I am a Pharmacy Owner in Queensland with one store in a Pharia 6 in Cooktown.

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

I believe there should be fewer pharmacies in suburban areas however maintain the numbers in rural areas. My reasoning is that with fewer outlets there’s more opportunity for profitable pharmacies which will allow for better servicing of the community and more opportunity for multiple pharmacists in one location. To achieve many of the 6CPA and cognitive services having more than one pharmacist on duty is essential for the best patient outcome.

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?

In suburban/built up areas I believe the ratio of community pharmacies to population should decrease. This should be achieved by limiting new pharmacy approval numbers and by either reducing the number of pharmacies or allowing long distance relocations. I think for rural pharmacies there should be a different set of rules to allow for certainty and to ensure a consistent service to the community. By strengthening the rural pharmacies this would allow for more services to be delivered to in need areas. For example to aboriginal health services, isolated communities etc.

3. 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?

The income from retail activities has absolutely NO relevance to the remuneration that a pharmacy should get. These are commercial issues what do not impact the consumer and surprised how this should be linked. However the question that should have been asked which I believe is what intended is should the remuneration for dispensing be linked to the level of service/advice/consultation etc. My view is in a limited way there should be some differentiation. There are many larger pharmacies dispensing large numbers of scripts with a very high prescriptions/pharmacists ratio. There should be a minimum pharmacist to prescriptions ratio to ensure that our customers are achieving the best outcome.

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?

With decreased margins for prescriptions and downward pressure from the $1 discounting the level of customer service decreases. It’s simple economics, as
pharmacy owners we can’t afford to offer the same level of service with less margin. With the changes to margins via price disclosure the gross profit per prescription has decreased to a point where it’s unprofitable in the dispensary. The $1 discounting has been a failure for the customer and a failure for the pharmacies. If a pharmacy wants to charge more they should be allowed (within boundaries) however I strongly protest that there should be no discounting to the copayment allowed.

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?

RPMA is the correct method however there are some areas where it misses. For example the s100 tendering for Aboriginal Health Services (AHS’s) is a farce. In my area of Cooktown we have the Cairns and Hinterland Health Service (Qld Government) have the s100 contracts for all the AHS’s in our region. They then outsource this service to the Cape and Torre Straight Health Service (Qld Government) who then contracts us to deliver the Dose administrative aids (DAA) only. Yes that’s correct QLD Regional Health service profits out of another QLD Regional Health service and the local pharmacy becomes a DAA provider only. Should we not be looking at the pharmaceutical services that should be supplied to the AHS and work out the best outcome for the communities? The s100 services to the indigenous communities is awash with profiteering and not the best outcome for those that need it.

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?

Absolutely. Why should the community pharmacies receive $70 for a $20,000 plus medicine where the hospital receives over $1000 for Hep C medicines. No logic to this at all.

Regards

Nick Loukas