tendering delivery on a nation-wide basis to one or two wholesalers (with appropriate redundancies)? Should it be done on a national, state or local basis? Should tendering be limited to only Pharmacy Accessibility Remoteness Index of Australia (PhARIA) 2, 3 and 4 locations, with open competition in PhARIA 1 areas?

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)?

Accountability and Regulation

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?

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

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?

93. Is there a role for pharmacists to work with patients and other health professionals, possibly relating to individual medicines or specific conditions, to better create the data to analyse the health outcomes for that particular patient or group of patients, including through the use of a patient’s existing My Health Record?

94. If this data collection and analysis is desirable, would funding be needed from Government or from another source? If so, what would be the avenue for such funding?

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?

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?

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?

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?

Consumer Experience

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?

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

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?

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

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

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

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

106. How do we measure the level of service provided by the pharmacy?

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

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?

109. What examples can you provide of variation in prices for regular PBS prescriptions?

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?

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

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?

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?

118. Does the ‘retail environment’ within which community pharmacy operates detract from health care objectives?

119. Are the current consumer payments for the supply and dispensing of PBS listed medicines transparent? Are they appropriate?

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?

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?

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?

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?

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?

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?

126. Does more need to be done to encourage greater access to medicines and professional services through the expansion of existing rural and remote programs?

127. Is it reasonable for consumers to expect that all community pharmacies provide these specialist services? If so, why? If not, why not?

128. Would it be desirable to align the delivery of specialist services to population need in local communities? If so, what is the best way of coordinating appropriate and relevant services for populations of need?

129. How might access and service barriers identified above be resolved and consumer needs be better met? Is additional training and support within community pharmacy sites needed?

130. Are there other inequities in terms of access to and quality use of medicines? If so, how should those be addressed and what population groups could be targeted?

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

132. How can we encourage and support consumers to engage more with their local pharmacy and what specific patient groups require more general awareness about available pharmacy services?
## APPENDIX B – GLOSSARY

<table>
<thead>
<tr>
<th>TERM</th>
<th>DEFINITION</th>
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<tr>
<td>5CPA</td>
<td>the Fifth Community Pharmacy Agreement between the Commonwealth and the Guild dated 3 May 2010</td>
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<tr>
<td>6CPA</td>
<td>The Sixth Community Pharmacy Agreement between the Commonwealth and the Guild dated 24 May 2015</td>
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<td>ACP</td>
<td>Australian College of Pharmacy</td>
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<td>Act</td>
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<td>Aboriginal Health Service</td>
</tr>
<tr>
<td>APP</td>
<td>Approved Price to Pharmacist</td>
</tr>
<tr>
<td>approved ex-</td>
<td>has the meaning given in Part VII of the Act</td>
</tr>
<tr>
<td>manufacturer price</td>
<td>approved pharmacist has the meaning given in Part VII of the Act</td>
</tr>
<tr>
<td>approved pharmacist</td>
<td>approved supplier has the meaning given in Part VII of the Act</td>
</tr>
<tr>
<td>approved supplier</td>
<td>culturally and linguistically diverse</td>
</tr>
<tr>
<td>CALD</td>
<td>has the meaning given in Part VII of the Act</td>
</tr>
<tr>
<td>community pharmacy</td>
<td>has the meaning given in clause 6 and CPP has the same meaning</td>
</tr>
<tr>
<td>programs</td>
<td></td>
</tr>
<tr>
<td>CPD</td>
<td>continuing professional development</td>
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<tr>
<td>CSO</td>
<td>Community Service Obligation</td>
</tr>
<tr>
<td>CSS</td>
<td>Customer Service Statement</td>
</tr>
<tr>
<td>CTG</td>
<td>Closing the Gap</td>
</tr>
<tr>
<td>dangerous drug</td>
<td>has the meaning given in the Determination</td>
</tr>
<tr>
<td>Determination</td>
<td>means the determination in force from time to time under subsection 98B(1)(a) of the Act</td>
</tr>
<tr>
<td>EFC</td>
<td>Efficient Funding of Chemotherapy</td>
</tr>
<tr>
<td>Ex-Manufacturer Price</td>
<td>means, as applicable, the: approved ex-manufacturer price; or proportional ex-manufacturer price for a pack quantity (other than the pricing quantity) of a listed brand</td>
</tr>
<tr>
<td>Guild</td>
<td>Pharmacy Guild of Australia</td>
</tr>
<tr>
<td>HMR</td>
<td>Home Medicines Review</td>
</tr>
<tr>
<td>HSDs</td>
<td>Highly Specialised Drugs</td>
</tr>
<tr>
<td>listed brand</td>
<td>has the meaning given in Part VII of the Act</td>
</tr>
<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
</tr>
<tr>
<td>NMP</td>
<td>National Medicines Policy</td>
</tr>
<tr>
<td>OTC</td>
<td>over-the-counter</td>
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<tr>
<td>Panel</td>
<td>the three independent reviewers appointed to conduct the Review of Pharmacy Remuneration and Regulation</td>
</tr>
<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
</tr>
<tr>
<td>PFDI</td>
<td>Premium Free Dispensing Incentive</td>
</tr>
<tr>
<td>PhARIA</td>
<td>Pharmacy Accessibility Remoteness Index of Australia</td>
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<tr>
<td>pharmaceutical benefit</td>
<td>has the meaning given in Part VII of the Act</td>
</tr>
<tr>
<td>pharmacy location rules</td>
<td>the rules determined by the Minister under section 99L of the Act</td>
</tr>
<tr>
<td>PHN</td>
<td>Primary Health Network</td>
</tr>
<tr>
<td>PPI</td>
<td>Pharmacy Practice Incentive Program</td>
</tr>
<tr>
<td>PSA</td>
<td>Pharmaceutical Society of Australia</td>
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<tr>
<td>QCPP</td>
<td>Quality Care Pharmacy Program</td>
</tr>
<tr>
<td>QUM</td>
<td>Quality Use of Medicines</td>
</tr>
<tr>
<td>RAAHS</td>
<td>Remote Area Aboriginal Health Services Program</td>
</tr>
<tr>
<td>RPBS</td>
<td>the Repatriation Pharmaceutical Benefits Scheme established under the: Veterans’ Entitlements Act 1986 (Cth); Military Rehabilitation and Compensation Act 2004 (Cth); and Australian Participants in British Nuclear Tests (Treatment) Act 2006 (Cth)</td>
</tr>
<tr>
<td>RPMA</td>
<td>Rural Pharmacy Maintenance Allowance</td>
</tr>
</tbody>
</table>
Safety Net means, as applicable:
- the concessional beneficiary safety net; or
- the general patient safety net,
as defined in Part VII of the Act

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHPA</td>
<td>Society of Hospital Pharmacists of Australia</td>
</tr>
<tr>
<td>TGA</td>
<td>Therapeutic Goods Administration</td>
</tr>
</tbody>
</table>
APPENDIX C – STAKEHOLDERS CONSULTED

The Review acknowledges the assistance of the following organisations and individuals, who provided valuable insights and information during bilateral discussions held with the Review Panel from December 2015 to March 2016.

- Alfred Hospital Clinical Pharmacy
- Alzheimer’s Australia
- Arthritis Australia
- Australian Federation of AIDS Organisations
- Australian Injecting and Illicit Drug Users League
- Australian Medical Association
- Australian Pharmaceutical Industries
- Australian Private Hospitals Association
- Australian Self Medication Industry Ltd
- Baxter Healthcare
- Boehringer Ingelheim
- Canadian Pharmacists Association
- Cancer Voices Australia
- Catholic Health Australia
- Charnwood Capital Chemist
- Chemist Warehouse
- Chronic Illness Alliance
- Cincotta Chemist Mascot
- Cominos Pharmacy Services
- Commonwealth Department of Health stakeholders
- Consumers Health Forum of Australia
- Davidsons Chemist Mascot
- DHL Supply Chain Australia
- Diabetes Australia
- Epic Pharmacy
- Fordgate Pharmacy
- Friendlies Pharmacy High Wycombe
- Friendly Society Medical Association (National Pharmacies)
- Generic and Biosimilar Medicines Association
- GuildLink
- Health Care Consumers’ Association
- Hepatitis Australia
- Jayson Atkins Pharmacy
- Leukaemia Foundation
- Lymphoma Australia
- McCarthy’s Pharmacy
- Medici Capital
- Medicines Australia
- Melanoma Patients Australia
- Mr Mouhamad Zoghbi
- Mt Hawthorn Community Pharmacy
- National Aboriginal Community Controlled Health Organisation
- National Pharmaceutical Services Association
- National Pharmacy Association (UK)
- National Seniors Australia
- NPS MedicineWise
- NSW Users and AIDS Association
- Pfizer Australia
- Pharmaceutical Services Negotiating Committee (UK)
- Pharmaceutical Society of Australia
- Pharmacy Guild of Australia
- Pharmacy Guild of New Zealand
- Pitcher Pharmacy
- Professional Pharmacists Australia
- Ramsay Health Care
- Samford Chemmart Pharmacy
- Sigma Pharmaceuticals Limited
- Slade Pharmacy
- Society of Hospital Pharmacists of Australia
- Symbion EBOS Group
- Terry White Group
- 777 Pharmacy Nollamara
APPENDIX D – FURTHER READING

Listed below are relevant documents referred to throughout the Discussion Paper. This is intended to provide the reader with additional information or context should they wish to understand the issues further.

- **National Medicines Policy**  
  Last accessed:  

- **Sixth Community Pharmacy Agreement**  
  Last accessed:  

- **Sixth Community Pharmacy Agreement Programs**  

- **National Health Act 1953**  
  Last accessed:  

- **National Health Reform Agreement**  
  Last accessed:  

- **Pharmacy Location Rules and the Australian Community Pharmacy Authority**  
  Last accessed:  

  Last accessed:  

  Last accessed:  

- **Review of drugs, poisons and controlled substances legislation (the Galbally Review)**  
  Last accessed:  

- **Department of Health Post-implementation Review of Pharmacy Location Rules (2010)**  
  Last accessed:  


- **National Commission of Audit (2014)**  
  Last accessed:  

- **Competition Policy (Harper) Review (2015)**  
  Last accessed:  

- **Pharmacy Location Rules**  
  Last accessed:  

- **Community Pharmacy Service Charter**  
  Last accessed:  

- **Customer Service Statement**  
  Last accessed:  