The Pharmacy Guild of Australia

Submission

In Response to the Interim Report on the Review of Pharmacy Remuneration and Regulation

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1. EXECUTIVE SUMMARY

The Pharmacy Remuneration and Regulation Review (the Review) is a lost opportunity.

The Review should have sought to identify practical ways to build upon a community pharmacy model that works extremely well, enjoys the overwhelming support of the public and is fiscally sustainable. It should have focused on the potential to utilise this critical piece of privately-financed health infrastructure and the highly trained health professionals who work in it to deliver better and more cost-effective health outcomes for all Australians.

Instead, it has been hijacked by a combination of ideology and economic theorising leading to conclusions that would dismantle if not destroy the tried and tested, mature community pharmacy model, forcing the closure of an estimated 1,700 community pharmacies with major losses of jobs, and an irreversible corporatisation and commoditisation of medicines related care.

The fact that the Review has chosen quite deliberately to go down this route is unfortunate and unwarranted. The Review has not produced the evidence required to substantiate such a radical and untested approach. On the contrary, the evidence before the Review overwhelmingly confirms the ongoing success of and the high levels of public and stakeholder support for maintaining the existing community pharmacy model. Rather than objectively considering and forming conclusions based on the entirety of the evidence before it, the Review has been highly selective in seeking to substantiate its seemingly pre-determined dispositions and views in the key areas of dispensing, the Location Rules and the negotiation of future community pharmacy agreements.

The Review's approach to dispensing would be bad for patients, bad for the pharmacist profession, bad for community pharmacy owners and bad for the broader health system. The proposed Efficient Long Run Incremental Cost (ELRIC) benchmarking metric is unworkable in practice, unprecedented in the health sector, and completely lacking in terms of any cost benefit analysis. It seeks to impose on 5,600 health-focused, multi-output small pharmacy businesses a highly regulated approach that applies to large single-output utilities. It glosses over the complexity of calculating an efficient average dispensing cost, the onerous and ongoing intrusion on pharmacies in extracting the necessary financial and health information, and the implications of such a least-cost driven approach on patient health outcomes.

The Interim Report advocates for the combination of a single flat dispensing fee that would eradicate any recognition of the additional costs entailed in dispensing dangerous drugs or extemporaneous preparation, and the setting of that fee at a level that is so significantly below current average dispensing remuneration levels that it would likely render an estimated 1,700 smaller pharmacies unviable and unable to continue operating. This brazen approach is predicated on the completely unsubstantiated and inflammatory assertion that smaller pharmacies offer low-value services and do not have sufficient size to be economic in an efficiently run system.

Without the necessary evidence, the Interim Report pre-supposes that current levels of dispensing remuneration are too high in spite of the fact that the Interim Report acknowledges that 15 per cent of pharmacies are not earning taxable profits and that even the most profitable pharmacies only earn normal rates of return on their investments. It fails to take into account the health benefits of the government remunerating the dispensing of PBS medicines or the social cost that would be incurred with the loss of so many pharmacies. Worst of all, it effectively recommends that government should deliberately set remuneration levels for the core clinical

service of dispensing in the full knowledge that they would result in large numbers of community pharmacies going out of business.

The Review recommends the removal of the pharmacy Location Rules, including the prohibition on co-location in supermarkets, without providing any substantive evidence that this would increase patient access or improve health outcomes while conveniently ignoring the results of multiple studies that demonstrate the superior level of consumer access to community pharmacies compared with other similar service without location rules. Similarly, it completely ignores the adverse impact on both access and competition that has resulted from the removal of pharmacy locational restrictions in overseas markets. As is the case with dispensing remuneration, the Review fails to recognise the core social purpose of the Location Rules, which is to enable government to ensure that the supply objectives of the National Medicines Policy are delivered as equitably and efficiently as possible.

The Review recommends a radical change to the pharmacy supply chain, whereby individual manufacturers would take direct responsibility for ensuring that their medicines are distributed to patients. This major departure from the established system of wholesaling would create increased uncertainty and complexity for community pharmacies, along with a raft of transitional issues. It is not supported by any of the major participants in the medicines supply chain. Again, the overriding purpose appears to be to further reduce government funding, putting at risk the sustainability of a medicines supply chain that is already under severe financial strain after a decade of PBS reform.

On the matter of future community pharmacy agreements, the Review erroneously uses a 2014 report of the Australian National Audit Office to effectively assert that the well-established agreement based approach to community pharmacy remuneration should be overhauled. This is in spite of the fact that six successive community pharmacy agreements over thirty years have not only provided high levels of certainty for government and community pharmacies, but have underpinned a system that is fiscally sustainable and consistently delivers very high standards of medicines supply and care for patients.

Finally, it is important to put on the record the Guild's serious concerns about the way the Review has been conducted.

In the Sixth Community Pharmacy Agreement, the Guild agreed to an independent review of the Commonwealth's remuneration and regulation of community pharmacy and committed to cooperate with the review.

Alarm bells began to ring when the former Minister appointed competition economist Professor Stephen King to head the Review, in spite of his public statements supporting the removal of the pharmacy Location Rules and ownership restrictions after the release of the Harper Competition Policy Review. These concerns were heightened when the Review Panel refused to rule out extending its remit to the State-based regulation of pharmacy ownership.

Virtually from the start, the Panel Chair was deliberately provocative, creating unnecessary angst and uncertainty in the sector. The Discussion Paper, with its 140 questions, canvassed a raft of issues that were outside the purpose and the remit of the Review.

The Review's commissioning of consultancies raises serious conflict of interest concerns, particularly the decision to continue retaining Deloitte Access Economics after it became known that this firm had produced a major report co-authored by Professor Ian Harper advocating for the removal of the pharmacy Location Rules and ownership restrictions, which formed part of the Chemist Warehouse submission to the Review.

The Review's approach to the collection of pharmacy financial data has been flawed and in some instances highly questionable. It has been confirmed from the lodging of multiple FOI requests that the Review sought access to pharmacy tax return data. The Guild is also aware of the Review approaching banks for financial data on pharmacies.

A financial survey of pharmacies was conducted in January 2017, over a year after the Review commenced when the Panel was well advanced in its deliberations and had proceeded well beyond the evidence-gathering phase. When the Guild was provided with a copy of the draft survey prior to its release, we pointed out a number of serious methodological flaws in it. The survey proceeded without the flaws being rectified. As a result, the Guild advised its members to be wary about completing the survey. In turn, the Interim Report accuses the Guild of being uncooperative, without explaining the relevant facts or that the Guild had separately provided the Review with large amounts of pharmacy financial data and briefings.

From start to finish, the Review has constantly missed deadlines. It publicly committed to publishing its consultancy reports last December but failed to do so. The RSM Bird Cameron financial analysis upon which the Review relies in relation to dispensing and the Location Rules, contains serious methodological and factual errors. However, the ability to scrutinise this analysis has been curtailed by the fact it was released three weeks prior to the deadline for responses to the Interim Report. The Review Panel refused to engage with the Guild on any aspect of our highly detailed, 200 page plus submission in response to the Discussion Paper. An FOI request has highlighted the ongoing behind-the-scenes involvement of the central agencies (Treasury, Finance and PM&C) in the so-called independent Review, as well as an intervention by the Department of Finance asking that the Review curtail its deliberations pertaining to the future role of pharmacists for budgetary reasons.

After thoroughly analysing the Interim Report, considering all relevant facts and receiving detailed economic advice and analysis from eminent Professors Ergas and Pincus, the Guild has come to the conclusion that the Review is so fundamentally flawed and inherently damaging that it cannot and should not be relied upon by government as a credible input on the key issues of dispensing remuneration, pharmacy Location Rules, the medicines supply chain or future community pharmacy agreements.

Notwithstanding, the Guild is determined that this opportunity is not lost and is committed to working with government and all relevant stakeholders in ensuring that a viable community pharmacy network continues to deliver the best possible health outcomes for patients into the future, working in partnership with the profession and collaborating and integrating with the broader health sector.

2. INTRODUCTION

The Guild welcomes the opportunity to respond to the Interim Report ("the Report") of the Review of Pharmacy Remuneration and Regulation with a view to correcting its many flawed assumptions and conclusions.

It needs to be stated at the outset that it is profoundly disappointing that the issues raised by the Guild, and other stakeholders, in respect of the obvious conflicts of interest that have tarnished this Review remain unanswered and unresolved. Those conflicts go to the heart of the objectivity and independence of the Review and must inevitably cast doubt on the credibility of the Review's conclusions. Moreover, any confidence stakeholders may have in the integrity of the Review must surely be gauged against the pre-conceived agenda of the Chair of the Panel, who has publicly espoused deregulation of pharmacy before his appointment to the Panel and apparently before reviewing all the available evidence. It is therefore important to place these unresolved conflicts and biases on public record.

It is equally disappointing, but not surprising, that after an inordinately long gestation period (of nine months), stakeholders are offered barely three weeks to respond to research commissioned by the Panel. No justification can be found for delaying the publication of any supporting research that the Panel has commissioned, and relied upon, in arriving at its conclusions, particularly one that is evidently the centrepiece of the Review's findings: the RSM report. This is all the more damaging to the credibility of the Report in view of the Panel's early statements emphasising scrutiny and transparency of the process. After nine months of deliberations, there is no reason why such research should not have been available in a timely manner.

This Review is best described as an exercise in looking for solutions to non-existent problems and as a consequence has been a lost opportunity. It should have sought to identify practical ways to build upon a community pharmacy model that works extremely well, enjoys the overwhelming support of the public and is fiscally sustainable, and is arguably the most sustainable part of the health system. It should have focused on the potential to utilise this critical piece of privately-financed health infrastructure and the highly trained health professionals who work in it to deliver better and more cost-effective health outcomes for all Australians. Regrettably, it has instead promoted budget savings as the central goal of its inquiry, taking precedence over social objectives.

A focus on budget outcomes alone is not 'socially optimal' or 'efficient', nor would it enable the Government to achieve objectives that include good health outcomes for Australians, equitable access to quality medicines, as well as cost-effectiveness objectives.

3. CONFLICTS OF INTEREST

The Review's commissioning of consultancies raises serious conflict of interest concerns, particularly the decision to continue retaining Deloitte Access Economics after it became known that this firm had produced a major report co-authored by Professor Ian Harper advocating for the removal of the pharmacy Location Rules and ownership restrictions, which formed part of the Chemist Warehouse submission to the Review.

That the Panel has allowed the Review to be tainted by conflict of interest, perceived or otherwise, is an indictment of the way in which this Review has been managed from start to finish.

In a message posted on 16 December 2016, the Panel released a list of consultants and scope of work that had been commissioned to date in effort to share with the public to provide transparency to the work of the Review. This list effectively confirmed that Deloitte Access Economics had been engaged to undertake major work for the Review. The message stated:

> "*Deloitte Australia – Comprehensive study and analysis of literature relating to the models in place for the remuneration and regulation of community pharmacies in overseas jurisdictions, including a comparative analysis of selected overseas models with Australia's current arrangements under the 6CPA.*"

At the same time, Deloitte Access Economics (DAE) had been engaged by Chemist Warehouse to produce a major report on behalf of Chemist Warehouse as an appendix to its submission to the Review. The focus of that submission is to abolish ownership and location rules for community pharmacy in Australia (No. 218). The appended report by DAE was itself accepted by the Panel as 'formal evidence' (No. 218A) (p 195 of Interim Report). By any standard, there is a fundamental conflict of interest having one organisation working for the Review and participating in submissions to the Review over the same period. This conflict seriously undermines the independence of the Review and makes it impossible for it to make untainted recommendations, particularly in regard to location rules.

It is of grave concern that the Panel's message of 16 December, while paying lip service to transparency, makes no mention of this obvious conflict of interest, let alone how it is being managed. In the interests of transparency, the Guild urged the Panel to release all relevant documentation relating to the Review's interactions with DAE, with little success.

After a number Freedom of Information (FOI) requests, the Guild's concerns with respect to the mismanagement of this conflict have been confirmed. The last tranche of the requested documentation, with heavy use of FOI exemptions, was released only on 10 July 2017. Despite statements to the contrary by the Panel, the Department and DAE, this issue casts an unsavoury shadow of doubt on the credibility and independence of this Review, and its recommendations need to be viewed through that lens.

4. A PRE-CONCEIVED AGENDA FOR DEREGULATION OF PHARMACY

In articulating the strategic vision and intent of the Review, the Panel states that it has:

> *"…considered options for constructive pharmacy reform by anticipating the future requirements of the community pharmacy in Australia."* (p3)

And that it:

> *"…recognises that regulation presents costs to the public, the government and the participants in the medicine supply chain. Regulation must be sufficient but not excessive and must underpin sustainable consumer access."*(p4)

It further states:

> *"Options have been deliberately left out because the Panel has not found compelling evidence for change."*(p4)

Taken together, these imply that the Panel has put forward options for improvements to the pharmacy sector *only* where it has found *compelling* evidence to do so.

This is in stark contradiction to what has been presented in the Report.

No evidence, let alone *compelling* evidence, has been canvassed in the Report (or the various consultants' contributions) that warrants fundamental change to the regulation and remuneration of community pharmacies.

This submission examines the so-called "compelling" evidence with particular focus on the evident errors which have presumably directed the members of the Panel to arrive at their flawed conclusions. These errors include errors of fact, errors of omission and errors of logic.

We note that the RSM Report forms a crucial part of the thinking behind the Report's recommendations in respect of location rules and remuneration. This submission therefore deals with both Reports interchangeably, and where relevant, examines the RSM Report in its own right as the primary document and source of calculations.

Finally, the notable biases woven throughout the two Reports, in relation to their assumptions and arguments, against the status quo are dealt with separately and contained in Appendix 1.

4.1 The Case for Dismantling the Current Model of Community Pharmacy?

To say that change has been a constant in health care is to state the obvious. From evolving technologies to the ageing of the population, community pharmacy has been at the forefront of utilising developments in technologies to meet the changing demands of health consumers. Nor is the idea of reforms new to pharmacy. The Guild and its membership has actively advocated reforms over many decades aimed at bolstering the distribution network, enhancing the role of pharmacists in the primary care team and improving the quality use of medicines. Ongoing reforms since the inception of the PBS has both challenged and strengthened the profession to transform the sector to arguably the most efficient and sustainable part of the health care system. However, change must be embraced for the right reasons, not merely for the sake of change, and must be shown to improve the quality of care and health outcomes.

While there is always room for improvement in any human endeavour, and the Guild's first submission has proposed improvements in a number of areas, there is no evidence in this Report that justifies fundamental structural change to the current model of community pharmacy. Regrettably, this Review itself has generated fear and anxiety about the future viability of the sector because of its provocative style of inquisition. The intent of the Review was never to dismantle the most productive and efficient component of the health care system. Nor were there any grounds for the Panel to approach the Review with a presumption that the system is fundamentally broken because of regulation.

5. YOUNG PHARMACISTS

The Panel states it has:

> *"...received first-hand accounts from young pharmacists of the large financial risk they are forced to accept to enter the tightly controlled pharmacy market." (p15)*

This is at odds with the evidence in two respects:

1. one would think a "tightly controlled market" would in fact lower the financial risk, not raise it; and
2. Guild membership, which excludes Chemist Warehouse owners, shows that nearly half of Guild members are in fact aged under 45 years. And significantly, women make up over half of business participants in every age demographic below 55 years old.

In reality, the underlying anxiety about financial risk is not about the tight market control, but festering uncertainties about government policies engendered by Reviews of this type. This is borne out by the recent survey conducted by the Australian Journal of Pharmacy. Nearly one in five employed pharmacists said they were "discouraged [from owning a pharmacy] by uncertainty in the sector stemming from price disclosure, rents, wages and any ramifications from the King Review". Another 21% indicated that they are not interested in ownership. Only 9% of employed pharmacists cited affordability and financial risk as reasons for not owning a pharmacy, and a further 7% said they plan to own a pharmacy.[1] What the profession and the sector need, following the decade-long reforms of price disclosure, is stability, not more uncertainty.

Nothing speaks more eloquently to the fears of young pharmacists about their future than the evidence submitted to the Review by the Chemist Warehouse group. To control 20%[2] of the market with only 8%[3] of registered community pharmacists speaks volumes in terms of what young pharmacists can expect from deregulation and all that is entailed in it. Here is a thought experiment. With deregulation comes the inevitable prospect of market dominance. And in order to compete in a race to the bottom, if all pharmacies adopted the business model espoused by Chemist Warehouse, conservatively that would make over half the number of community pharmacists redundant. What that would mean for professional standards, professional job satisfaction, quality use of medicines and health outcomes is anyone's guess. That's a future neither young pharmacists nor consumers should look forward to.

6. LOCATION RULES

The Panel foreshadows that:

> *"given the Government's recent commitment to continue the current location rules, the Panel considers that its options to replace the current location rules are no longer immediately relevant to this Review. While they are included in the Interim Report for the sake of transparency around the Panel's consideration of the issue, they will not be presented in the Final Report."*(p8)

[1] Megan Haggan, 05/05/2017: https://ajp.com.au/news/dont-fear-future/?utm_source=AJP+Daily&utm_campaign=3d7e18f63b-EMAIL_CAMPAIGN_2017_05_07&utm_medium=email&utm_term=0_cce9c58212-3d7e18f63b-109984793

[2] IBIS Pharmacies in Australia – July 2016, p23

[3] Chemist Warehouse – Submission #218/218A p40/p5

However, the Panel has also simultaneously argued that remuneration needs to be analysed in the context of location rules:

> *"..The examination of the location and number of retail outlets, and any price control, cannot be analysed separately."* (p96)

Therefore, it is not quite clear how the Panel might reconcile the two statements. That is, it cannot be both relevant and no longer relevant at the same time. In this respect, this submission assumes the Panel will persist with the latter statement.

6.1 The Evidence Used by the Panel

While it is not entirely clear which piece of evidence has been accepted or rejected by the Panel, the Panel's inclination towards removal of location rules is abundantly clear and relies on four discrete sources of information with respect to regulation and remuneration:

1. Evidence provided by Deloitte Access Economics and Professor Ian Harper on behalf of Chemist Warehouse;
2. Submission by Consumers Health Forum;
3. Empirical evidence cited by the Panel in respect of a study of pharmacy distribution in Melbourne in 1979-80 – M Waterson, 1993; and
4. RSM Geospatial Research.

It is important to note that while evidence has been cited from these sources, no effort has been made by the Panel to scrutinise or verify the accuracy of the information put forward. These are examined in turn.

6.2 DELOITTE ACCESS ECONOMICS / HARPER for CHEMIST WAREHOUSE

In its submission to the Review, Chemist Warehouse introduces the authors of a report, prepared by Deloitte Access Economics, which forms the basis of the evidence submitted by Chemist Warehouse:

> *The Deloitte Access Economics Report (Deloitte Report), which was prepared by a panel of eminent economists including Professor Ian Harper (FASSA FAICD), looked at all relevant literature and policy documentation that could assist in their investigation; both local and international, considered various case studies on the practical operation of the Rules and finally conducted a geospatial analysis investigating the current distribution of retail pharmacies in Australia. (Emphasis added)* (p6 of Submission #218)

The Panel has accepted the Deloitte report as *formal evidence*, by way of submission #218A. Quite apart from the obvious conflicts of interest this raises (see Section 3. above), the Panel has made no attempt to scrutinise the evidence presented in the Deloitte report, and appears to have concluded that any information presented is accurate. However, this is based on erroneous and selectively cited evidence.

For instance, the Report seems to have accepted the flawed evidence in respect of Ballarat, or at least felt an unexplained need to refrain from pointing out the geospatial errors. The error becomes readily apparent when one examines the population-to-pharmacy ratio presented in the Deloitte analysis against the *actual* ratio for the Ballarat region. Deloitte make a fundamental error in applying SA4 population to SA3 pharmacy numbers. (That error of course also extends to their calculation of items to pharmacy ratio). Despite the impressive glossy graphics, their 'evidence' that the "population-to-pharmacy ratio of the Ballarat region is 69% higher than the Australian average" is the result of a fundamental and embarrassing error. The SA4 population of Ballarat is approximately 156,000 and it is served by no fewer than 32 pharmacies, resulting in a population to pharmacy ratio of 4,842 not 7,372. Taking the SA3 population with its corresponding number of 22 pharmacies, produces a ratio of 4,727, again much lower than 7,372. Yet these disparities don't even rate a mention in the Interim Report which seems to have accepted this information as fact.

Another example is the evidence provided in respect of Blacktown and Seven Hills. It is not clear whether the information regarding population and pharmacy numbers are up to date. Nor is it clear that the information has been scrutinised or accepted at face value. What is obvious, however, is that statistics have been accepted and repeated in the Interim Report without checking their accuracy. The Deloitte estimate of nine pharmacies in an area of 340m2 cannot be taken seriously. This is at best a silly error and at worst an attempt to exaggerate the density or clustering of pharmacies in certain areas. Either way, the Panel seems to have accepted the evidence without qualification.

As to the merit of the argument that location rules have given rise to clustering, it assumes that excess entry or clustering will never occur under free entry. However, as noted in the Interim Report, in the case of fixed prices, the theory suggests excessive entry is likely. The economics of outlet location is discussed in Attachment A.

It should be noted for completeness that one of those caught up in the cluster of nine is a Chemist Warehouse. Nothing in the location rules prevents Chemist Warehouse to relocate away from the cluster by up to 1 km and into the alleged under-serviced circle shown in Figure 3.2 of the Deloitte report. Nor are there any rules preventing Chemist Warehouse from buying out existing pharmacies in areas they would like to open, as they have proven able to do repeatedly.

A further and more serious example of unqualified acceptance of evidence is in the context of the elaborate analysis showing variations in population-to-pharmacy ratios and prescription volumes by Primary Health Network. Again, this is accepted without qualification and, if the Ballarat example is any guide, these numbers should have been carefully scrutinised. At the very least, this analysis should have been replicated by the Panel (RSM) not only to confirm accuracy with respect to pharmacy but also to compare the results with respect to other health service providers. After all, in a counterfactual context, the distribution of GPs, dentists and optometrists would provide valuable insight into the distribution of essential health services in the absence of location rules. Variability in the pharmacy ratios is not necessarily evidence of problems caused by regulation. Nor can it be assumed that in the absence of location rules such variability would miraculously disappear, and every pharmacy in the country will have a population of 4,300, no more no less. This is a case of serious error of omission and a lost opportunity to bring meaningful analysis to the issues. We discuss the distribution of pharmacies relative to other health services in Section 6.6.

Section 3.2.3 of the Deloitte report cites South Perth (at a 32% higher ratio of people per pharmacy than the national average) and Central and Eastern Sydney (at a 23% lower ratio of people per pharmacy than the national average) as the most extreme districts in Australia. They are held up as evidence that the location rules have "constrained the sector's ability to respond to demand". This statement shows the shallow nature of Deloitte's research and analysis. Had Deloitte taken another step in their analysis, they would have concluded that the variation in these two districts is in fact likely to be evidence of the sector's ability to respond to demand. It is well known that many working people commute to Central and Eastern Sydney, primarily from western suburbs. These people are not part of the resident population. The presence of a greater number of pharmacies there is in fact a response to the demand from these commuter consumers. Conversely, South Perth is a predominantly residential area from which workers travel to the central business district each day. It is therefore quite reasonable that there would be fewer pharmacies per head of resident population in South Perth, as the daytime demand is not there to attract and sustain more pharmacies.[4]

Finally, the Interim Report refers to a range of submissions that according to the Panel have highlighted the potential for underserved areas to arise under the location rules and the potential for 'gaming' of these rules. It cites two cases as examples of such gaming.

> *"The Panel has heard accounts of the current location rules being open to gaming in some circumstances. For example, an owner-pharmacist notes that the current location rules can lead to clustering and underserved areas. The submission discusses how two community pharmacies were relocated from Invermay to the centre of Launceston: "[B]oth [were] within 200m of another pharmacy and [left] Invermay without a pharmacy".* (p100, p195)

The first relates to submission No 505 by an anonymous owner pharmacist who has provided four pages of genuine testimony about the many issues raised in the Review's Discussion Paper. On the question of location rules, the submission states:

> *"… location rules have helped numbers but also distribution. Some clustering is evident but this is generally historical and generally seems to be ok. Newer approvals seem to deliver good ratios to patients and allow good access to consumers whether metro, urban or rural."*

And,

> *"Commercial interests in location rules. Example Launceston. 2 pharmacies in Invermay – bought by CW moved to opposite centro shopping centre and moved to Mowbray market place. Both within 200m of another pharmacy and leaving Invermay without a pharmacy. I am sure this is not the intention of the short distance relocation rules which aims to avoid clustering and enable greater access to pharmacy services. This is relevant to the 1km relocation and one of the approvals was moved over a 2 year period to allow a move of 2km."*

[4] The Panel agrees: "The distribution may vary for a number of reasons. If there are particular communities with a high demand for medicines then it would be expected that more pharmacies would serve these communities. If there are areas of concentrated foot-traffic that differ from the residential population density (e.g. CBD areas where individuals who live in other areas find it convenient to buy medicines) then it would be expected that a 'cluster' of pharmacies would form in these areas.
It should also be noted that the distribution of these pharmacies may not be 'optimal' from a social perspective. In particular, areas of 'thin' population may have no pharmacy even though, as a society, we would like to see people in these areas able to access medicines. …" (p99)

Surprisingly, all that the Panel seems to have gleaned from this 4-page submission is that "the current location rules can lead to clustering and underserved areas". The Panel completely ignores the underlying testimony that location rules have helped not only numbers but also distribution.

Also ignored in the Panel's thinking is the fact that the aggressive manipulators of the rules seem to be, more often than not, the Chemist Warehouse group. It is particularly galling for a group to profess a concern for consumers' welfare and access to pharmaceutical services but at the same time leave a community underserved for commercial reasons.

In this context, it is also instructive to examine the second example cited by the Panel:

> *"The potential for 'gaming' is presented by Ingham Family Medical Centre submission, which argues that, when they sought to open a new pharmacy, "a false and misleading statement [was given] to ACPA".* (p195)

The Ingham Medical Centre submission is cited no fewer than three times in the Interim Report (as Submission No 313). Yet no attempt has been made to test their allegation, or at least to provide some semblance of balance with a submission holding a different view about the same subject matter. That submission (No 146) was made by a pharmacy owner whose community pharmacy would have been affected by the actions of Chemist Warehouse and the Ingham Family Medical Centre designed to circumvent the clear guidelines set by the ACPA. Yet Submission 146 does not even rate a mention. Nor is there any discussion by the Panel about the desirability of a sixth pharmacy to enter the market serving a population of around 12,000, either on access or competition grounds.

We raise the above issues not only with the purpose of highlighting errors, minor or major, but also to highlight a more serious recurring theme. It is patently obvious from the Interim Report that the only submissions that have been subjected to any level of scrutiny are those in support of the status quo. All other submissions appear to enjoy the support of the Panel without question or qualification, and are used to substantiate the Panel's preferred position to remove location rules. And as demonstrated in the last examples, the Panel has even sought to cherry pick statements that support its own conclusions from an array of submissions that generally support the retention of location rules. This is untenable for a Panel that has an obligation to evaluate the available evidence and to do so objectively and independently.

6.3 CONSUMERS HEALTH FORUM

The Interim Report concludes:

> *If the existing location rules were providing appropriate access to consumers, compared to the alternative of pharmacies choosing their locations, then it would be expected that the rules would be supported by consumers. After all, the objective is consumer benefit. However, the Consumers Health Forum of Australia (CHF) recommends the opposite, as it has advocated for the removal of location rules to allow new pharmacies to be established by competition for the benefit of consumers*. (p100)* [Repeated in Appendix D, p195]

To accept this at face value is to confuse evidence with position statement and therefore devalues the primary objective of any Review: to scrutinise and evaluate evidence.

Despite its explicit reference to a 2015 CHF survey of consumer views, the CHF submission offers nothing by way of evidence in respect of location rules (p5). On closer examination, the 2015 CHF survey says nothing about location rules or pharmacy remuneration. The CHF obsession with location rules appears to stem from its opinion that: "The continuation of the location rules in 6CPA protects the high profits of pharmacy owners and businesses at the cost of delivering better patient outcomes" (p8). As we discuss in Section 7, and revealed by the Panel's own analysis, there is no evidence of excess profits in pharmacy, let alone any grounds for the extraordinary claim that they are at the cost of better patient outcomes.

Finally, the CHF submission appears to contradict its own stance on deregulation: "*The access to community pharmacy in normal business hours is generally good and meets most people's needs*" (p11), but let's deregulate anyway, in the hope that after hours service would *somehow* improve in the new deregulated environment. Not a shred of evidence is offered to support removal of location rules and it is plainly wrong for the Panel to legitimise its own preference on the basis of mere opinions.

6.4 M WATERSON MODEL and ANALYSIS

The Panel states "*that the information available to it strongly indicates that the removal of location rules with appropriate behavioural regulation to remove any economic rents and protect against excessive entry will lead to a desirable distribution of community pharmacies.*" (p104)

Having made up its mind that location rules must be abolished and remuneration reduced, it goes on to say that it would be *useful* to find some analysis that might support such decision. And, as good fortune would have it, M. Waterson is seen as providing just such an empirical analysis:

> *"In Australia, we are in the fortunate situation that this analysis was carried out for community pharmacies in Metropolitan Melbourne using data collected in 1979–80…"* (p195)

The Panel therefore heavily cites the analysis by M. Waterson in an effort to show that the distribution of pharmacies in the absence of location rules would roughly correspond to the distribution of the population. However, the results are not as clear cut as indicated by the Panel, and nor are the consequences of applying the type of scale economies referenced by Waterson.

Waterson himself qualifies the results in a number of important respects. He states:

- There may be issues around the "circle metric" employed, as opposed to the "square metric", in the theoretical development – i.e. grid patterns and right-angle paths may produce different outcomes;[5]

- The very high density in the CBD is not explain satisfactorily, and the overall explanation is some way off being perfect;

[5] In addition, the geospatial analysis undertaken on behalf of the Guild shows that pre-defined circular or other geometric shapes represent a very inexact tool for estimating a particular pharmacy's catchment area.

- The optimal number cannot be pinned down exactly since the starting point for calibrating pharmacy numbers is not a pure market-based system; and, most important of all,

- In drawing any policy conclusions it must be recognised that any changes to the system would influence factors not fully taken into account in his analysis, among them the greater possibility of monopoly power in pricing, and important dimensions of welfare such as opening hours, provision of free advice by pharmacists.

Moreover, Waterson would not have been aware of a number of serious flaws in the BIE's original data used in his analysis. The fact that the BIE information ignored 25 to 30 percent of pharmacy costs was a serious omission in the BIE analysis that was uncovered many years later by KPMG. The BIE data ignored the cost of goods sold. Other deficiencies included BIE's assumption that the pharmacy cost function exhibits uniform returns to scale for all output levels, and the failure to allow for bulk discounts in medicines. These factors would have a major effect on the calculation of economies of scale in pharmacies and therefore on the output generated by the Waterson model.

The methodological aspects of the Waterson analysis, together with the implied economic savings, are discussed in greater detail in the attached Assessment – Attachment A.

6.5 RSM Geospatial Research

The Panel's conclusions in respect of location rules and equity of access to pharmacy services also rely on the Geospatial Information System (GIS) model produced by RSM. The Report states:

- *The residents of Australia's major cities have to travel the least distance to visit their nearest pharmacy…;*
- *The further Australians live from a major city, the further they have to travel to visit their nearest pharmacy…; and*
- *Residents in very remote regions of Australia have to travel the longest distances to visit their nearest pharmacy*

(p18)

There is nothing particularly revelatory about these findings. Indeed they mirror the findings contained in the Guild's submission based on the geospatial models developed by MacroPlanDemasi in 2014 and repeated in 2016. The fundamental problem, given the geographic spread of the Australian population, is that the further away individuals live from major cities the further they have to travel to access services. This is not a problem unique to community pharmacy. It is an inherent problem across the board: doctors, hospitals, specialists, schools and supermarkets to name a few. This common trend is largely a function of population density.

What is of great concern, however, is that the Panel confuses two quite separate issues: mal-distribution of services generally and mal-distribution of services as a result of regulation. The Report states: *"The differences in access [to community pharmacies] highlighted by the GIS model will underpin a number of options in this Report."* (Emphasis added) (p19)

As discussed above in Section 6.2, the Panel has made no attempt to compare and contrast the distribution of pharmacies that is essentially shaped by regulation (location rules) against the distribution of other health service providers that are not subject to similar locational regulations. This is an error of omission. Based on this flawed premise, the Panel's conclusions that freedom of location will miraculously produce a better distribution of pharmacy services lacks logical rigour and takes a leap of faith.

6.6 The Evidence Ignored by the Panel

The Panel had an obligation to examine any available evidence (or commission its own) to independently assess the impact of regulation on the accessibility of pharmacy services. Implied in that, is the question of whether distribution would be more optimal in the absence of location rules. No such analysis is found anywhere in this Report.

Therefore, this submission directs the Panel's attention to precisely such evidence which is readily available and should have been top of mind for the Panel:

1. Pre-1990 mal-distribution of pharmacies

Since 1990, location rules have delivered significantly improved access to pharmacy in communities that had been underserved for decades. As the analysis compiled by the University of Adelaide shows, over 200 communities nationwide have secured the services of a new pharmacy as a result of the restriction placed on locations in more densely populated areas.[6]

The results highlight the movement of pharmacies away from over-served areas and into areas of unmet community need. Pharmacy numbers in large population centres (CAT A) reduced from 3,745 from 1990 to 3,464 in 2014, while less populous centres (CAT B and CAT C) increased from 1,833 to 1,990 over the same period.[7] By any analysis, this is a remarkable redistribution of resources to equitably meet the health needs of the population irrespective of their geographic location.

Their analysis also highlights the fact that, while population-to-pharmacy ratios *increased* overall, these ratios *decreased* in rural locations from 2007 to 2014. And, importantly, the analysis found no relationship between pharmacy locations and socio-economic status.

2. Recent trends in European jurisdictions following deregulation

- Recent trends in European jurisdictions suggest a level of disillusionment in the aftermath of deregulation – neither prices nor quality of service has improved despite the touted benefits of deregulation;

- Vogler et al. (2014), consistently found 'urban clustering' in all deregulated countries, while accessibility in rural areas remained unchanged;

[6] Lange J & Franzon J, University of Adelaide, Geographic Access and Spatial Clustering of Section 90 Pharmacies -1990 to 2014: An Exploratory Analysis. Canberra, Commonwealth of Australia, Department of Health 2016 - Appendix 5

[7] Lange J & Franzon J, University of Adelaide, Geographic Access and Spatial Clustering of Section 90 Pharmacies -1990 to 2014: An Exploratory Analysis. Canberra, Commonwealth of Australia, Department of Health 2016 - Appendix 3
CAT A: 250,000 persons or more; CAT B: 48,000 – 249,999 persons; CAT C: fewer than 48,000 persons

- The European experience also suggests that the quality of dispensing outcomes may suffer post deregulation. Vogler et al. (2014) reported markedly increased workloads and reduced professional training in three countries where community pharmacy has been deregulated: Norway, Sweden and England;

- Swedish studies also report a deteriorated environment for counselling and advice, and lower consumer satisfaction, including a negative effect on safety;

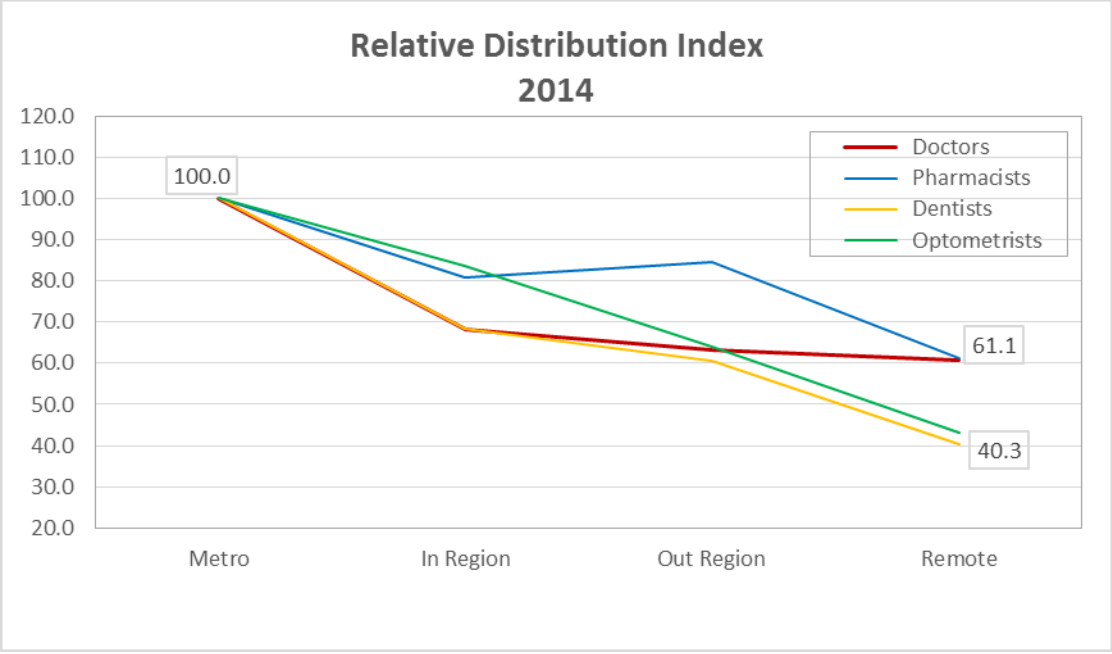
- As discussed in Attachment A, the UK experience post-deregulation has prompted a re-think regarding the 1995 NHS relaxation of 'controls on entry'. The English Department of Health's Impact Assessment notes that unlike in other industries, consumers would not benefit from increased price competition, given that prescriptions are dispensed at a fixed price. While there were some benefits to having more pharmacies, these would need to be set against the additional (fixed) costs of the new pharmacies. Analysis commissioned by the Department then found that these costs amounted to £143,000 (AU$ 243,000) per new entrant pharmacy. 'Doing nothing' (i.e. leaving the entry restrictions unchanged) would lead to (p12):

  > *… continued and possibly increased over-provision of services, most likely in areas already well served, and to greater financial pressures. These would need to be met either by increased payments by the NHS, or by pharmacies if funding remained unchanged.*

3. Comparative distribution of medical, dental and optometry services in Australia

Chart 1 shows unambiguously the benefits that have accrued to regional and remote communities as a direct result of location rules by encouraging pharmacies to open in areas of unmet need. No other health service has achieved similar distributional equity.

CHART 1



The Chart shows the relative accessibility of community pharmacists compared to other health professionals across different locations. Relative to people in major cities (whose index value is assumed 100), remote/very remote populations have 60% less access to dentists (on a full-time equivalent basis per 100,000 people). This compares to only 38.9% (100% – 61.1%) less access to pharmacists for remote/very remote populations relative to people in major cities – a ratio similar to GPs but significantly higher than both dentists and optometrists. The differences are even more pronounced in outer regional areas where access to pharmacists is only 15.4% lower than that for people living in major cities (on a full-time equivalent basis per 100,000 people). By contrast, access to GPs, dentists and optometrists are around 40% lower than for major cities.

Together, the evidence unequivocally points to a more optimal distribution of pharmacies than would otherwise be the case if location rules are relaxed. Thus, the error of omission has also led the Panel to arrive at an inconsistent conclusion – error of logic. To expect that the removal of locational regulations will, by the operation of market forces, produce a superior distribution of pharmacy services is simply illogical in light of the evidence.

7. REMUNERATION

There can be no doubt that the aim of the Panel is to close down a significant number of pharmacies based on a notion that they are too small to be efficient. The economic basis, methodology and application of the Panel's arguments are comprehensively discussed in the attached Assessment by Professor Henry Ergas and Professor Jonathan Pincus - Attachment A. This section focuses on the serious errors and methodological problems contained in the RSM report.

The Panel states:

> *"…remuneration of dispensing and, more broadly, the PBS is intimately tied to the viability of most community pharmacies."*(p69)

It also states that:

> *"…based on data provided by the Treasury, which provides the most comprehensive, consistently derived and independent data on total revenues and expenses derived and incurred by Pharmacies for 2013-14"…"the most profitable pharmacies are only <u>earning normal rates of return</u> on their investments."(*Emphasis added)(p82).

That is, on average, there are no economic rents in the sector. In fact, it shows that:

1. 15% of all pharmacies are not earning taxable profits;
2. that profitability increases in line with the pharmacy's size; and
3. the most profitable pharmacies are only earning normal rates of return on their investment.

The fact that 15% of pharmacies are not earning any taxable income does not appear to satisfy the Panel of the extraordinary financial pressures that pharmacies are under. Instead, the Panel single-mindedly latches onto the notion that profitability increases with pharmacy size – putting aside the evidence that even the most profitable are not earning economic rents – and therefore it needs to estimate the costs and revenues of "efficient" pharmacies.

To build its case against regulation, the Panel has expressed concern that pharmacies are generally too small:

> *"…the Panel is concerned that data provided by the Treasury suggests that the current pharmacy regulations and remuneration arrangements have facilitated the development of a large number of very small pharmacies"* (Emphasis added) (p75).

The implication of this concern is that pharmacies need to be larger, presumably to be "efficient" because of economies of scale.

It should not come as a surprise to any objective observer that pharmacies are predominantly small businesses and that the vast majority of small businesses have a turnover of less than $10 million.

The linkage of pharmacy regulation and remuneration to pharmacy size is misleading. Moreover, by extension, any proposition to relax regulation will invariably lead to greater numbers of mal-distributed pharmacies resulting in even smaller pharmacies. The evidence for this can be found not only in the Australian context (as evidenced by the pre-1990 outcomes), but also in England and Norway post-deregulation.

It may be argued, as the Panel has, that such excess numbers may be controlled by reducing remuneration. This is more wishful thinking than evidence-based.

First, it is not as straightforward as implied by the Panel. Indeed the Panel itself qualifies such outcome:

> *"The distribution may vary for a number of reasons. If there are particular communities with a high demand for medicines then it would be expected that more pharmacies would serve these communities. If there are areas of concentrated foot-traffic that differ from the residential population density (e.g. CBD areas where individuals who live in other areas find it convenient to buy medicines) then it would be expected that a 'cluster' of pharmacies would form in these areas.*
>
> *It should also be noted that the distribution of these pharmacies may not be 'optimal' from a social perspective. In particular, areas of 'thin' population may have no pharmacy even though, as a society, we would like to see people in these areas able to access medicines."* (p99)

The distribution of pharmacies in a deregulated environment *may not be socially optimal*, and if the past Australian experience is any guide it is highly unlikely to be socially optimal.

Second, as the Panel notes,

> *"if the government reduces remuneration to existing pharmacies in order to eliminate…[economic] rents …the cost may fall on parties who do not benefit from the [economic] rents."* (p98)

The direct implication of this is that a lower remuneration will force many pharmacies, including those in areas of community need, to close down. This is particularly obvious in light of the evidence from Treasury showing 15% of pharmacies are not earning taxable profits. The theoretical and practical implications of trying to control entry by 'calibrating' a single efficient

dispensing cost demonstrate both a level of naivety and a total disregard for the social consequences of such a recommendation. These implications are discussed in detail in the attached Assessment – Attachment A.

7.1 RSM's Contribution

The RSM analysis of pharmacy remuneration can best be described as an insult to objectivity. It is a flawed piece of analysis that at times is illogical but mostly lacking any real evidence and replete with bias.

The RSM analysis and report is clearly led by the Review's recommendations, rather than leading or informing the review. It uses similar language to the Interim Report in a number of areas, such as the comparison of the agreement process with that of determining the "efficient costs of supplying other essential government services, such as electricity, gas, water, telecommunications and some transport services)" (RSM p10).[8]

In this respect and in others, RSM shows little understanding of the community pharmacy sector, and little appreciation of the nuances and special considerations that should apply to the small business or healthcare contexts.

However, the most serious problem with the RSM analysis is that it is riddled with bias in data selection, methods and presentation. The quality and consistency of data used are also suspect, as are the methods used for analysis. In some cases the analysis is a mathematical exercise devoid of any relevance or real meaning. These analytical flaws are discussed in detail in Appendix 1, while the broader economic concepts and methods are discussed in the attached Assessment – Attachment A.

The use of ELRIC as the fee metric is based on the assumption that such a fee would allow an 'efficient' pharmacy to cover all of its costs: that the sales of non-dispensary items would automatically be sufficient to recover all joint and common costs. Thus, for a typical pharmacy, twenty per cent of its revenue, gained in the competitive market for non-prescription goods, would supposedly cover the great bulk of pharmacy costs. In reality, many 'efficient' pharmacies would fail and the RSM analysis is biased towards the closure of smaller pharmacies in Australia. It purports to provide the basis to enhance distributional equity but if acted upon could reduce access to affordable medicines across Australia by resulting in closures of many smaller pharmacies.

The 'effective rate of assistance' (or ERA) for various types of dispensing conflates tasks with size of pharmacies by assuming that small pharmacies undertake 'low value' tasks, while large pharmacies undertake 'high value' tasks. The purported calculations of ERAs bear no relationship to conventional measures of ERAs, and are best considered as complicated economic nonsense. These calculations assume that, if the Government ceased paying a dispensing fee, it would continue to prevent pharmacists from setting their own dispensing fees, and that pharmacists would then continue the activity of dispensing, but do so for free.

[8] We note in passing that the RSM Report referenced throughout the Interim Report as March 2017 appears to refer to a different version to that published in May 2017. We assume that the contents are substantively the same.

The analysis also ignores the social reasons for the PBS scheme and the broader benefits of the community pharmacy model and PBS. Fiscal savings from closure of some or even many of the three thousand or so so-called 'micro' pharmacies is not socially 'optimal' – it is without considering the additional costs to PBS customers, especially those in lower socio-economic locations; or the lessening of localised competition: there is an obsessive focus on cost-effectiveness in a pure economic sense. To achieve real resource savings mooted by RSM and in the Interim Report, around 30 per cent of pharmacies may need to close. The closure of such a large number of pharmacies, even if staged over a number of years, would have major impacts on consumers' travel times and access and potentially have adverse effects on health outcomes (as well as imposing massive losses on the sector). Further, many of the pharmacies that survive would have no choice but to cut staffing levels and reduce services, with a corresponding impact on quality. How does this improve distributional equity and promote a socially 'optimal' outcome, let alone the quality use of medicines?

The economic and social costs of closures of smaller pharmacies, acknowledged to be concentrated in remote regions is merely referenced in the commissioned analysis but not quantified in arriving at a true cost-benefit ratio of introducing a flat fee in the name of equity of access of pharmacies to revenue. The analysis offers that these pharmacies should be "monitored' and required to provide copies of 'their income tax returns". Moreover, the analysis states the Rural Pharmacy Maintenance Allowance (RPMA) may need to be increased, pending the increase of efficient pharmacies in those regions.

However what is the expected increase in the RPMA that is required to ensure pharmacies are present in these regions? The RPMA already ranges up to $45,930 per annum – the additional fiscal costs of raising the RPMA further (and the deadweight loss of raising taxation revenue to fund an expanded RPMA) are conveniently ignored.

By suggesting each individual pharmacy be compared to a conceptual 'efficient benchmark' pharmacy or relative to an 'efficient, average, long-run incremental cost' (ELRIC) the analysis ignores the fact that it is a virtually impossible task to assess a diverse population of almost 5,600 pharmacies against a uniform efficiency metric. Moreover, the administrative and implementation costs of such a regulatory system are ignored and would include the costs of establishing effectively a new regulatory body and the (opportunity) cost burden placed on pharmacies which will in turn be required to compile the information.

The commissioned RSM analysis is also an attack on the Pharmaceutical Benefits Scheme (PBS). The RSM analysis lays the blame for "real economic costs on the nation" in the PBS and regulation which have reduced consumption efficiency by altering the relative prices Australians pay for alternative medicines and reducing production efficiency by distorting relative rates of return that pharmacies earn from supplying medicines on behalf of the government. But the altering of relative prices Australians pay for alternative medicines is exactly what the PBS is intended to do – the PBS is designed to achieve nominal rate of assistance to patients increasing with the cost of medicines prescribed and higher levels of assistance provided to those that hold a concession card and have a greater need for medicines to meet their needs.

Apparently, if the arguments of the analysis are to be believed, the important health outcomes that the PBS and current community pharmacy model currently contribute to, and which have universal support from patients and consumers, are just too costly for Australia. Instead, this important piece of Australia's health infrastructure should be abandoned for an untested commoditised and corporatist approach.

No evidence has been presented in the Report to justify a fee reduction, any more than a fee increase.

After concluding that *"the same formula should be applied to all dispensed medicines"* (p75), i.e. no differential fees on the basis of time and effort involved, the Panel has reversed that conclusion in an attempt to justify a (lower) flat dispensing fee. In a hypothetical exercise, RSM have presented an analysis that simply shows that there are varying degrees of effort and time in the dispensing of different items – Activities 1 to 9 (p82). Nothing new in this.

The Guild has always maintained that there are different levels of effort depending on patient and medicine, but that the current remuneration structure is the most appropriate – some take less time, some more. Of concern, though, is the choice of $10 instead of the current average value (of say $11.50) in its hypothetical analysis. The $10 dispensing fee is baseless and unnecessarily provocative, and in no way justifies merging the various add-on fees into a single flat fee of $10. RSM's focus on the "equity" and "effective rates of assistance" from a lower flat fee is in fact nothing more than a meaningless mathematical exercise.

8. SUPPLY CHAIN

Full-line wholesalers are an integral part of the pharmacy distribution infrastructure.

To be clear, the Guild rejects the proposition that the government should devolve its responsibility over full-line wholesalers to manufacturers. Wholesalers should be regulated and appropriately remunerated to ensure that medicines are delivered in a timely way (within 24hrs) and that the cost of goods supplied is no more than the Approved Price to Pharmacist referenced in the Commonwealth Price of PBS medicines.

Relying on a bilateral relationship between manufacturer and wholesaler is likely to open the supply chain to unintended risks and consequential erosion of quality use of medicines. As there are over 100 manufacturers of PBS medicines, compared to only five CSO distributors, the proposal is also likely to be highly inefficient. It would create a new layer of regulation, far more complex to effectively administer and monitor than the current one. Further, the report makes no attempt to examine the consequences that the proposal would have for patients in rural and remote regions, and to those who are prescribed one of the many low volume, but often high cost and life-saving, drugs listed on the PBS. The references to acceptability of the Pfizer model, which are at best debatable, would not automatically flow to the other 100+ manufacturers, most of which are far smaller companies than Pfizer and consequently have little bargaining power and rely on the CSO for efficient national distribution.

With respect to wholesaler remuneration, the Panel concludes:

> "*The evidence supporting the 7.52 per cent mark-up is ambiguous. It is hard to determine exactly what value the government is getting for this, particularly when this margin is being used by wholesalers to provide discounts to pharmacy customers to win market share…"* because*, "…like current remuneration arrangements for pharmacies, they are the result of historical precedent as amended by an ongoing process of negotiation"*. (p 125)

Regardless of the Panel's views of the history of wholesaler mark-up, it makes no attempt to even confirm whether CSO wholesalers will be compensated to the value they have been promised as part of the 6CPA. The reality is that the funding allocated to wholesalers will not be delivered in full because of the ongoing impact of price disclosure. While the Panel notes the wholesalers' intentions to pass on additional costs to community pharmacies, it appears to have glossed over this inevitable outcome and the ultimate effect it would have on pharmacists' income and potentially the timely access by patients to PBS medicines.

Without a remuneration floor that de-links wholesaler remuneration from the price of the PBS subsidised medicine, wholesalers' percentage mark-up continues to be directly impacted by falling PBS prices. Like pharmacy, pharmaceutical wholesalers have also relied on trading terms to cross-subsidise their costs associated with the core services required for the delivery of PBS and RPBS medicines to community pharmacies in a timely manner.

Wholesalers are impacted as a result of the reduction in the prices of PBS medicines brought about by price disclosure by both a reduction in direct remuneration and trading terms reductions. Unlike pharmacies, however, this direct impact on the profitability of the wholesalers in turn has a direct impact on the trading terms offered to their community pharmacy clients. Given the lack of immunity wholesalers have to PBS price reductions, the remuneration structure for the distribution of PBS and RPBS medicines by pharmaceutical wholesalers deserved a little more than a passing comment about 'the correct' number.

Positive recommendations by the Panel to address this funding anomaly, should have included:

- a floor on wholesaler mark-up to delink wholesaler remuneration from PBS medicine prices;
- alignment of the level of remuneration caps with that of community pharmacies;
- fees that reflect the actual service costs for distribution of items listed on the PBS, RPBS and NDSS, including S100 medicines;
- recognition of the additional costs associated with the distribution of Controlled Drugs, fridge lines and high-cost items;
- To implement these changes, the Federal Government must commit to fully expend the wholesaler funding of $2.803 billion (inclusive of CSO and NDSS) committed in the 6CPA.

9. FUTURE COMMUNITY PHARMACY AGREEMENTS

The Panel begins this section with a sweeping statement:

> *"The Sixth Community Pharmacy Agreement (6CPA) process was not adequate, as reflected in the submissions to this review. The Australian National Audit Office (ANAO) was also critical of some of the processes in the Fifth Community Pharmacy Agreement (5CPA), which have been partially addressed in 6CPA."*(p132)

The Guild categorically rejects the Panel's assertion that 'the submissions to the Review' claimed the 6CPA process was not adequate. It may be argued that a small number of submissions claimed the process to be inadequate because of a belief that they had not been consulted sufficiently. That is a matter for government to manage together with relevant stakeholders. In reality, the 6CPA was the first agreement to have formally canvassed the views of a broad array of stakeholders ahead of negotiations proper.

None of the ANAO criticisms (and resulting recommendations) with respect to the 5CPA related to processes outside of government agencies. And contrary to the assertion that those processes were partially addressed in the 6CPA, all recommendations relating to process have been addressed by Department of Health in the context of the 6CPA. To deliberately understate that achievement is an affront to the Department's professionalism.

Over the past 25 years, community pharmacy agreements (CPAs) have been central to the practical implementation of the Government's National Medicines Policy (NMP). They have consistently delivered on the core objectives of the NMP by ensuring the efficient distribution of PBS medicines through the community pharmacy network.

These successive CPAs have been have been negotiated between the Government, as the central purchaser of dispensing and related services, and the Guild, as the representative of owner-pharmacists who are directly financially affected by the remuneration arrangements. The proposition that consumers should have a role as signatory to future agreements appears to lack any practical purpose other than, perhaps, to provide moral support to Government negotiators.

Each CPA has been negotiated between the Government and the Guild as the designated representative of the majority of the owners of the community pharmacies that make the capital investment in the infrastructure that delivers the PBS to the Australian public on behalf of the Government. This ensures that the negotiation occurs between the appropriate representatives of the two parties that together have financial and practical responsibility for delivering the CPAs' core objective of dispensing PBS medicines and related medication management.

There can be no doubt that consumers need to be active participants in any agreement the government enters on their behalf. Consumers also have a role as evaluators of the services they receive as a result of those agreements. And while consumers may enter into various understandings with governments as shapers of health policy, they have no role as signatory to an agreement which is essentially a financial contract between funder and service provider.

That role and responsibility resides with the Government which has an obligation to protect the rights, health and interests of its citizens. Health consumers represent an important subset of the broader citizen population and therefore by extension the government has an obligation to represent the interests of health consumers. Any suggestion that consumers should negotiate the terms of future agreements in their own right is an abrogation of government responsibility.

Throughout CPA negotiations, the Guild has actively consulted with all sector stakeholders to ensure common ground for the viability of the pharmacy network. None has been more closely consulted than the Pharmaceutical Society of Australia and that tradition is unlikely to change in the future. Where relevant the PSA has also been a direct participant in matters where professional quality standards and programs have been introduced or enhanced.

These consultations with relevant stakeholders should continue in future CPAs in a way and at a time that ensures the input, ideas and views of stakeholders are able to be fully taken into account during the negotiation. It also needs to be recognised that any concurrent negotiations, including with the pharmaceutical sector in relation to medicines pricing, can directly impact the ability of community pharmacies to deliver the PBS to the Australian public. Similarly, if it is decided in future CPA negotiations that wholesaler remuneration and CSO standards should be negotiated directly with wholesalers, it needs to be recognised that there is a direct flow-on to pharmacy remuneration.

APPENDIX 1

RSM REPORT – ISSUES OF QUALITY, BIAS & CONSISTENCY

RSM's report is clearly led by the review's recommendations, rather than leading or informing the review. It uses similar language to the interim report in a number of areas, such as the comparison of the agreement process with that of determining the "efficient costs of supplying other essential government services, such as electricity, gas, water, telecommunications and some transport services)" (RSM page 10).

In this respect and in others, RSM shows little understanding of the community pharmacy sector, and little appreciation of the nuances and special considerations that should apply to the small business or healthcare contexts.

The most serious problem, however, is that there is clear evidence of bias in data selection, methods and presentation. The quality and consistency of data used is also suspect, as are the methods used for analysis. In some cases the analysis is a mathematical exercise devoid of any relevance or real meaning.

ISSUES SET 1: QUANTITATIVE AND TECHNICAL PROBLEMS, INCLUDING BIAS

Issue A: Deliberately minimised expenses ratios

The summary financial data (Tables 27 to 31), which is used to come up with the $6.66 to $12.33 range quoted on page 10, raises serious questions of quality, method and bias. Most obvious is the **deliberate selection of the lowest expense ratio amongst the data sources**, rather than something more reasonable such as the average. The following unpacks the bias:

- Table 27 (Micro pharmacies):
    - The right-most column (RSM's core estimate) uses 17.3% for Total Expenses (BOS). Yet the (non-redacted) figures from the data sources range from 28.5% to 39.1%. The "minimum" (which must come from a redacted source) is shown as 17.3%, and this is what they chose to use for their core estimate for profitable micro pharmacies (which is also presented in Table 12, page 49). Why choose the minimum, especially if it is from a source that is not transparent to the reader? Clearly, this is designed to deliberately under-estimate expenses, to under-estimate the cost of dispensing and therefore to over-estimate profit.
- The same problem of bias (i.e. using the minimum expenses ratio, which is redacted) is evident in the tables relating to Small and Medium pharmacies (Tables 28 and 29).

Issue B: "Return on Capital" unjustified and out of line with relevant comparators

The "return on capital" used has multiple issues.

Page 49 (Table 12) states that "Return on capital includes $0.1 for working capital and a 10% margin to allow for a return on capital."

- Nowhere is this level justified or explained.

- In any case it is not actually applied as a cost of capital. It is applied as a mark-up on costs. It is applied as a ratio of Earnings before Interest, Tax, Depreciation & Amortisation (EBITDA) to Operating Expenses.

- More importantly, it can easily be argued that this 10% + 10c mark-up should be in the range of 20% to 25% - see below. This unreasonably low add-on just exacerbates the effect of RSM deliberately selecting the lowest available expense ratios (Issue A above).

- There are a few ways of putting the 10% + 10c into perspective:

    - ABS data for 2015-16 shows the following EBITDA/Operating Expenses ratios[9]:
        - 23.5% overall for Retail Trade (it was 23.8% in 14-15 and 23.0% in 13-14)
        - 25.5% overall for Health Care and Social Assistance (private). It was 25.8% in 14-15 and 24.8% in 13-14.
        - See footnote for the data source and method for these figures.

    - Another way to look at this issue is to convert RSM's figure to a profit-to-turnover ratio (EBITDA/Sales). Even at the high end of their estimate of dispensing cost per prescription, the 10% is only worth about $1.10, plus 10c = $1.20. As a proportion of PBS revenue this means that it provides a profit ratio (EBITDA/Sales) of 2.7%, given that the average revenue per prescription was $45.01 for 2015-16 according to Department of Health data[10]. This 2.5% ratio is far too low and not realistic compared with what is achieved in other industries. For example, across all Retail, ABS data indicates the average was 5.5% in 2015-16[11]. It is much higher than that in other relevant ABS-defined sectors (eg. 17.1% in Health Care).

- **The conclusion from this is that <u>the "10% + $0.10" should be at least doubled if it is to reflect the norms in the Australian economy. Even before correcting for other biases, this would add at least ~$0.90 to ~$1.20 to the dispensing cost estimates range in Table 12.</u>**

<u>Issue C: Inclusion of 1% of pharmacies results in biased low-end dispensing fee range</u>

Table 21 shows that the Medium, Large and Very Large categories of pharmacies used by RSM add to only 1% of pharmacies. Using any normal statistical methods, the data for these three categories would largely be disregarded as unrepresentative. One major outcome of that 1% of pharmacies being considered by RSM is that their $6.66 figure (the low end of their $6.66 to $12.34 remuneration range) is what they have calculated for "Large" pharmacies - that is, less than 1% of pharmacies. Had the analysis only used the Micro and Small pharmacy data (representative of 99% of pharmacies), **their range would automatically become $8.65 to $12.34, even if RSM persisted with their use of non-transparent, cherry-picked expense data and their unreasonable 10% profit add-on** (Issues A & B above). Doubling the 10% + $0.10 "return on capital", to deal with Issue B, would add another ~$0.90 to ~$1.20 to these numbers, bringing the range to around **$10 to $13.50**.

[9] http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/8155.02015-16?OpenDocument, "Australian industry by subdivision" data cube, Table 4, [Total expenses minus Purchases of Goods & Materials plus Change in Inventories minus Interest Expenses minus Depreciation & Amortisation] / [Earnings before interest tax depreciation and amortisation]

[10] https://www.pbs.gov.au/info/statistics/pbs-expenditure-prescriptions-30-june-2016 (Table 3(b))

[11] http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/8155.02015-16?OpenDocument, "Australian industry by subdivision" data cube, Table 1, [EBITDA]/[Total Income]

Issue D: Misrepresentation in comparison of inter-sector profitability (Appendix 4)

The only effort RSM makes to compare profitability of community pharmacy with that of some comparable sectors is Appendix 4. This appendix has multiple problems:

- It uses benchmarking.com.au data for the comparator sectors, but uses RSM's constructed data for pharmacies. **Most importantly this has the problem of using the minimum, redacted 17.3% expense ratio from Table 27, as mentioned in Issue A above. Given that they are comparing with benchmarking.com.au data, it would have been logical (and unbiased) to use the benchmarking.com.au pharmacy expense ratios as the comparators (these are 28.5% to 30.1% in Table 27). If they had, the "Total Income (bos)" in Appendix 4 would be approximately the same, or even below, cornerstores and Health Food Retailers.** This is clear bias – the report's authors appear to be going out of their way to try to show (false) excess profitability.

- In addition, Appendix 4:

  - only analyses Micro pharmacies. Why? Was this the only comparison RSM could make to suit their arguments?
  - uses as comparison apparently open-ended categories for "Cornerstore" and "Health Food Retailers" (i.e. ">=$600k" and ">=$650k").
  - makes no attempt to compare the After Owners Salary aspect, which is more relevant.
  - contains no discussion of the quality of the comparison data – eg. sample sizes. We only know that, overall, benchmarking.com.au has 132 pharmacies in their sample. But we don't know how many of the other outlets they have, nor do we know whether there is any systemic bias.

Issue E: Selection of $10 as "illustrative" fee

Notably, the $10 is referred to in Table 26 (page 88) as being "proposed", despite RSM's assertions elsewhere in their report (eg. page 10) that the $10 level is "merely illustrative" and "selected from within the range".

> [similarly notable is that the Interim Report (page 83) also refers to the $10 as "illustrative" but goes on to try and justify its use by saying that it is "drawn from the 2015-16 median dispensing fee" – anyone with passing knowledge of the 6CPA remuneration structure will recognise this as complete nonsense: the structure of fees (dispensing fee + AHI) placed the *minimum* per script for 2015-16 above $10, and a median cannot be below a minimum.]

Issue F: Use of Before Owners Salary for comparison (Table 19)

In another example of biased data selection, the percentage changes presented in Table 19 are based on profit levels Before Owners Salary (BOS). Use of After Owners Salary (AOS) data would have been more appropriate to compare like with like, and would have shown larger percentage reductions.

Issue G: Pointless analysis of "same fee for performing different activities" (Table 15)

The analysis in Table 15 is meaningless. The whole table is merely a mathematical exercise that could be performed at a primary school level, but is presented as high level economic analysis. Look at the last two columns, and add 100% to each number. You will then derive the following:

ERA with a $11.50 dispensing fee (+ 100%)	ERA with a $10 dispensing fee (+ 100%)
82.7%	69.6%
86.5%	72.7%
90.6%	76.2%
95.1%	80%
100%	84.1%
105.67%	88.9%
111.88%	94.1%
118.88%	100%
126.8%	106.7%

Dividing each number in the second column above by the corresponding number in the first, we note that the ratio is a consistent 0.841 or 0.842 for every row (varying only due to rounding). Why? Because **all Table 15 shows is that $8/$9.50=0.842!** The conclusion RSM goes on to make – namely that the flat $10 fee is "more equitable" - is based on the mathematical reality that multiplying a ratio by a set of smaller values results in a smaller range of results than multiplying a ratio by a set of larger values. By this logic, the lower the fee the more "equitable" it becomes, even if that fee was set at 1 cent per prescription.

It highlights an important disconnect in thinking: to produce a more equitable remuneration for pharmacists, the RSM recommendation is to punish all pharmacists equally! Even the highest value adding activity (Activity 1) is punished by increasing the under-compensation from -17.3% to -30.4%. This reasoning is devoid of any meaningful common sense.

As a point of clarification, the figures above are $8 and $9.50, rather than the $10 and $11.50 used as the fees, simply because RSM have applied a notional $2 value for "other inputs" at all points in their table.

ISSUES SET 2: LACK OF RIGOUR, AND NOT INFORMATIONAL TO PANEL

RSM admits in their Executive Summary that in large part their analysis is of options presented in the Panel's Interim Report. In that respect it is an "after the fact" report. Its language similarities show that it is designed to provide justification for the Interim Report recommendations, rather than to inform the Panel. The question that arises is: why did the Panel spend money commissioning the RSM report when the Interim Report recommendations were already determined? Was the purpose of the RSM exercise simply to provide a veneer of legitimacy the Panel's recommendations?

Points of relevance include:

- RSM accepts the panel's $9.00 to $11.50 dispensing remuneration range without question.
- Wherever the $10 originated from, it is clear that it is a figure without basis. Ipso facto, the RSM analysis has no basis.
- The primary analysis RSM performs on the $10 relates to the "equity" between pharmacies of a flat rate of remuneration vs the current arrangements. Equity of remuneration should be a secondary consideration, well behind the consideration of whether the level is appropriate and delivers a viable network capable of servicing the Australian community.

- RSM determines a reduction in net profit for the five pharmacy size categories. This reduction ranges up to 43% for the Small group (from $234,661 to $134,300, after owners salary – Tables 16 and 18). However they make no effort to:

  a) comment on the impact that this level of reduction would have on aspects of employment, quality, viability or debt serviceability and bank loan covenants (yet they do comment on the mathematically simple aspect of what government would save as a result of the change);

  b) analyse the impact on pharmacies that are most vulnerable and vital to their local communities (eg. in one pharmacy towns);

  c) compare the post-$10 level of profitability with that which prevails in other sectors; and

  d) comment on the effect closures would have on the medium-long term levels of competition within the sector.

ISSUES SET 3: POOR UNDERSTANDING/APPRECIATION OF SMALL BUSINESS & HEALTHCARE

The two statements below (on pages 67 and 72) show a lack of understanding of the role of pharmacy and wholesalers in the PBS supply chain. The statements imply a classical, all-purpose economic view (i.e. higher profit -> higher supply of products, and vice versa). This shows no understanding of the way in which medicines are supplied. The reality is that demand is almost completely determined by prescribers in response to the requirements of patients – the product supply chain merely reacts to that demand with matching supply (applying appropriate levels of professionalism, checking, safety, monitoring and advice). Also, "types" of medicines are determined by drug companies and then by government decisions on PBS listing. Pharmacies and wholesalers have no impact on those decisions.

- *Page 67: "pharmacy and wholesale remuneration arrangements are intended to increase the types and quantities of medicines that would otherwise have been available to Australians at the prices they currently pay for those medicines"*

- *Page 72: "The current pharmacy remuneration and regulation provide significant levels of assistance to pharmacies which encourages the provision of much higher quantities and types of medicines to Australians than would have occurred in the absence of such assistance."*

These statements also show no appreciation of the real purpose of the remuneration arrangements. Another important illustration of RSM's lack of relevant knowledge of healthcare and small business is their categorisation of pharmacies. 99% of pharmacies are in two of the five turnover categories invented by RSM (Table 21). From this they assert, among other things, that "location rules may have encouraged the emergence of large numbers of very small pharmacies" (which is a counter-intuitive statement anyway, as it is unclear how rules around market entry could lead to such an outcome).

However, lack of relevant sector knowledge may be too generous in this case. It is more likely that these categories were fashioned with the deliberate aim in mind: to show that pharmacies are too small to be "efficient". No objective observer with a proper understanding of the pharmacy sector would classify a $10 million turnover pharmacy as a 'small' pharmacy. It is clearly a small business by ATO definition but not a 'small' pharmacy. Nor is a $2 million pharmacy a 'micro' pharmacy. It is a 'micro business' on a scale of incomes ranging from $1 to above $250m – not an appropriate range for community pharmacy.

Finally, more recent FOI requests by the Guild reveal further evidence of dubious analysis. Apart from the inherently questionable manner in which these data were obtained, the data provided by the Australian Taxation Office and Treasury casts serious doubts about the credibility and rigour of RSM's analyses. The information obtained from Treasury shows that their tabulations are based on 6,742 discrete entities, ranging from sole proprietors to partnerships and companies. It is not clear how RSM have reconciled that number with the known number of pharmacies, 5,456, for the same period under consideration (2013-14). What is clear, however, is that nearly 1,200 unexplained entities, whether they included non-pharmacy businesses or partial year pharmacies, would have had a significant effect on the results.

ATTACHMENT A

AN ASSESSMENT by

Professor Henry Ergas

Professor Jonathan Pincus

Sabine Schnittger

GREEN SQUARE ASSOCIATES

Interim Report – Review of the Pharmacy Remuneration and Regulation

An Assessment

Professor Henry Ergas
Professor Jonathan Pincus
Sabine Schnittger

July 2017

Key points

In applying economic concepts and analyses, the Panel makes errors so central and egregious as to suggest that the Interim Report does not deserve to be taken seriously.

The Panel's 'vision' is to eliminate many smaller pharmacies, through a large cut in the remuneration for dispensing—a 13 per cent cut is highlighted. How many would go? The Panel did not trouble to ask. Using a report that the Panel relied upon, we estimate up to 1,700.

Eliminating a large number of small pharmacies would impose costs on society, especially of access, that do not feature in the Panel's reasoning: there is an obsessive focus on cost reductions in the simplest sense—reducing Commonwealth spending is confused with securing efficient outcomes for consumers, the health system and the Australian community.

The Interim Report concludes that the 'smallest, and potentially least efficient' pharmacies receive the highest 'effective rates of assistance'. This claim depends on a piece of complicated economic nonsense, a calculation that—astonishingly—assumes that, in the absence of a government fee, pharmacists would dispense for free. There is, to the best of our knowledge, no precedent for using the concept of 'effective rates of assistance' in the way adopted by the Interim Report.

The Interim Report relies on non-existent 'economic theory' to justify setting the dispensing fees equal to the 'efficient long-run incremental cost' of dispensing, or ELRIC—a concept it never properly or clearly defines. In its view, the mark-up on non-PBS sales would cover all common and joint costs: yet non-PBS sales typically account for 20 per cent of revenue, and pharmacies compete with non-pharmacies in that market.

Despite concluding that most pharmacies are earning no more than normal returns, and despite finding no serious deficiencies with the sector, the Interim Report recommends radical changes in remuneration and an end to what has been effectively collective bargaining, instead advocating a change from light-handed to heavy-handed regulation.

The Panel concludes that the pharmacy network is 'good', but nonetheless asserts that radical change is required: the urban location rules should go, and an untried and potentially expensive planning and subsidy scheme used to ensure fair access elsewhere. The Panel gives no details as to how that scheme would work; and in recommending removing the location rules for urban areas, it fails to give due weight to the clear overseas evidence that unregulated entry invites unacceptable outcomes: locational clustering, rather than a better spread of pharmacies, and industrial consolidation into the hands of a few larger players.

The Panel admits that its and other surveys show that customers do not favour permitting supermarkets to host pharmacies, but asserts that consumers will change their minds once confronted with a new reality.

Executive summary

We have been asked by the Pharmacy Guild of Australia to review the economic arguments put forward by the Independent Expert Panel (the Panel) in its Interim Report for the Review of Pharmacy Remuneration and Regulation.

The Panel applies a variety of economic concepts and analyses to the remuneration and regulation of community pharmacy. In doing so, the Panel makes errors of commission and omission so central and fundamental as to suggest that the Interim Report does not deserve to be taken seriously.

Small community pharmacies

The Panel's 'vision' for community pharmacy is one of a greatly diminished pharmacy network. The central theme in the Interim Report is that the pharmacy regulations and remuneration arrangements have resulted in 'too many' small community pharmacies, and that this outcome is somehow 'inefficient'. Yet the Panel offers no arguments that the level of remuneration for dispensing is too high. To the contrary, the Interim Report acknowledges that even the most profitable pharmacies are only earning 'normal' rates of return on their investments. The Panel furthermore states that the dispensing fees paid by the Government constitutes 'assistance', and that the 'smallest, and potentially least efficient' pharmacies receive the highest 'effective rates of assistance'. The Interim Report does not say why payments for dispensing services would constitute 'assistance', let alone why the Panel believes that small community pharmacies provide low value services.

Moreover, the Panel ignores the Government's broader health policy objectives, including as these relate to the community pharmacy network. In setting pharmacy remuneration, the Government seeks to achieve a broader set of goals that include good health outcomes for all Australians, equitable access to quality medicines, as well as narrow cost-effectiveness objectives. Hence, remunerating pharmacies so as to achieve a socially efficient optimum must include factors such as convenience and equity for consumers, and the direct and indirect health consequences. Eliminating a large number of small pharmacies, as intended by the Panel, will significantly reduce the accessibility of dispensing and related advisory services, in particular for older and less mobile consumers. These are costs to society that do not feature in the Panel's reasoning.

The Interim Report stresses the necessity of reducing the number of pharmacies with a turnover of less than $2 million per annum (so-called 'micro' pharmacies), in order to secure cost savings from economies of scale. In particular, the Panel nominates a 13 per cent reduction in dispensing fees as a reasonable target. However, the Panel appears not to have investigated the number of pharmacy closures that would be required to achieve this target. Using the estimate of economies of scale from Waterson (1993) – a paper heavily cited in the Interim Report – we show that around 1,700 of the 3,300 or so 'micro' pharmacies, or around 30 per cent of all pharmacies would close. The economic and social costs would be large and a reasonable assessment would have estimated those costs before making such a sweeping recommendation.

Dispensing fees

The Panel makes various recommendations as to how the 'optimal' level and structure of dispensing fees should be set. These recommendations are also shaped by the desire to reduce the number of small pharmacies: cutting dispensing fees is the means to that end. The Panel advances these recommendations without considering the additional costs to consumers of PBS-subsidised medicines or the lessening of localised competition and choice: there is an obsessive focus on cost reductions in the simplest sense.

Nor does the 'economic theory' set out in the Interim Report, to justify particular dispensing fees, stand up to scrutiny. One of the Panel's central recommendation is that the dispensing fee should be set equal to the average of the 'efficient long-run incremental cost' of dispensing, or ELRIC for short:

- There is no support in economic theory for regulating the price of one activity of a multi-output firm (such as a pharmacy) to be equal to ELRIC. Contrary to what is suggested in the Interim Report, there can be no presumption that such a price would improve economic efficiency. The recommendation to set the dispensing fee equal to ELRIC is, therefore, simply arbitrary.

- Setting the dispensing fee at ELRIC implies that a pharmacy would have to recover all of its overhead and similar costs from (retail) sales of non-PBS products. If a typical pharmacy, which derives about 20 per cent of turnover from retail sales, were to apply corresponding mark-ups on the retail products that it sells and where it competes with other retail outlets, it would soon go out of business.

- Setting the dispensing fee at ELRIC as a means of making budget savings ignores the Government social (health policy) objectives. Treasury will only save money if pharmacies close. But by minimising taxpayer funding for dispensing services, neither total costs, including the costs consumers incur in travelling to pharmacies, nor health costs will be minimised. On this occasion as on many others, the Panel seems to confuse 'efficiency' with minimising public outlays.

- It is misleading to suggest that ELRIC is 'a number' that can be calculated and used to set a price (the dispensing fee). Absent special assumptions to the contrary, ELRIC is a complex function that depends on multiple parameters, including ones that are not observable, such as the level of demand.

The Panel also presents no evidence that the existing structure of dispensing fees is unrelated to the costs of providing specific dispensing services (and is therefore inefficient). The Panel nonetheless recommends that the existing differentiated structure of dispensing fees should be rolled into a single, flat fee. Yet none of the claims made in the Interim Report – that a flat fee would reduce the deadweight loss of tax, and that a flat fee would increase overall efficiency – has any basis in economics:

- The discussion around the inefficiency arising from the deadweight loss of taxation confuses two separate effects: the Interim Report calculates the

Treasury savings from cutting the *level* of the fees, and wrongly attributes the saving to the *flattening* of the fee structure.

- The Panel relies, in its pricing recommendations, on a commissioned study of what is called the 'effective rate of assistance' (or ERA) for several types of dispensing. That analysis conflates tasks with size of pharmacies by assuming that small pharmacies undertake 'low value' tasks, while large pharmacies undertake 'high value' tasks. The larger point is that the purported calculations of ERAs bear no relationship to conventional measures of ERAs, and are best considered as complicated economic nonsense. These calculations assume that, if the Government ceased paying a dispensing fee, it would continue to prevent pharmacists from setting their own dispensing fees, and that pharmacists would then continue the activity of dispensing, but do so for free. We know of no precedent for defining ERAs in this way.

There is a broader theme that underpins the Panel's various dispensing fee proposals. To-date, the 5,600 or so pharmacies that make up the sector have been subject to a system of light-handed oversight that seeks to balance efficiency and equity of access objectives, while ensuring that pharmacy services are provided by small businesses with the incentives to provide a high quality service. The Panel's approach instead implies transforming community pharmacy into a highly regulated sector that would be subject to strict oversight and scrutiny:

- dispensing fees would be calculated by the Government or a regulator of its choosing according to one or more of the Panel's highly prescriptive cost metrics (namely, the 'efficient costs of dispensing' (Option 4-2), the 'benchmark for a best-practice dispense' (Option 4-3), or the 'efficient, average, long-run incremental cost of a dispense' (Option 4-4));

- in order for these metrics to be determined, pharmacies will be required to provide detailed annual financial and operational information; and

- these information requirements would be supplemented by a new quality reporting and monitoring regime.

The consistent theme throughout the Interim Report is that the corresponding costs of establishing what amounts to an all-embracing and intrusive regulatory regime are never discussed, let alone accounted for.

Service quality

Medicine dispensing and advisory services require different levels of care and engagement, depending on a customer's individual circumstances and the type of medicine that has been prescribed. Yet the Panel's preoccupation with achieving (narrowly defined) budget savings on the basis of a 'least-cost' approach to remuneration would fundamentally change the incentives of community pharmacy in this regard. If only large pharmacies with a focus on commercial retailing and a minimalist approach to providing dispensing and related advisory services can stay in business, then it is clear that commercial retailing, rather than patient care will be prioritised. If, furthermore, differentiated fees for specific services such as dispensing dangerous drugs are rolled into a single, lower fee, pharmacies serving disadvantaged or chronically ill patients will be additionally penalised and discouraged from providing these services.

The Panel offers no evidence of quality of service concerns in community pharmacy. To the contrary, consumer surveys, including the Panel's own research, consistently show that pharmacists and pharmacies engender very positive attitudes and trust. The Panel nonetheless recommends establishing new 'minimum requirements' that pharmacies must meet, and initiating procedures to 'enforce these requirements'.

The Panel's consultants offer an example of a 'detailed performance-based contract' – akin to that applied for rural and regional business services – which Government and individual pharmacies would enter into. Among other things such a contract would stipulate the types, quantities and quality of services to be supplied, as well as detailed performance indicators and financial reporting requirements. However, the Panel appears to have overlooked the fact that pharmacists are already subject to stringent professional and licensing standards. More generally, simplistic performance metrics have little, if any, relevance to community pharmacies that serve different catchment areas with consumers that differ in their socio-economic status and individual health needs. Indeed, such metrics can be dangerous if used as a policy tool. Finally, no mention is made of the tremendous resources needed by Government to apply a detailed monitoring and reporting regime to Australia's 5,600 pharmacies, nor of the administrative burden and damage to professional self-esteem that this would impose on community pharmacy.

Removal of the Location Rules

The Panel's proposal to fundamentally change community pharmacy is perhaps best encapsulated in the recommendation to eliminate the so-called 'Location Rules'. To date, the Australian government has relied on the Location Rules to ensure equitable access to dispensing and related advisory services, while maintaining a cost-effective medicines distribution system that avoids unnecessary duplication. The empirical studies that have been undertaken to date, including those by the Panel's own consultants, have found that these objectives are being achieved.

The Panel also concludes that the pharmacy network is 'good', but nonetheless asserts that radical change is required in terms of where pharmacies should be permitted to open up for business. The corresponding discussion is characterised by inconsistent and poorly justified assertions, including the claim that the Location Rules are the cause of both 'too many' and 'too few' pharmacies, and that the Location Rules are a material source of costs.

At the same time, that discussion skirts over the outcomes that would arise if the recommendation to eliminate the Location Rules were implemented. The experience in England, similar to that in other European countries, is that the (soon reversed) loosening of locational restrictions did not result in better or more equitable health outcomes for consumers. Instead, rapid new entry in commercially attractive locations put additional financial pressure on existing pharmacies that serve an identified community need. By the same token, the Panel's claim that the Location Rules impede competition is neither factually correct, nor does it recognise that unrestricted entry has uniformly resulted in horizontal and vertical industry consolidation in the pharmaceutical industry in Europe.

In combination with the proposed significant cut in pharmacy remuneration, the consequence of removing the Location Rules will be to facilitate new entry by large, retail-warehouse style pharmacies in commercially attractive settings, while

simultaneously forcing the closure of a small, local pharmacies. The Panel's consultants clearly state that the eventual result will be the closure of 'a large number' of small pharmacies in Australia's major cities and inner regional areas, but also in Australia's remote and very remote regions, where 84 per cent and 98 per cent of pharmacies, respectively, are small. Yet these outcomes are said not to be of great consequence. Consumers would still have access to other pharmacies in cities and inner regional areas, even if the small pharmacies that constitute around half the population close. In more remote areas, the Government would step in and institute a new system of payments to support failing pharmacies. Overall, the new regulatory landscape would be characterised by 'free-for-all' entry in urban parts of Australia, combined with novel planning and subsidy arrangements everywhere else.

Supermarket pharmacies

The Location Rules and the jurisdictional 'ownership rules' currently prevent pharmacies from locating inside supermarkets. As such, supermarkets are prohibited from owning and operating community pharmacies. All of the research that has been conducted to date, including that prepared on behalf of the Panel, shows that this outcome accords with the views of the Australian public: consumers are almost universally opposed to permitting pharmacies to locate inside supermarkets. The Panel nonetheless concludes that 'there is no reasonable rationale for maintaining' the restriction of co-locating pharmacies in supermarkets.

The Panel offers very little by way of rationale for overturning the supermarket co-location restriction other than the suggestion that consumers will change their minds once confronted with a new reality. Yet, the restriction on locating pharmacies inside supermarkets has a sound rationale that is founded in broader public policy objectives.

First, the pharmacy ownership rules, including the restriction on supermarkets owning and operating pharmacies, have preserved a dispersed industry structure in community pharmacy. In contrast, a clear trend of vertical and horizontal industry consolidation has been observed in countries that have relaxed their pharmacy ownership rules. Eliminating the ownership rules therefore risks putting the Australian pharmacy sector on a path to greater concentration of ownership, be it in the hands of the major supermarkets, upstream wholesalers, or large pharmacy chains. Consolidation trends are difficult or impossible to reverse once they have been set in motion, and would furthermore confer a high degree of bargaining power on players with a predominant position in dispensing services vis a vis the Government (and therefore taxpayers).

Second, the pharmacy ownership rules create far stronger quality incentives than could be achieved by fining or prosecuting a large pharmacy chain or other corporate entity. By placing the pharmacist and his or her professional reputation at the centre of the distribution relationship, a position that the pharmacist stands to lose if quality standards are not met, the Government 'raises the stakes' for non-performance. Owner-pharmacists therefore have an enhanced incentive to conduct themselves and their pharmacies ethically and professionally, so as to not risk loss of registration and, therefore, loss of value in the pharmacy.

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1. Introduction

The Independent Expert Panel (the Panel) has recently released an Interim Report that presents the findings and options for reform arising from the Review of Pharmacy Remuneration and Regulation. The Interim Report covers a broad range of issues, and proposes significant changes to the pharmacy remuneration arrangements and regulations.

We have been asked by the Pharmacy Guild of Australia (the Guild) to review and comment on the economic arguments made by the Panel, specifically as they relate to the recommended community pharmacy remuneration arrangements and the removal of the Pharmacy Location Rules (the Location Rules).

This report is structured as follows:

- in Section 2 we describe the Panel's overall 'vision' as to how community pharmacy should be remunerated and regulated;
- in Section 3 we assess the Panel's recommendations for the remuneration of community pharmacy; and
- in Section 4 we discuss the Panel's recommendation to remove the Location Rules.

2. The Panel's 'vision' of community pharmacy

In this section, we offer a 'roadmap' to the Panel's 'vision' of community pharmacy, as reflected in the discussion and recommendations in the Interim Report. In Sections 3 and 4 we discuss the proposals for pharmacy remuneration and the Location Rules, respectively.

2.1 Community pharmacy as a regulated industry

The regulation of community pharmacy involves a number of strands, including rules that govern the location of pharmacies (which is regulated by the Commonwealth), and their licensing and ownership (which are the responsibility of the states and territories). The remuneration of community pharmacy has in turn been determined through successive community pharmacy agreements (CPAs), with the Sixth Community Pharmacy Agreement (6CPA) taking effect from 1 July 2015. Individually and in combination, these provisions have shaped the evolution of community pharmacy to date.

The Panel is proposing to fundamentally change how community pharmacy is regulated, and as a consequence, the number and distribution of community pharmacies. To-date, the 5,600 or so pharmacies that make up the sector have been subject to a system of light-handed oversight that seeks to balance efficiency and equity objectives, while ensuring that pharmacy services are provided by small businesses which have incentives, and ample room, to provide high quality services. The Panel's vision is to transform community pharmacy into a highly regulated industry, with the explicit aim of reducing regulated payments so as to force small pharmacies to close.

The Panel is eager to point out that the current framework for pharmacy remuneration and regulation is not 'perfect'. In reality, any framework is certain to fail that test. Rather, the question is how well the counterfactual proposed by the Panel would perform when compared to the current arrangements. Nowhere does the Interim Report discuss the costs and risks inherent in the Panel's approach. This is hardly a trivial oversight. Any regulatory impact statement for a change to a regulation must compare the benefits and costs of the proposal relative to the status quo.

Given that the Interim Report makes radical recommendations, we would expect to find sufficient supporting evidence and argument that the current and past sets of arrangements, comprising the CPAs and attendant rules and regulations, have led to outcomes that are significantly unsatisfactory; and that the proposed changes will make a significant improvement on those outcomes without causing serious transitional disruption to customers and pharmacies, or posing long term risks. However, that is not the case. According to the Panel's own assessment, the network is 'good' and community pharmacies are not earning 'economic rents'.

2.2 Budget versus health policy impacts

To date, Government policy in relation to community pharmacy has been shaped by health policy objectives that, directly or indirectly, focus on outcomes for consumers,

as well as costs to the Budget. The Interim Report pays lip service to these broader social objectives, but fundamentally promotes budget savings as the central goal. However, a focus on budget outcomes alone is not 'socially optimal' or 'efficient', nor would it enable the Government to achieve objectives that include good health outcomes for Australians, equitable access to quality medicines, as well as cost-effectiveness objectives.

The Panel has then not been careful enough in distinguishing pharmacy from regular retailing. In consequence, the Interim Report makes judgements of fact and recommendations for action that may well apply to retail in general, but that are inappropriate for pharmacy. A prime example is that the Panel relies on the report it commissioned of RSM Australia, in which RSM describe community pharmacies as commercial businesses like any other, and include as 'comparable businesses' that should be used for the purposes of benchmarking: corner stores, health food retailers, and supermarkets (P.110). None of these have the professional obligations and fiduciary duties of pharmacies towards their customers, nor do they bear the regulatory burdens associated with dispensing potentially dangerous products.

Given the focus on budget savings, the Panel elevates dispensing fees as the central mechanism for arriving at what it considers to be a more desirable number and pattern of geographical distribution of community pharmacies. The Panel's 'vision' implies cutting dispensing fees, thus closing a large number of small pharmacies which, the Interim Report claims (without evidence), are inefficient.

Rather than considering the community pharmacy network overall, the Panel has elected to focus on costs at the level of the individual pharmacy. The Interim Report proceeds to describe a range of cost metrics that it claims would deliver more 'efficient' outcomes for taxpayers. The subtext is that an all-knowing central planning authority could easily calculate these metrics – the 'benchmark for an efficient dispense' and the 'efficient, average, long-run incremental cost of a dispense' (ELRIC), set dispensing fees accordingly, and thereby bring about the desired outcome for community pharmacy. In reality, these cost metrics could not be calculated without enormous effort and cost, if at all. The bigger issue, however, is that the Panel's economic reasoning is fundamentally flawed. In particular, setting dispense fees at ELRIC would result in the closure of all but large, warehouse-style pharmacies, an outcome that is fundamentally inconsistent with broader Government health policy objectives.

The Panel claims that replacing the existing system of dispensing fees with a single flat fee would constitute an efficiency improvement. That discussion too, is characterised by errors in reasoning. Contrary to what is stated in the Interim Report, a flat fee would not reduce the deadweight burden of taxation relative to the current differentiated fee structure, nor does the current fee structure offer greater 'effective rates of assistance' to smaller pharmacies. All that remains of substance in the Interim Report's reasoning is that the Panel wishes to reduce the number of small pharmacies: cutting dispensing fees is the means to that end.

The level of dispensing fees is similarly the preferred instrument for shaping the geographical distribution of community pharmacies. The Panel recommends eliminating the Location Rules, thereby enabling unrestricted entry into community pharmacy. A significantly reduced level of remuneration from a cut in dispensing fees would undermine the viability of small local pharmacies; an effect that would be

reinforced via unrestricted entry by large players in commercially attractive locations. In other (rural and remote) areas, government would intervene to maintain those pharmacies whose ongoing operation is deemed to be desirable. The outcome overall is an incoherent hybrid, whereby large commercial players can be expected to drive out small local pharmacies in urban areas, and whereby a new system of government intervention would be needed elsewhere to support community pharmacies who will no longer be viable. Precisely how such a system of government intervention would work, and why it might be superior to the current arrangements, is not explained by the Interim Report (much less empirically demonstrated), which simply assumes these questions away.

2.3 Dispensing fees as the sole policy instrument

The central reliance on 'efficient' dispensing fees goes to the fundamental difference between the approach to pharmacy regulation and remuneration described in the Interim Report, and the framework which has applied to date. The CPAs, the Location Rules and the ownership rules make a package of regulation of pharmacies. To outside observers, this may seem messy. However, the package brings to bear a number of instruments of incentive and control, in order to achieve excellent outcomes, when those outcomes themselves have a number of dimensions, some quantitative and relatively easy to measure, some qualitative and a matter of judgement.

A rule often articulated in the economic theory of public policy is that the number of instruments should generally be as many as the number of objectives; Mundell refined this by noting that it is best to assign an instrument to the target for which it has a comparative advantage. Under the norm of 'N-objectives, N-instruments', the question then becomes 'What instruments?' In economic theory, in a number of situations, the best instrument is a price of some kind: 'N-objectives, N-prices'? Price regulation of public utilities or monopolies is designed to achieve a close balance between the quantity demanded and quantity supplied, while ensuring the on-going viability of the industry, but without generating excess profits.

The aim of the Interim Report is to eliminate the existing messy set of regulations and rules, and substitute what can be characterised as a 'laser-ray' price: a single scientific price for dispensing that, it implies, will induce the appropriate number, size distribution and geographical dispersion of pharmacies, while ensuring that there are no significant excess profits (or 'rents') being earned: many objectives, one instrument.

But price regulation is inevitably accompanied by regulation of other dimensions of outcomes or objectives. Somewhat reluctantly, the Panel then recognises that a single policy instrument is not enough, and so in Option 3-1, it recommends a process for determine the 'minimum requirements' that a community pharmacy must meet: that is, to substitute for the existing light-handed and cooperative regulation, a heavy-handed bureaucratic alternative. Again, issues such as quite how that alternative would work, how much it would cost to design and implement, and why it would perform better than the current arrangements, are nowhere discussed.

3. Remuneration of community pharmacy

In recent years, the level and form of remuneration of community pharmacy has been determined through successive CPAs, with the Sixth Community Pharmacy Agreement (6CPA) taking effect from 1 July 2015. 6CPA explicitly recognises the integral role of community pharmacies within the infrastructure of the health care system, and articulates three key objectives:

- promoting the sustainability, efficiency and cost-effectiveness of the Pharmaceutical Benefits Scheme (PBS) within the broader context of health reform;
- ensuring that community resources are appropriately directed across the health system; and
- supporting the sustainability and viability of an effective community pharmacy sector.

6CPA furthermore clarifies that the pharmacy remuneration and medicines pricing arrangements are intended to support the objectives of the National Medicines Policy (NMP) by balancing the need to:[1]

- ensure consumers can continue to have access to new and innovative PBS subsidised medicines at an affordable price that are necessary to maintain the health of the community;
- promote and improve the quality use of medicines; and
- ensure a cost-effective and sustainable PBS.

6CPA references the community pharmacy Location Rules, whose purpose is explicitly linked to the achievement of equitable health outcomes, in terms of the accessibility of pharmacies.

In this section, we discuss the Panel's recommendations as they relate to how pharmacy remuneration should be determined and the level and structure of dispensing fees, namely that:

- benchmarking should be applied to establish the efficient cost of dispensing (Section 3.1);
- dispense fees should be set on the basis of the efficient long-run incremental cost of dispensing (Section 3.2);

[1] The National Medicines Policy's overall aim is to meet medication and related service needs, so that both optimal health outcomes and economic objectives are achieved, in terms of (DOH 2014):

- timely access to the medicines that Australians need, at a cost individuals and the community can afford;
- medicines meeting appropriate standards of quality, safety and efficacy;
- quality use of medicines; and
- maintaining a responsible and viable medicines industry.

- pharmacies should be remunerated on the basis of a single, flat dispense fee (Section 3.3);
- alternatively, if the wholesale cost of drugs to community pharmacy is not limited, then remuneration should take the form of a two-part tariff (Section (3.4);
- the consequences of these remuneration arrangements for quality incentives (Section 3.5); and
- the consequences of the remuneration for the manner in which CPAs are negotiated (Section 3.6).

3.1 Efficient cost of dispensing and the benchmark pharmacy

The Interim Report's Option 4-2 deals with the general approach that should be adopted for remunerating dispensing services. The Panel says that payments to pharmacies are not based on (individual) pharmacy cost metric(s), and hence the Government cannot be assured that the fees that it pays reflect the efficient costs of providing pharmacy services. Pharmacy remuneration should instead be based on the costs of dispensing by an 'efficient pharmacy' (Option 4-2), with the fee to be determined via benchmarking a 'best-practice dispense' (Option 4-3), or as the 'efficient, average, long-run incremental cost of a dispense in a community pharmacy' (Option 4-4). In the following, we:

- describe how pharmacy remuneration and efficiency objectives have been addressed in CPAs to date, and contrast this approach with that embraced by the Panel;
- discuss the conceptual and technical challenges that arise in attempting to benchmark a large and diverse population of community pharmacies; and
- comment on the related benchmarking data required from pharmacies.

3.1.1 Context

The payments that pharmacies receive for dispensing PBS medicines and the funding for more specialised services have been defined in successive CPAs, beginning with 1CPA (December 1990). 1CPA was signed following a period when pharmacy remuneration had been determined by the Pharmaceutical Benefits Remuneration Tribunal, an approach that eventually proved unworkable. In successive CPAs, the Government removed the wage indexation provisions that had previously applied, and revised the structure of fees paid to pharmacists, including by putting in place a 'price disclosure' regime, such that the discounts offered on generic drugs had to be passed on to Government. Subsequent CPAs incorporated various risk sharing and savings measures. The evolution of CPAs can then be summarised as follows:

- 2CPA (April 1995) introduced savings measures, estimated at $100 million, whereby pharmacies were required to forego a share of inflation adjustments if growth in prescriptions exceeded a given percentage;

- 3CPA (July 2000) introduced two risk sharing arrangements, whereby the Commonwealth clawed back some share of fees if average mark-ups on wholesale drug prices exceeded the central estimate by a given percentage, and whereby dispensing fees would be retroactively adjusted if the growth in prescription volumes was above or below expectations;

- 4CPA (November 2005) changed dispensing fees, resulting in a $350 million saving over the term of the agreement, and applied a risk sharing arrangement that was applied to unanticipated changes in prescription volumes; and

- 5CPA (May 2010) also changed dispensing fees, resulting in a $1 billion saving over the term of the agreement.

6CPA (May 2015) incorporates a range of savings measures, including delinking pharmacy remuneration from medicine pricing by replacing the previous pharmacy mark-up component of fees with a new tiered administration, handling and infrastructure (AHI) fee. 6CPA is estimated by the Commonwealth to deliver net savings of $3.7 billion over the life of the agreement.

The Government has, to date, rightly stepped back from attempting to tie dispensing fees to the costs of individual pharmacies, which vary along multiple important dimensions. Broadly speaking, the aim of Australian Governments, as reflected in the CPAs to date, has been to maintain a network of community pharmacy that is cost-effective and accessible to all consumers. This will invariably require a mix of pharmacies with distinctive characteristics that serve differing catchment areas, including many small pharmacies that are located in areas where the scope for securing any economies of scale, to the extent that these are material, will be limited.

Governments' accessibility and cost-effectiveness goals have then been achieved by defining a limited number of fees for common dispensing services over the respective five-year terms of the CPAs. A standardised fee schedule gives pharmacies a clear financial incentive to provide the required dispensing services, as well as some indication of forward earnings over the term of the agreement. From the Government's perspective, such a fee schedule enables forecasts to be made of budget outlays over the term, while the limited terms of the agreements offer the flexibility to revise fees and other aspects to reflect changing health policy and budget circumstances.

The various efficient cost metrics advocated by the Panel represent a significant departure from how pharmacies have been remunerated to date. Rather than looking at the community pharmacy network overall, and managing accessibility and cost trade-offs at that basis, the Panel has chosen to focus on costs at the level of the individual pharmacy and to disregard consumer access objectives. Furthermore, by requiring each individual pharmacy to be 'efficient' relative to an 'efficient benchmark' pharmacy (as discussed below) or relative to an 'efficient, average, long-run incremental cost' metric (Section 3.2), the Panel has set itself a task that would virtually impossible in the best of circumstances, namely to assess a diverse population of almost 5,600 pharmacies according to a uniform efficiency metric. As we explain in our evaluation of the recommended remuneration arrangements, the Panel has not succeeded in defining an economically coherent 'efficient cost' metric. Nor does the Panel address the complexity and costs of its proposed approach, or the consequences for the pharmacy network and therefore for consumers.

3.1.2 Utility benchmarking

We turn now to concept of the 'best-practice benchmark' metric advocated by the Panel. As we explain in Section 3.3, the effects of a dispensing fee will depend on its level, rather than how it has been calculated, but it is nonetheless important to understand the rationale behind the fee recommendations and its implications.

The Interim Report glosses over the formidable technical and data challenges that arise in practice in attempting to calculate an efficient benchmark across a large and diverse population of pharmacies, let alone how to incorporate quality of service considerations in such a benchmark. It is difficult to view the notion of a representative 'efficient pharmacy' put forward by the Panel as anything more than a theoretical abstraction.

The Interim Report notes that the 'efficient business' benchmark is the standard used in a variety of regulatory contexts, including in the regulation of electricity and gas utilities (P76). Benchmarking methods are used in conventional utility regulation as a basis for determining potential efficiency improvements and translating these into maximum price caps. Regulators have developed a variety of benchmarking methods that can broadly be classed into frontier-based and non-frontier techniques. Frontier-based techniques include Data Envelopment Analysis, Corrected Ordinary Least Square Analysis, and Stochastic Frontier Analysis. These techniques measure the relative performance of a regulated firm in the form of efficiency scores against the best practice or efficient frontier of a sample of firms. Non-frontier techniques mainly focus on Total Factor Productivity metrics.

Whichever approach is adopted, efficiency benchmarking poses significant conceptual and technical challenges, and related data requirements. Here, the recent Competition Tribunal decision in relation to the Australian Energy Regulator's (AER's) use of economic benchmarking for the purpose of determining electricity distribution tariffs is instructive. The Tribunal remarked that the AER's approach was not 'sensible', given that "*benchmarking in Australia is in its infancy*" [389]. The Tribunal furthermore criticised significant aspects of the benchmark modelling relied upon by the AER, including that the regulator used flawed data, applied statistically flawed modelling techniques, failed to account for the distortions that were created in order to enable the econometric model to function, and failed to apply a 'reasonableness' check to the results of econometric modelling.

It is notable that the AER encountered these difficulties in attempting to determine efficient prices for a handful of distribution networks. Such utilities are regulated and subject to access regimes all over the world, and quality of service objectives can be specified in terms of minimum performance standards. In contrast, the Australian Government (or any regulator it may choose to appoint) have no expertise in or knowledge of the cost conditions facing community pharmacy.

3.1.3 Benchmarking data

Option 4-1 states that the best-practice benchmark costs of community pharmacy can be determined on the basis of individual pharmacies' accounting information, but this statement trivialises the information that pharmacies would have to provide and the corresponding administrative burden.

The Panel states that this benchmark would fully reward an efficient community pharmacy '*for all the economic costs associated with dispensing*' (P.76), but deriving economic costs involves far more than gathering accounting data. Among other things, regulated prices must ensure that investors earn a fair return on the capital they have invested. Adequately compensating pharmacies then requires an estimate of the costs of individual pharmacies' physical infrastructure, a complicated and fraught undertaking, given the many ways in which assets can be valued, as well as an assessment on the appropriate rate of return.

Moreover, more sophisticated benchmarking techniques require adjustments to be made to account for the operating environment of a utility.[2] In the case of community pharmacy, this is the location and the consumer catchment area, which will affect the mix of dispensing activities. Furthermore, different pharmacies offer differing services, as is also reflected in the questionnaire put to pharmacies by the Panel. Thus, Question 16 asks about the remuneration received by a pharmacy for offering: dose administration aids, clinical interventions, staged supply, home medicines review, 'medscheck', diabetes 'medscheck', residential medication management review, and QUM (Quality Use of Medicines) services, respectively. Question 18 explore the detailed circumstances of pharmacies in regional and remote areas. It is then perhaps not surprising – and indicative of the time that would be required to complete the survey – that of the 144 pharmacists who began the survey, only 38 completed it. Hall& Partners' (2017) comments about the information they eventually received also provide an indication of the difficulties pharmacists encountered, given that 'outliers beyond the realms of probability' had to be excluded, and that data appeared to be internally inconsistent.

The absence of consideration of the (counterfactual) costs that would be incurred if the Panel's recommendations were implemented is a consistent theme throughout the Interim Report. In the case of Option 4-1, the administrative and implementation costs *alone* will include:

- the costs of establishing and manning what is effectively a new regulatory body which would be tasked with defining the new efficient benchmark performance metric, gathering and analysing data from almost 5,600 pharmacies, and attempting to calculate the efficient benchmark costs of a dispense on that basis; and

- the (opportunity) cost burden placed on pharmacies who will in turn be required to compile the information.

3.2 Efficient long-run incremental cost of dispensing

The Interim Report recognises that a stand-alone dispensary would not be viable (P.88). The Panel therefore resiled from a recommendation that the dispensing fee should be set on the basis of the costs of a dispensary-only pharmacy. The reasoning must include that a stand-alone pharmacy would have costs so high that no government would be willing to pay for these. Even the most efficient stand-alone dispensary would then have unacceptably high costs, because dispensing costs fall

[2] For instance, different climatic conditions may affect the cost of maintaining utility poles, which would need to be accounted for in a 'like with like' benchmarking exercise.

when a pharmacy also retails non-PBS goods (or, dispensing costs fall over some range of non-dispensing activity). The implication is that community pharmacy exhibits economies of scope between dispensing activities and retailing non-PBS goods.

Given that is the case, the Panel opted for Option 4-4, whereby dispensing fees should be based on the efficient long-run incremental cost (ELRIC) of a dispense in a community pharmacy. As we explain in more detail in Section 3.3, the effects of a dispensing fee will depend on its level, rather than how it has been calculated. Here, we focus on the rationale behind the fee recommendations and its implications.

Below we discuss the implications of the ELRIC proposal, hampered, however, by the fact that the Interim Report does not adequately define what is meant by ELRIC in any practical sense. We suggest that ELRIC cannot be calculated except over some ranges of PBS and non-PBS activities; who will choose those ranges and how is not clear. Furthermore:

- The Panel clearly believes that there is some presumptive gain in economic efficiency from setting the dispense fee equal to incremental dispensing costs. We argue that there can be no such presumption, that setting dispense fees on this basis is arbitrary, and not based on economic theory: if one wanted to get to economic efficiency, one would not start from there.

- The recommendation to use ELRIC as the fee metric is based on the assumption that such a fee would allow an 'efficient' pharmacy to cover all of its costs: that the sales of non-dispensary items would automatically be sufficient recover all joint and common costs. Thus, for a typical pharmacy, twenty per cent of its revenue, gained in the competitive market for non-prescription goods, would supposedly cover the great bulk of pharmacy costs. This Panglossian world seems more than unlikely; in reality, many 'efficient' pharmacies would fail.

- Finally, in advocating Option 4-4, as a means of saving money for the Treasury, the Panel ignored the social reasons for the PBS scheme. Treasury will save money only if some pharmacies close, and the Panel is clearly of the opinion that some or even many of the three thousand or so so-called 'micro' pharmacies should close: the ELRIC dispense fee is an instrument to that end. However, the 'optimal' fee is recommended on the basis of a deeply flawed concept of efficiency; in particular, the recommendation is put forward without considering the additional costs to PBS customers, especially those in lower socio-economic locations; or the lessening of localised competition: there is an obsessive focus on cost-effectiveness in a simple sense.

3.2.1 Why set dispense fees equal to ELRIC?

By definition, the total costs of a pharmacy equal the stand-alone costs of producing non-PBS output (undertaking mostly conventional retail sales), plus the incremental costs of PBS output (dispensing medicines). The stand-alone costs of producing non-PBS output include such items as overheads and rent, which are 'joint' or 'common' costs since they cannot easily be attributed to any specific activity. By saying that dispensing costs should only cover the ELRIC of dispensing, the Panel is therefore making an arbitrary decision that all of a pharmacy's joint and common costs should be attributed to non-PBS sales. Put in another way:

- the sales revenue of a community pharmacy from non-PBS retail products would have to cover all of a pharmacy's joint and common costs; that is,

- the prices and the volume of sales for non-PBS retail products would have to be such that the non-PBS revenue covers joint and common costs.

The decision that all of a pharmacy's joint and common costs should be attributed to non-PBS sales (so that the fee for dispensing equals the incremental costs of dispensing) is entirely arbitrary. There is a long tradition in economics that economic efficiency is furthered when price is set equal to the marginal costs of a product: price represents the marginal willingness to pay on the part of consumers; marginal cost is the marginal willingness to supply on the part of the producers. If this price is too low to cover average cost, then economists have devised schemes, including multipart tariffs, to cover the gap and still have an outcome economically superior to average cost pricing. This readily applies to the single product case. However, there is no economic theory we can find that supports the proposition that, in the multi-product case, pricing one product at incremental costs is presumptively efficient. Indeed, the opposite is more usually the case: the burden of joint and common costs should be spread across all of a firm's products, albeit to potentially varying extents. Ignoring that standard result, the Interim Report simply assumes allocating all of the joint and common costs to one product set will be efficient.

3.2.2 Most community pharmacies would not be viable under ELRIC pricing

Moreover, there is no reason to think that a pharmacy operating on the basis recommended by the Panel would be viable. The prices of many, maybe most non-PBS retail goods (such as beauty or general health products) are constrained by competing retail outlets, including supermarkets. It is therefore not the case that a pharmacy could simply devise a mark-up for its non-PBS sales to recover all of its joint and common costs; in the great majority of cases, it would soon go out of business. Such an outcome would certainly be assured in the case of a pharmacy that derives, say, 20 per cent of its turnover from non-PBS sales. In this respect, the claim in the Interim Report that the approach to setting dispensing fees is 'business model neutral' (P.75) is plainly wrong.

There is an important and revealing difference here, between the approach of the Panel in the Interim Report, and the work of Waterson (1993) that the report cites. Waterson estimated the efficient geographical distribution of Melbourne's then pharmacies in a model in which the pharmacies were constrained to break even. Waterson modelled pharmacies with some localised market price setting power in the non-PBS markets; if that was not sufficient to break even, given the dispensing fee, then that pharmacy was assumed not to operate. In contrast, the Interim Report merely assumes that, with a fee set at the average ELRIC of dispensing, all or some pharmacies would break even through the excess of their non-PBS sales over that part of their cost that are not recouped via the dispensing fee.[3]

Additionally, it is obvious that the average ELRIC will be below incremental cost for some pharmacies and above it for others: indeed, that is inherent in its nature as an

[3] In Waterson's simulation of the optimal geographic distribution, all pharmacies operated under a common cost function and so all were 'efficient' in that sense.

average, and is all the more certain given uncontrollable variability in efficient dispensing costs. It follows that in some cases, pharmacy remuneration will fall short of total incremental costs, which is only viable if the PBS activity is cross-subsidised: in other words, if prices for non-PBS sales are above stand-alone costs, with the excess being used to fund dispensing. However, it is unclear why such an operation would continue to dispense, even assuming it could: it would maximise profits by ceasing to do so. As a result, even assuming the average ELRIC could be calculated 'correctly' (an issue discussed in the next section), there is a real prospect of such a scheme unravelling, as each average induces a round of exits which alter the proper level of the fee.

3.2.3 ELRIC prices cannot be calculated

The Interim Report appears to assume that all that is involved in implementing the recommendation to base dispensing fees on ELRIC is gathering financial pharmacy data and then calculating a number. However, that assessment is not correct. Rather, under most assumptions, ELRIC takes the form of a function rather than a fixed, numerical parameter. Furthermore, calculating ELRIC requires information not just on pharmacy costs but, as was argued above, also on demand conditions, and is therefore not something that can be calculated on the basis of pharmacy data alone.

The reason why this is the case is because, given that there are economies of scope, ELRIC will be a function of *both* sales of PBS goods (dispensing) and sales of non-PBS goods (retailing). The level of sales of non-PBS goods in turn depends on demand and pharmacy attributes, such as the size of the pharmacy, its location and other factors. There is no reason why the underlying cost function would be linear additive in its parts; or more generally, why it would be separable. The Interim Report uses the results from Waterson (1993); the Cobb-Douglas cost function that Waterson relied upon is neither linear additive nor separable: cost is not defined nor separable (it is zero) for a stand-alone pharmacy without a dispensary.[4] In short, absent special assumptions to the contrary, ELRIC is a complex function that depends on multiple parameters, including ones that are not observable.

In this context, it should be pointed out that to understand the implications of Option 4-4, it is necessary to clarify the concept of 'average incremental' costs as it is used in the Interim Report. Unfortunately, the Interim Report does not satisfactorily define or expand on this important term.

The Interim Report tells the reader that the incremental costs of dispensing refer to 'all the extra costs that a community pharmacy faces when it operates a dispensary compared with operating a pharmacy without a dispensary' (p. 88). Presumably, these extra costs include the rent on additional space, fitting out that space and the like; but does it include the salaries or opportunity costs of one or more pharmacists? A stand-alone non-dispensing pharmacy does not require a pharmacist in attendance, whereas a dispensing pharmacy must have a registered pharmacist in attendance at all times

[4] The Cobb-Douglas cost function used by Waterson (1993) is: $C = 8.14 \times R^{0.5392} \times Q^{0.3938} \times RE^{0.0618}$, where R is retail sales, Q is the number of PBS scripts, and RE refers to rental costs. Thus, the cost C of the pharmacy is *not* simply the sum of the cost of dispensing PBS scripts plus the sum of retailing activity, but a combination of the two activities. Furthermore, retail sales R must equal the demand for retail products, which in turn depends on the price of these retail products.

when the dispensary is operating. How many pharmacists, and how is their number chosen for the calculation of ELRIC of dispensing? Recall that ELRIC of dispensing relates to the cost of *operating* a dispensary, not merely the incremental costs of *setting up* a dispensary.

Similarly, the Interim Report recommends that the dispense fee be set equal to the *average* of ELRIC; but exactly what average is never explained, nor why that average ought to be preferred, on efficiency grounds, to others. For example, ELRIC might be averaged across some number of PBS items. How many? How is that number to be chosen? The Interim Report does not say. Its failure to do so has substantial implications: in particular, without properly explaining the nature of this average, and how it relates to the cost function for pharmacy, there is no reason whatsoever to believe the scheme will promote efficiency or even be sustainable.

3.2.4 ELRIC pricing is not consistent with a social optimum

The Panel's choice of the ELRIC cost metric seems designed to minimise Treasury budget outlays for community pharmacy, but that approach is not consistent with the Government's broader health policy objectives, nor would it achieve a 'socially optimal' outcome. In setting dispensing fees, the Government is not just intending to minimise expenses to taxpayers. Rather, as reflected in the objectives of the NMP and 6CPA, the Government is seeking to achieve a broader set of goals that include good health outcomes for Australians, equitable access to quality medicines, as well as cost-effectiveness objectives. Hence, setting dispensing fees so as to achieve a social optimum must include factors such as convenience for consumers (and therefore the costs that consumers incur to travel to the nearest pharmacy), as well as other direct and indirect health consequences from determining dispensing fees in a particular way.

To put this point in another way: by minimising taxpayer funding for dispensing services, neither total costs, including the costs consumers incur in travelling to pharmacies, nor overall health costs will be minimised. Moreover, the costs will compound: if travel costs rise, or access to pharmacy service is in other ways compromised, health outcomes will suffer, shifting costs on to consumers in the first instance and on to other parts of the health system in the longer term.

That these are real concerns should be obvious. Although the Interim Report is extremely vague as to precisely what it means by ELRIC, it is clear that a dispensing fee set on the basis of ELRIC might well result in the closure of all but the largest (warehouse-style) pharmacies for whom dispensing is a smaller share of activities. Closing large numbers of local community pharmacies will cause consumers, particularly consumers who are less mobile, to incur greater costs in accessing medicines. It may also result in consumers accessing less advice about these medicines with potential negative health consequences. In aggregate, the (opportunity) costs to consumers and the broader health costs incurred by the Government will rise. There is no economic sense in which such an outcome would be efficient, much less equitable.

3.3 Remuneration on the basis of a flat fee

In the following, we review the recommendation to roll the existing differentiated dispensing fees into a single flat fee (Option 4-4). The discussion in the Interim Report

around the merits of a flat fee is closely linked with the proposal to reduce dispense fees from currently around $11.50 on average to a flat fee of $10 per dispense.

As a general matter, there are two sources of economic inefficiency that are caused by setting incorrect administrative prices:

- the inefficiency that would arise because dispensing fees are 'too high' due to Treasury paying out excessive amounts of taxation revenue, with its associated excess burden or deadweight loss; and
- the inefficiency that arises due to behavioural demand and supply responses.

Neither of the respective claims made in the Interim Report – that a flat fee would reduce the deadweight loss of tax, and that a flat fee would increase overall efficiency – has any basis in economics. The discussion around the inefficiency arising from the deadweight loss of taxation confuses two separate effects: the effects of changes in the level of fees, and the efficiency implications of flat versus differentiated fee structures. The discussion around the efficiency implications of different fee structures also appears to assume that pharmacies are ordinary retail business, as opposed to agents of the Government, dispensing subsidised drugs at administered prices. Finally, the Panel offers no convincing arguments that either the level of remuneration for dispensing is too high in general, or that the current fee structure is unrelated to the costs of providing specific dispensing services (and therefore inefficient). At the same time, an indicative calculation suggests that adopting the Panel's $10 dispense fee proposal so as to achieve 'real' cost savings in the order of $278 million would result in more than 1,700 small pharmacies closing.

3.3.1 Context

Under the current dispensing fee structure, the vast majority of dispensing receives a single or flat fee of $11.09, equal to the sum of a $7.15 for a dispense fee plus $3.94 for an AHI fee. Together these fees account for about 95 per cent of dispensing income for community pharmacies. Table 3-1 describes the current differentiated fee structure for dispensing. It is apparent that separate dispensing fees cover different dispensing activities. While ready-prepared medicines attract only the basic dispense fee and AHI fee, additional fees are paid for extemporaneously prepared medicines, and for the dispensing of dangerous drugs and generics.

Table 3-1. 6CPA fee structure – dispensing (2017)

Professional fee	Payment	Notes
Administration, handling and infrastructure (AHI) fee (Ready-prepared medicines)	$3.94	Tiered fee consisting of: ▪ $3.94 per dispense for medicines up to a price of $180 ▪ $3.94 per dispense plus 3.5 per cent of the amount by which the price of the medicine exceeds $180, up to a price of $2,089.71 ▪ $72.43 per dispense if the price of the ready-prepared medicine exceeds $2,089.71
Dispense fee (Ready-prepared and extemporaneously-prepared medicines)	$7.15	Flat fee covering the cost of time spent dispensing ready-prepared and extemporaneously-prepared medicines
Dispense fee (Extemporaneously-prepared medicines)	$2.04	Flat fee covering the cost of time spent compounding extemporaneously prepared medicines Additional to the dispense fee for ready-prepared medicines
Dangerous drug fee (Ready-prepared medicines)	$3.01	Fee covers specific costs incurred in dispensing dangerous drugs, e.g. documentation, notification and storage requirements.
Premium Free Dispensing Incentive (PFDI)	$1.78	Fee is applied when brand substitution by generics is available, covers the cost of additional consumer interactions and guidance to counsel patients about generic drugs.
Container fee, wastage amount fee, water fee	Varies	Separate fees for extemporaneous dispensing for direct costs incurred

Notes: The dispense fee (ready-made medicines), the AHI fee, the PFDI fee All fees are indexed by CPI.

Source: 6CPA.

The Panel offers two conclusions in relation to dispensing fees. First, the Panel claims that the current structure of fees is 'overly complex and opaque' (P.90). A single dispense fee should therefore replace the current system that recognises a small number of sub-categories of dispensing activities. Thus, the following fees would be rolled into the single flat fee proposed by the Panel:

- the dispense fees for ready-made and extemporaneously prepared medicines;
- the three-tiered AHI fee;
- the premium free dispensing incentive (PFDI) for generics;
- the dangerous drug fee (Schedule 8, or drugs of addiction);
- the electronic prescription fee; and
- the container fee, the wastage amount fee and the water fee, which reimburse pharmacists for the direct costs incurred in extemporaneous dispensing.

The Interim Report gives no explanation as to why the Panel believes that the structure of the current fee system is too complex. After all, a professional pharmacist might be expected to master the various types of activities covered by different fees, given that these fees are an essential source of income to him or her. Consumers would naturally not be expected to understand the fee structure, but that is arguably the point of the pharmacy remuneration arrangements: that individual consumers are insulated from the delivered costs of medicines. This has nonetheless not prevented the Panel from seriously contemplating a radical simplification of fees that would (in combination with the proposal to reduce dispense fees to $10) impose an even greater loss on pharmacies who currently undertake activities that are valued by the Government, for instance, pharmacies whose customers include above-average numbers of users of drugs of addiction.

Indeed, the change the Panel proposes seems starkly inconsistent with the philosophical premise on which the Interim Report is built. That premise is that the price system is the key to efficiency and can be used to secure socially efficient outcomes. Now, as a general matter, activities which involve different resource costs should attract different prices, unless the transactions costs of price differentiation are so high as to offset any efficiencies the differentiation might bring. But in recommending that separate fees be abolished, the Interim Report simply ignores that principle – a point we discuss in greater detail below.

Second, and while Option 4-3 states that the benchmark for a best-practice dispense is in the range of $9.00 to $11.50, the Panel suggests that a flat fee should be set at a level of $10 per dispense. Accordingly, all of the calculations in relation to the level of dispensing fees that are shown in the Interim Report and in Rees (2017) rely on a flat $10 dispensing fee.

The fact that the Panel's opted to direct its entire analysis on the effects of a significant fee reduction is striking. Thus, according to the Interim Report (P.69), "*the average pharmacy remuneration per subsidised script paid by government … in 2015–16, the first year of the Sixth Community Pharmacy Agreement (6CPA), increased to $11.50 per script*." At the same time, the Panel concluded that there is no evidence that, on average, pharmacists are earning economic rents under the current remuneration arrangements (P.82).[5] When the Panel reports the results of setting a (combined) flat fee for dispensing services, it nonetheless selected a fee of $10, a cut of $1.50 from the $11.50 average that pharmacists earned per script. All else equal, the flat $10 fee would then lead to a 13 per cent reduction in the income of pharmacists and, therefore, to sub-normal returns to the industry. The Panel also claims that such a reduction in dispensing fees would generate economic cost savings. We estimate the corresponding number of pharmacy closures that would be required to achieve 'real' cost savings of the magnitude discussed in the Interim Report in Section 3.3.4 below.

3.3.2 Budget impacts and deadweight loss from flat versus differentiated fees

The switch to a flat fee would, the Panel claims, lead to substantial cost savings over the life of 6CPA (Table 7, P.86). By choosing a flat fee of $10, the Panel reduces the

[5] As noted in footnote 134 in the Interim Report, there is a difference between economic rates of return and accounting rates of return. The latter are easily observable, the former are not.

payments that would have been made to pharmacies by a total of $1.479 billion. When two items in Table 7 in the Interim Report are added to that total – namely, 'opportunity cost' and 'deadweight loss' – the alleged 'total economic cost saving' becomes $1.879 billion.

The Interim Report provides no argument to suggest that remuneration for dispensing is 'too high' in general. The analysis set out in the Interim Report on PP.81-82 in fact shows the opposite. That is, 15 per cent of all pharmacies are not earning taxable profits, and even the most profitable pharmacies are only earning normal rates of return on their investments.[4] The Panel nonetheless appears to seriously consider setting a $10 'flat fee' per dispense, which would slash the *level* of dispensing income by thirteen per cent.

Furthermore, the Panel's claim that 'cost savings' of almost $1.9 billion can be achieved by cutting dispensing fees mixes up two issues:

1. the effect of a flat fee *versus* that of differentiated fees; and
2. the effect of a fee schedule that support normal returns to pharmacy, *versus* one that would produce sub-normal returns.

The claim that a switch to a flat fee would result in a budget cost saving is solely due to the arbitrary choice of a flat fee *that would not be revenue-neutral for Treasury*. If the Panel's purpose was to show that a flat fee would be superior on efficiency or other grounds to a set of differentiated fees, then the Panel would need to test the merits of one against the other *when either fee structure would impose the same cost on Treasury*. For 2015-16, that flat fee would be around the $11.50 that the Panel estimated was the average remuneration per dispense in that year. Absent changes in behaviour, the fiscal savings from setting that flat fee would be zero.

Table 7 in the Interim Report therefore provides no insight as to the effects of a flat versus differentiated dispensing fee. Table 7 merely shows that, if the government were to cut dispensing fees, there would be some budget savings. The text also makes it clear that the larger the cut, the higher the Treasury savings. Hence the maximum budget savings would arise from a fee of zero.

Table 7 in the Interim Report is also seriously misleading, in terms of how the so-called economic cost savings are calculated. In respectable economics, tax revenue is a transfer, not an 'economic cost'. Thus, it is economic nonsense to claim that the $1.479 billion that the Treasury is estimated to save represents an 'economic cost' of not imposing the $10 flat fee. The reference to an 'opportunity cost' is equally specious. $100 not spent on dispensing is $100, no more, no less. It is a separate decision what to do with the $100; i.e. whether to cut taxes, reduce class sizes or subsidise a wind farm. The social value of the $100 can only be worth more than $100 if, without it, $100 is not spent on an object worth more than $100. In short, the only applicable 'economic cost' of taxation is the deadweight loss.

3.3.3 Efficiency implications of different fee structures

As a matter of principle, fees should be related to the costs of the services provided, both in terms of their overall level and in terms of their structure. The 'best' fee structure invariably involves a trade-off between tailoring fees to the costs of providing a service, on the one hand, and the inevitable costs of constructing,

implementing, administrating and monitoring a complex fee system, on the other. The Interim Report contains no discussion that would evaluate this trade-off. The Panel discussion as to the merits of different fee structures instead relates to differences in purported 'assistance' created by a flat fee structure, versus the supposed inefficiency of a differentiated fee structure. As they are described in the Interim Report, both of these arguments are wrong.

The case against a flat fee: effective rates of assistance

The Panel's argument against a flat fee is based on the calculations shown in Table 6 of the Interim Report (P.85). Table 6 reports calculations of what it refers to as the ERA for simple dispensing (Activity 9), which would use $7.50 worth of a pharmacist's time and effort; and complex dispensing (Activity 1), which would use $11.50 of a pharmacist's time and effort; and seven intermediate cases. Table 6 purports to show that for a flat fee of $11.50, the more complex and time-consuming dispensing activities (e.g. Activity 1) receive negative ERAs, while the simplest dispensing activities (e.g. Activity 9) receive positive ERAs. This theoretical example is intended to indicate that the payment of a single fee would under-remunerate those pharmacies that on average perform greater value-adding activities.

The Panel then proceeds to conflate tasks with size of pharmacies, by implicitly assuming that small pharmacies undertake 'low value' tasks, while large pharmacies undertake 'high value' tasks (P.82):

> *The smallest, and potentially least efficient and profitable, pharmacies may receive the highest effective rates of assistance.*

The Panel offers no indication why it should be assumed that small pharmacies predominantly provide 'low value' dispensing services, and why, to the contrary, large pharmacies predominantly provide 'high value' dispensing services.

The larger point, however, is that the purported calculations of 'effective rates of assistance' bear no relationship whatsoever to conventional measures of ERAs; rather, the ERA calculations in Table 6 are best considered as complicated economic nonsense. These calculations assume that, if the Government ceased paying a dispensing fee, it would continue to prevent pharmacists from setting their own dispensing fees, but that pharmacists would nonetheless continue the activity of dispensing, presumably for free.

The concept of an ERA was first developed to summarise the effects of tariff schedules on the capacity of import-competing industries (or export industries) to generate unit value added: the effective rate of protection (ERP) took into account tariffs on intermediate inputs, as well as on outputs. The former provided assistance to the activity, the latter provided anti-assistance. Later, the Industry Commission and others extended the notion of effective protection to effective assistance, where assistance included subsidies to an activity or its intermediate inputs, and negative assistance included taxes on an activity or its intermediate inputs. ERP became ERA, but the concepts remained the same.

The ERA compares the value-added that the activity would earn in the presence of assistance (AVA, or assisted value added) to the value-added that the activity would earn in the absence of assistance (UVA):

$$ERA = 100 \times \frac{(AVA - UVA)}{UVA}$$

The underlying concept is to compare values of output and value added under the actual system of government taxes and subsidies, against a counter-factual scenario in which there are no relevant taxes or subsidies. For internationally traded commodities, the counterfactual price of output was set equal to the world market price: in the absence of government interference in the market for the product, the product would sell at the world price. For non-traded goods, the counterfactual price is typically set to resource cost, thus eliminating positive and negative assistance.

But instead of following the standard approach, the Interim Report, in Table 6, without any discussion or explanation 'solves' the question of the counterfactual price that pharmacists would receive by setting that price at zero. That is, Table 6 simply assumes that, in the absence of government paying dispensing fees, a pharmacist would receive nothing for the time and effort that went into dispensing. For instance, with a government-provided dispensing fee of $11.50, Table 6 shows an ERA of minus 17.3 per cent for the complex Activity 1. That estimate is a simple reflection of the counterfactual assumption that, were the government to see a zero dispensing fee, the government would also prevent pharmacist from charging for dispensing. In reality, of course, if government removed itself from the market for dispensing PBS drugs but, as Table 6 assumes, exactly compensated pharmacists for the costs of the medicines – then dispensing activities involving much time and effort would command higher prices than the simple forms of dispensing.

What those prices would be is unknown, but they would certainly be greater than zero. If, for the sake of argument, pharmacists charged a price that exactly corresponded to the cost of the pharmacist's time and effort (i.e. a dispense fee ranging from $7.50 to $11.50 according to the complexity of the dispensing activity), the ERAs shown in Table 6 would all be zero.

It is difficult to understand why the Interim Report adopted the approach it used; to the best of our knowledge, there are no precedents for so doing. Be that as it may, the effect is to generate high 'ERAs', although the resulting numbers have no normative implication.

The Case in favour of a flat fee: the square rule of inefficiency

The Panel's case for a flat fee is based on an application of a correct economic proposition – that the economic loss from a price distortion is a function of the square of the distortion. However, the case is incomplete and not proven, because the Panel does not discuss, let alone show, that the distortions are larger under the current system than they would be under a flat fee.

The Panel states at P.83:

> *The economic cost arising from differences between the fees that pharmacists are paid to supply medicines on behalf of the government and the actual efficient marginal costs of performing those activities will be many times higher than the economic benefits that the nation would derive if those differences did not exist (i.e. since the deadweight costs arising from those unintended differences increase with the square of the magnitude of those differences).*

While the Panel's statement is correct in principle, the Interim Report fails to make the case that the conditions it identifies as a source of economic efficiency in fact hold.

First, the entire argument involving the 'square' rule depends on the difference between the 'actual efficient marginal costs' of performing an activity and the fee for that activity. The Interim Report presents no evidence on these gaps, with its estimates of what it refers to as ERAs being entirely meaningless in that respect. Furthermore, the Panel does not make a convincing case that the correlation between fees and costs would be tighter under a flat fee than under the current system. In fact, a flat fee would be either less efficient or no more efficient than a set of dispensing fees that are roughly determined by the costs of specific kinds of dispensing.

Second, the 'deadweight costs' referred to by the Panel depend not only on what are referred to as the 'unintended differences' between fees and their 'actual efficient long-run marginal costs', but also – and this is crucial – on the behavioural responses on the part of pharmacists and consumers to these prices.

The Panel makes no mention of these behavioural responses. However, given that the Panel appears to conclude that the current fee structure is a source of inefficiency, it can only be assumed that it believes these exist. Behavioural responses to inefficient prices can be a problem in the context of ordinary retail businesses. But in the context of pharmacies acting as agents of the Government, dispensing subsidised drugs at administered prices, such behavioural responses will be very small or non-existent, unless there is a very large gap between the government's fee and what the pharmacist thinks is a reasonable fee.

If a fee for an activity is set 'too low', a pharmacist may theoretically have an incentive to dispense carelessly or too quickly.[6] However, such a response would violate a pharmacist's professional, legal and ethical responsibilities, with potentially very serious consequences. Alternatively, if a dispensing fee is set 'too high', there is no way for the pharmacist to obtain more scripts of that kind in order to enjoy additional surplus. Either way, there will be no demand response on the part of consumers, because there is a tenuous or no connection between what consumers pay for medicines, and what pharmacists are paid for that specific dispensing. (Of course, if the fees were generally set too low, there would be a behavioural response: pharmacies would close.)

[6] Also, pharmacists may try to avoid setting up their businesses in areas of a very costly customer mix.

3.3.4 Claimed benefits of scale economies

One of the characteristics of community pharmacy that is emphasised by the Panel is the existence of economies of scale. Thus, it is argued that a per dispense payment would provide 'strong and appropriate' incentives for community pharmacy to grow to reach an 'appropriate' level of scale in their operations and reduce costs (P.89).

Setting dispense fees at a level of $10 implies a trade-off between achieving budget savings, on the one hand, and reducing consumers' access to pharmacies by closing pharmacies, on the other. This trade-off is not discussed in the Interim Report, but it is apparent in the arguments made in the report, and in RSM's (2017) discussion around the implications of cutting pharmacy remuneration for small pharmacies and their conclusion that 'a large number' of small pharmacies would close.

Table 7 in the Interim Report shows a first year savings of $278 million to the Treasury from a $10 dispense fee. For that saving to be an economic gain, and not merely a change in the amount of cash transferred from taxpayers to Treasury, there must be a reduction of $278 million in the real resources used up by pharmacies. The Interim Report emphasises that, because of economies of scale, there would be real resource savings if there were fewer micro or small pharmacies. In order to achieve such production cost savings, some pharmacies will need to grow in terms of the volume of prescriptions they dispense. Given that, for all practical purposes the overall volume of prescriptions is exogenous (or at least independent of the number of pharmacies), some pharmacies will correspondingly have to close.

To assess the approximate magnitude of the cost – accessibility trade-off, we have prepared an illustrative calculation to estimate the number of pharmacies that would have to close to achieve a saving – in terms of reduced 'production costs' from achieving greater scale economies – in community pharmacy of $278 million.

There are very few publications that provide estimates of economies of scale in pharmacy. The Interim Report cited only one, that by Waterson (1993) which relied on a BIE estimate (derived in the late 1970s). Waterson's estimate implies that the average cost of pharmacy activity would fall by 4.6 per cent if the level of activity doubled. Lohrisch *et al*. 1976 estimated that there were no economies of scale in (US) dispensing activity.

It is worth briefly commenting on the origin of Waterson's economies of scale estimate. The original BIE analysis was not available to us, but was heavily criticised in a subsequent analysis prepared by KPMG on behalf of the Pharmacy Guild of Australia and the Pharmaceutical Society of Australia (1999). The joint submission reported that the BIE found the economies of scale to be 13 per cent, which we have taken to mean that, were output of a pharmacy to double, its average costs would fall by 13 per cent. Notably, KPMG reported that its preferred econometric model (which unlike BIE incorporated the costs of goods sold) showed that:

- economies of scale diminished significantly with pharmacy size; and
- about 70 per cent of Australian pharmacies had reached the level of dispensing where constant returns to scale set in.

Turning to Waterson's analysis, the author reports that BIE reported their estimation results for two different functional forms: a 'translog' cost function and 'Cobb-Douglas' cost function. Waterson used the BIE Cobb-Douglas function rather than the translog function to derive his results, on grounds of 'tractability', because BIE used it to estimate the reduction in pharmacy numbers required for a cost saving scenario, and because this functional form involved fewer assumptions of fact. The Cobb-Douglas function used by Waterson then has economies of scale of 4.6 per cent in the following sense: a doubling of output would reduce average costs by 4.6 per cent.

Applying the 4.6 per cent figure from Waterson (1993), it is possible to derive an indicative estimate of the 'production cost' savings that would accrue if some number of 'micro' pharmacies were shut, and their revenues reassigned to the remaining pharmacies. In doing so, we have chosen a method of reassignment that most likely overstates the cost saving: we assume that all the reassigned business goes to other 'micro' pharmacies. The calculation is shown in Box 3-1.

Box 3-1. shows that, for the kind of scale economies referenced by Waterson (1993), about 1,700 small pharmacies would need to close in order to secure the level of resource savings canvassed in the Interim Report. This would mean cutting the number of pharmacies from around 5,600 to around 3,900, and more than halving the number of what the Interim Report refers to as 'micro' pharmacies: those with sales of less than $2 million a year. To achieve real resource savings equal to the 13 per cent Treasury savings mooted in Table 7 in the Interim Report, around 30 per cent of pharmacies may then need to close. The closure of such a large number of pharmacies, even if staged over a number of years, would have major impacts on consumers' travel times and access and potentially have adverse effects on health outcomes (as well as imposing massive losses on the sector).

Box 3-1. Scale economies: Cost savings from closing 1,700 'micro' pharmacies

This Box indicates how the estimate of 1,700 was derived: this is the approximate number of small pharmacies that would need to close in order to save approximately $278 million in aggregate costs of the real resources used to produce the services provided by pharmacies.

1: Waterson's (1993) scale economies

Waterson's cost function is $C = 8.14\, R^{0.5392}\, Q^{0.3938}\, RE^{0.3938}$, where: R is the dollar value of non-PBS sales, Q is the number of scripts dispensed, and RE is the rental per square metre per week.

For simplicity, and without loss of generality, let $R = 1$ and $Q = 1$; then: $C = 8.14\, RE^{0.3938}$. Two identical pharmacies would have aggregate costs of $2 \times (8.14\, RE^{0.3938}) = 2C$.

Say, instead, that one pharmacy doubles in output, by taking over the throughput of the other (which closes), and nothing else changes. Then the double-scaled pharmacy would have cost equal to C', say, where:

$C' = 8.14\, (2R)^{0.5392}\, (2Q)^{0.3938}\, RE^{0.3938} = 2^{(0.5392+0.3938)} \times C = 2^{0.9330} \times C = 1.909 \times C$

Box 3-1 ctd. Scale economies: Cost savings from closing 1,700 'micro' pharmacies

There would then be a saving of $0.091\ C$ from the original cost of $2\ C$. Note that 0.091/2 = 0.046 (rounded up). That is, comparing one pharmacy with twice the output of each of two pharmacies, there would be a real resource saving of 4.6 per cent, due to economics of scale. Thus, when the number of pharmacies is cut in half, and each of the remaining pharmacies doubles in scale, there would be a cost saving of 4.6 per cent.

From the derivation above, it can readily be shown that, for purposes of scale economies, Waterson's cost function simplifies to become:

$C = (a\ constant) \times (level\ of\ activity)^{0.9330}$

2: Close 1,700 pharmacies and save $278m in real resources

A savings target of $278 million is to be achieved by economies of scale involving only 'micro' pharmacies, of which there are about 3,300. We now show that a very large proportion, more than half of the 'micro' pharmacies may need to close, if a resource saving target of $278 million is to be achieved.

For purposes of the exercise, we assume that the 'micro' pharmacies each have overall revenue of $1.7 million. For simplicity, assume that, initially, each 'micro' pharmacy is just covering its costs. The aggregate costs of the 3,300 would be 3,300 x $1.7 million = $5,610 million. Using the scale-economies version of Waterson's cost function, we have that $1.7 million = (a constant) x (1.7 million)$^{0.933}$. Solving yields the value of the constant as 1.036.

Were 1,700 'micro' pharmacies to close, and their sales of $2,890 million equally distributed amongst the remaining 1,600 'micro' pharmacies, these would scale up to $3.5 million each, with cost equal to 1.036 x ($3.5 million)$^{0.933}$ = $3.34 million, or $5,340 million in aggregate, a saving of about $270 million.

The results are not very sensitive to variations in data. It can be shown that the required number of closures would be smaller than 1,700, if we assume that the closed 'micros' have sales of more than $1.7m each. For example, if the initial throughput were $2 million, then 1,600 rather than 1,700 pharmacies would need to close. Similarly, if the population of 'micros' is fewer than 3,300 – for an initial 3,000 with sales of $2 million each, 1,500 closures would be required. However, the required number falls to around 1,100 – a third of the 'micros' – if the economies of scale were larger, for example, as with the cost function C = (a constant) x (level of activity)$^{0.875}$. Finally, the number of pharmacy closures would rise, if the displaced sales went to pharmacies bigger than micro, or were distributed unequally.

3.4 Two-part tariff dispensing fee

Option 4-5 is an alternative recommendation to Option 4-4, and is referenced to Option 6-2: that a cap in the range of $700 to $1,000 should be placed on the amount that a community pharmacy contributes to the cost of a medicine. If such a cap were not to be put in place by the Government, then Option 4-5 recommends that a two-part tariff payment should be applied; that is, a dispense fee that involves a fixed payment per dispense, plus a payment that varies with the relevant cost of the medicine. Option 4-5 states that if such a two-part tariff is adopted, the average payment for a dispense should equal that of the flat fee.

However, determining a two-part dispense fee as described in the Interim Report risks undermining the effectiveness of Option 6-2, such that the pharmacists' incentives to stock and dispense high-cost drugs may be further undermined. Option 6-2 is intended to assist pharmacists in managing the financial burden of dispensing high-cost medicines, given the financial risks and potential cash flow issues involved (P.130). These issues have been identified in the context of current fees, which are considerably higher on average than the $10 dispense fee recommended by the Panel.

At the same time, the implication of Option 4-5 is that a two-part dispense fee will result in a lower basic dispense fee. That is, if a flat dispense fee is set at $10, and a two-part dispense fee must deliver the same average payment of $10, then the combination of an alternative fixed fee payment plus a payment that increases with the cost of the medicine necessarily implies a fixed fee less than $10.

All things equal, a higher fixed dispense fee is more likely to enable pharmacies to recover the costs of stocking and dispensing higher-cost medicines and vice versa. Lowering the average dispense fee to $10 will therefore reduce the incentive that pharmacies currently have to dispense such medicines. That incentive will additionally be reduced if a two-part dispense fee with a basic fee of less than $10 is introduced. In all likelihood, the cap on wholesale drug prices will then need to be correspondingly lowered.

3.5 Least-cost remuneration and quality incentives

In this section, we comment on the relationship between the efficient 'least-cost' remuneration arrangements advocated by the Panel, and the Government's broader health policy objectives, as they relate to quality of service. As we have set out in Section 3.2, the focus in the Interim Report on minimising budget outlays for dispensing and related advisory services would not achieve the Government's broader health policy objectives. In addition, it would also change pharmacists' incentives.

The most obvious consequence of the recommendation to set a least-cost dispense fee for community pharmacy is to encourage all pharmacies to offer a least-cost service. As noted earlier, pharmacists are subject to strict professional and ethical rules, but a material reduction in remuneration can be expected to encourage pharmacists to shift the focus of their efforts correspondingly, including by:

- devoting greater effort and shop space to selling (unregulated) non-PBS products;[7] and
- devoting less effort and resources to making the pharmacy space one where customers are comfortable discussing their personal affairs.

Hall &Partners' (2016) survey of consumers found that, irrespective of why consumers visited a pharmacy, only between 3 to 6 per cent favoured a shop-style pharmacy with a large focus on retail products (P.42). A regulated outcome that essentially

[7] For instance, Vogler et al. (2014) report that post-deregulation in Sweden, pharmacies were criticised for increasing the share of body and beauty products while fewer prescription-only medicines were reported to be in stock.

encourages a greater focus on commercial retailing with a minimalist approach to pharmacy is therefore not an outcome preferred by consumers.

Over the longer term, the implications of a system of pharmacy remuneration that merely covers the costs of the largest pharmacies on the service quality experienced by consumers are unclear. From a public health policy perspective, the outcomes the Government seeks to achieve from community pharmacy extend beyond minimising public outlays – the goal is to ensure public outlays are efficient, in the sense of achieving the goals of public policy at no higher cost than is necessary. Moreover, the costs that are relevant are not restricted to the resource costs of dispensing, but include costs to consumers, especially those who are most vulnerable, and the broader cost consequences of different levels of access and services for the health system as a whole.

Medicine dispensing and advisory services require different levels of care and engagement, depending on a customer's individual circumstances and the type of medicine that has been prescribed. The composition and types of services provided by pharmacies will also vary by consumer 'catchment area', for instance, according to age and socio-economic demographics. A community pharmacy that serves a higher than average share of people who are elderly, who have chronic medical conditions, or a higher than average dependence on illicit drugs will need to expend more effort into offering advisory and monitoring services to ensure the safe use of medicines. Given the potential negative health and cost consequences of 'mistakes', quality of service therefore remains a crucial component of the 'output' of community pharmacy, albeit one that is very difficult to monitor or to quantify externally, except at a very high level.

The Panel deals with quality of service-type considerations in Section 3 of the Interim Report where it puts forward Option 3-1: Community pharmacies – Minimum Services: that the Government should establish a process to determine the 'minimum requirements' that a community pharmacy must meet, and 'initiate procedures to enforce these requirements'.

The Interim Report does not explain what form such processes and procedures would take, but the discussion in RSM (2017) may indicate what the Panel has in mind. RSM discuss minimum service requirements for pharmacies which, they suggest, should match those applied by governments to other agents that exclusively supply essential services, such as electricity, gas, water, telecommunications and public transport services (PP.36-37). RSM offer an example of the form that such minimum service requirements might take: a 'detailed performance-based contract' between the Government and individual pharmacies, similar to contracts for rural and regional bus services (P.85-86). According to RSM, such a performance-based contract would be expected to cover:

- a clear outline of the types, quantities and quality of services that are expected to be supplied on behalf of government;
- detailed key performance indicators to assess whether each provider is achieving the government's objectives;
- a detailed formula to calculate the remuneration that is to be paid to each provider to compensate them for the efficient long-run marginal costs of

supplying services, including the identification of benchmarks and appropriate inflation indices; and

- detailed financial reporting requirements, including the obligation to provide annual tax returns so as to enable government to identify those providers that might be in financial difficulties or that might be deriving economic rents.

RSM's description of these so-called performance-based contracts is indicative of a simplistic view of community pharmacy, and a failure to consider the implications of their recommendation in any depth. Instituting a detailed monitoring program of individual pharmacies and the manner in which prescriptions are dispensed and advice is provided would be both extraordinarily costly and intrusive. RSM make no reference to the tremendous resources that the Government would need to expend in order to apply a detailed monitoring and reporting regime to Australia's 5,600 pharmacies along the lines described for a handful of bus services; and the administrative burden and damage to professional self-esteem that this would impose. Instead of saying 'You are professionals and, within broad limits, we trust you and the enforcement processes you have agreed to', the Panel is saying 'You are professionals with a degree of self-regulation and so we do not trust you and will impose detailed regulation and reporting requirements on you'.

Like the Panel, RSM seems to ignore the reality that pharmacists are already subject to far-reaching professional and licensing standards that regulate the services they must provide. The fact that community pharmacists are required to provide an individualised service that is tailored to the needs of their customers means that conventional performance metrics, say, the number of prescriptions dispensed by a pharmacy have very little relevance, and can be dangerous, if used as guide to policy. The list of items that a performance-based pharmacy contract should cover according to RSM bears little or no relation to the reality of operating a pharmacy, including the extensive professional and ethical obligations placed on pharmacists:

- Community pharmacies focus their efforts on meeting the needs of consumers in their local catchment areas; across catchments, those consumers will differ by socio-economic and other characteristics, and therefore in their medicines needs. It is therefore entirely unclear how the Government could develop a standardised service description for pharmacies, for instance, as regards the number or types of medicines that are dispensed, or the number or types of flu shots. The alternative, developing a 'bespoke' service agreement for each pharmacy would be an impossible task.

- The suggestion that 'key performance indicators' could be used as a means for assessing whether a particular pharmacy is achieving the Government's objectives is devoid of practical meaning. The Government's aim is 'to promote and improve the quality use of medicines'. Among other things, this requires pharmacists to take care in dispensing medicines, inform themselves about a customer's broader health status and other medicines they may use, and ensure that customers are informed about when and how the medicines should be taken. None of these activities are amenable to being benchmarked, and this is all the more so as customer requirements will vary from person to person. Simplistic performance indicators, such as 'time spent with a customer' are obviously easily gamed and manipulated.

Other components of the 'performance-based' contract are equally specious. It is well known that setting regulated prices on the basis of long-run marginal costs may not permit the firm, efficient or not, to cover its total costs (and in the presence of economies of scope, marginal costs are not well-defined). Finally, the notion that a regulator would comb through almost 5,600 pharmacies' financial accounts to detect impending financial trouble or evidence of 'excess' rents suggests a degree of insight and expertise (as well as the resources) to analyse the affairs of third parties that does not accord with reality. Unsurprisingly, neither RSM nor the Panel cite any case where such an approach has been applied to community pharmacy, much less applied successfully.

3.6 Least-cost remuneration and CPA bargaining arrangements

In this section, we discuss how the efficient 'least-cost' remuneration arrangements advocated by the Panel relate to how agreement on remuneration is currently reached. To date, successive CPAs have been negotiated between the Australian Government, as the central purchaser of dispensing and related services, and the Guild, as the representative of owner-pharmacists who are directly financially affected by the remuneration arrangements. In contrast, the implication of the various 'efficient' pricing proposals reviewed in the previous sections is that the Panel proposes moving from a negotiation that is mediated by a representative body, to a situation where the Government will dictate the terms of the agreement according to a formula of its choosing.

There is a long history in Australia of collective bargaining between government, on the one hand, and a body which is deemed to represent the interests of those on whose behalf the negotiations take place. There is a clear parallel to these arrangements in the broader economy, with the *Competition and Consumer Act* 2010 (CCA) permitting collective bargaining arrangements when these are found to be in the public interest, for example in the case of smaller businesses negotiating with a large counterparty. The underlying rationale for these exemptions is to deal with a fundamental asymmetry of bargaining power. Collective bargaining mitigates two types of risks what arise when smaller sellers (buyers) are exposed to a larger buyer (seller):

- the risk of monopsony (monopoly) pricing by the more powerful firm, which is a source of allocative or pricing inefficiency; and
- the risk of the ex post expropriation of sunk investments by the more powerful firm, which will in turn result in under-investment.

The Harper Competition Policy Review (Commonwealth of Australia 2015) recognised this efficiency rationale, and considered that collective bargaining processes, as used by small businesses, were not being used as frequently as they might be. The Review Panel then put forward Recommendation 54, intended to strengthen the corresponding exemption in the CCA, so as to be capable of addressing a number of issues raised by small business in their dealings with big business.

The discussion in Section 7 of the Interim Report around the processes by which the remuneration arrangements are agreed between the Government and owner-pharmacists appears entirely disconnected to various earlier recommendations in the

Interim Report: that the pricing of dispensing should essentially be determined on the basis of one or more highly prescriptive formulae. If these options were taken up by the Government, negotiations would no longer be necessary.

The discussion around the CPA bargaining processes instead results in Option 7-4: that future participants in the CPA negotiations should additionally include the Consumers Health Forum of Australia (representing consumers) and the Pharmaceutical Society of Australia (representing pharmacists). The logic of this recommendation is not clear. The implication seems to be that the Commonwealth does not have the interests of consumers in mind; why that should be the case is not explained, any more than are the far-reaching implications of such a premise. As for pharmacists, they certainly provide inputs to pharmacies but so do many others. Government, as a matter of course, negotiates with suppliers to provide services on behalf of some or all Australians. Arguably, it is the central role of governments to resolve the cost-benefit trade-offs that will invariably arise in these negotiations. While consumers (as well as taxpayers) clearly have an interest in the eventual outcome of these negotiations, third parties do not typically participate as signatories. Why not let 'consumers' of, say, the ATO, be parties to the negotiations between the union and the ATO? Why should a Centrelink client representative not be part of the negotiation between the department and the union? The risk is that, as more interest groups which do not have a direct financial stake in the outcome are added to a bargaining process, any negotiations would become increasingly complex and difficult to manage.

The more important point, however, is that by dictating the manner in which dispensing fees are to be set, the Panel neglects the inefficiencies that collective bargaining is intended to address. In the context of the Panel recommendations, these are:

- a form of monopsony pricing, which would likely see a large share of smaller community pharmacies rendered unviable; and
- correspondingly diminished investment incentives, given that a fundamentally changed approach to charging for dispensing will devalue existing investment in pharmacy infrastructure.

4. Location Rules

The Location Rules that apply to community pharmacy represent criteria that must be met in order for the Australian Community Pharmacy Authority to recommend the approval of a pharmacy. The rules apply to the establishment of a new pharmacy and the relocation of an existing pharmacy, and set minimum distance requirements to an existing community pharmacy, as well as preventing pharmacies from locating in a supermarket.

To date, the Australian Government has primarily relied on the Location Rules to shape the geographical distribution of community pharmacy, and, to an extent, to limit the overall numbers of pharmacies in Australia. Given the Government's broader policy objectives as regards community pharmacy, the Location Rules reflect two basic aims:

- to ensure equitable access to dispensing and related advisory services for consumers, which requires that pharmacies are reasonably accessible to all consumers, regardless of where they live, their income or age; and

- to secure cost-effectiveness in the medicines distribution structure, by enabling economies of scale and scope in distribution and avoiding unnecessary duplication of dispensing infrastructure.

The Panel recommends that the Location Rules be eliminated, as well as a significant cut in pharmacy remuneration. In combination, these proposals can be expected to change the pharmacy landscape in terms of both the overall number and the distribution of community pharmacies.

In the following we discuss:

- the basis on which the Panel arrives at its recommendation (Section 4.1);

- the implications of removing the Location Rules (Section 4.2); and

- the Panel's recommendation to permit pharmacies to co-locate in supermarkets (Section 4.3).

4.1 Panel's rationale for removing the Location Rules

The Panel recommends that the Location Rules be removed, apparently on the grounds that while the community pharmacy network is 'good', it is not 'perfect'. In the following, we review the empirical evidence as to how the rules have worked in practice to enable consumer access, and discuss the various criticisms of the Location Rules made by the Panel.

4.1.1 Community pharmacy network outcomes

There are three recent empirical evaluations of the effects of the Location Rules: a detailed mapping analysis undertaken by MacroPlan Dimasi for the Guild in 2014, research prepared for the Department of Health in 2016, and a geospatial analysis undertaken by RSM on behalf of the Panel.

MacroPlan Dimasi (2014)

The mapping analysis of community pharmacy prepared by MacroPlan Dimasi showed that the Location Rules overwhelmingly achieve their intended accessibility and cost-effectiveness objectives (Guild, 2014).

MacroPlan Dimasi found that Australians – especially older and disadvantaged consumers – have a very high level of access to community pharmacy. In the capital cities, the average resident is located 1 kilometre from the nearest pharmacy, while 95 per cent of consumers are no further than 2.5 kilometres from a pharmacy. Outside of capital cities, Australians are just 6.5 kilometres on average from the nearest pharmacy, and 72 per cent have a pharmacy within 2.5 kilometres. As a result, travel times to pharmacies are also very low. In both the capital cities and in Australia's regions, the over-65s enjoy better access to pharmacy than the under-65s. In the regions, the difference between the age groups is significant, with the over-65s being much closer to the nearest pharmacy (4.3km) than the under-65s (6.9km).

Community pharmacy achieves high levels of access with relatively low numbers of outlets. For example, community pharmacy provides no less a level of access than medical practices, but does so with 16 per cent fewer outlets. There is therefore less duplication of fixed costs and a greater ability to achieve economies of scale, to the extent that they exist, than there would be were pharmacies located as are medical practices, thus saving resources and ensuring that the network of community pharmacies is sustainable over the longer term.

Department of Health (2016)

Lange and Franzon (2016) assessed Department of Health data on the location of community pharmacies for the years 1990, 2007 and 2014. Their research indicates that the total number of pharmacies in 2014 was lower than in 1990 despite Australia's increasing population over that timeframe. While population to pharmacy ratios *decreased* overall, these ratios *increased* in rural locations. Also, they found no relationship between pharmacy locations and socio-economic status.

These findings thus suggest that lower socio-economic 'catchments' are as well served by community pharmacy as is the case for higher socio-economic areas, consistent with the government's equity objectives. Furthermore, accessibility has been achieved with an expansion of the number of community pharmacies less than proportionate to the increase in the Australian population.

RSM (2017)

RSM (2017) developed a geospatial model of pharmacy locations on behalf of the Panel. RSM's analysis indicated that:

- the distribution of pharmacies in and around Australia's major cities broadly reflects the population distribution as well as areas of greatest socio-economic disadvantage; and
- the residents of Australia's capital cities have to travel the least distance to visit their nearest pharmacy, with travel distances increasing the further away Australians live from major cities; and

- socio-economically disadvantaged residents of remote parts of Australia have to travel significant distances to visit their nearest pharmacies.

RSM also analysed PBS and postcode data to establish the locations where consumers travelled to have their medicines dispensed:

- 54 per cent of scripts are dispensed by pharmacies located in the same postcode as where consumers live; and
- 29 per cent of scripts are dispensed by pharmacies located in a postcode that differs from the postcode where consumers live and the medical practitioner's postcode.

RSM's analysis similarly indicates that community pharmacies are located such that the great majority of Australians have equitable access to dispensing and advisory services. More than half of Australians have their prescriptions dispensed in a pharmacy near their residence.

Assessment

All of the studies summarised above essentially reach the same conclusion: that community pharmacy is highly accessible to the great majority of Australians. The study undertaken by MacroPlan Dimasi additionally shows that the community pharmacy network offers improved accessibility relative to medical practices, supermarkets and banks, but at a lower cost. The Panel nonetheless states at P.94:

> *The Panel has no evidence that the network of community pharmacies is inadequate. The starting point for this Review is that the network is good, but this does not mean that it cannot be improved.*

A statement to the effect that the underlying outcomes that the Location Rules are intended to achieve are 'good' would lend support to a position of incremental change whereby the Location Rules are refined to address demonstrably poor outcomes. By definition, policy recommendations that seek to improve on outcomes that are 'good' have limited upside, if any, given that real world outcomes are never 'perfect' and that the welfare gains from moving beyond 'good' tend to be slight, as diminishing marginal benefits are offset by rapidly rising costs. By contrast, in the case of community pharmacy, the potential downside of removing the Location Rules is large, as we describe in Section 4.2.

4.1.2 The Panel's criticisms of the Location Rules

The empirical studies of community pharmacies uniformly conclude that Australians have good access to community pharmacy. The Panel nonetheless concludes that radical change is required in a discussion that is characterised by inconsistent and poorly justified assertions, including the claim that the Location Rules are the cause of both 'too many' and 'too few' pharmacies, and that the Location Rules are a material source of costs.

Excessive and repressed entry

The Interim Report suggests that the geographical distribution of pharmacies is 'not perfect', in the sense that there may be 'too many' pharmacies in some regions, and 'too few' pharmacies in others (P.97).[8]

The Panel cites a number of submissions to suggest that the Location Rules 'repress' new entry (P.97), for instance, a submissions by Chemist Warehouse, which claims that the Location Rules are preventing it from opening 52 new outlets, and the Ingham Family Medical Centre, which claims that the Location Rules prevented it from offering pharmacy services in Ingham (also a Chemist Warehouse outlet).[9] At the same time, the Panel suggests that the existence of would-be new entrants (such as Chemist Warehouse) indicates that the Location Rules are enabling existing pharmacies to earn 'economic rents' (P.97-98). The existence of economic rents is in turn said to create the potential for 'excessive' entry.

It is difficult to know what to make of the Panel's various statements, other than that the distribution of community pharmacies is not 'perfect' relative to some unspecified ideal. The Panel's claim that the Location Rules induce 'excessive' entry is difficult to reconcile with the claim that the Location Rules 'repress' entry. Moreover, the statement economic 'rents' earned by pharmacies are the cause of 'excessive' entry is flatly contradicted by the Panel's own conclusions.[10]

None of the relevant discussion in the Interim Report refers to the Government's broader objectives of accessibility and cost-effectiveness in relation to community pharmacy. The Interim Report does not discuss how the unconditional approval of all new pharmacy applications (the Panel's preferred outcome) would affect the cost of maintaining the community pharmacy network and avoiding inefficient duplication. Moreover, it is clear from the overseas experience with loosening restrictions on pharmacy locations (Section 4.2.1), that unrestricted entry merely encourages pharmacies to 'cluster' in commercially desirable urban locations.

Costs of Location Rules

The Panel claims that the current pharmacy Location Rules are 'arbitrary' and a source of observable and hidden costs (P.103):

[8] As discussed in the Guild's submission in response to the Interim Report, the Panel appears to have accepted flawed estimates of local population / pharmacy ratios, as well as selectively cited submissions to advance its agenda.

[9] The Panel appears to accept these claims without making further enquiries, for instance, as to community need for an additional pharmacy. Ingham, for example, had a population of 4,706 in 2011 (ABS 2011 Census), but has three pharmacies, giving it a population to pharmacy ratio of around 1,570 that is close to three times the Queensland average of 4,333 people per pharmacy (Discussion paper P.12). If Ingham Family Medical Centre had been approved to open a fourth (Chemist Warehouse) pharmacy, the ratio of population to pharmacy in Ingham would have fallen to less than 1,180 or more than 3.5 times the Queensland average. At least on the basis of this example cited by the Panel, rather than 'repressing' entry, the location rules are working as intended.

[10] At P.82, the Interim Report concludes that the current pharmacy remuneration arrangements are not enabling pharmacies to earn economic rents, and that the most profitable pharmacies are only earning normal rates of return on their investments. Refer also to Footnote 5.

- the observable costs are said to relate to the costs of administering the existing system (in the range of $2-$3 million per annum), and the reduced consumer access that occurs when an application for a pharmacy is not approved; and

- the hidden costs are said to arise because of reduced consumer access, which occurs because some pharmacies are never developed as a result of the rules.

As we argue in the following, the costs of the Location Rules that the Panel identifies are likely to be small. Moreover, these costs are likely to be far smaller than those that would be incurred by the Government in a counterfactual situation where the Location Rules are removed.

The costs of administering the system falls on Government (and therefore taxpayers) and would-be entrants. In this regard, the Location Rules represent a relatively simple and transparent (albeit admittedly not 'perfect') mechanism that enables government to shape the distribution of pharmacies in a manner that balances two inherent trade-offs: the goal of ensuring accessibility for all Australians, and the goal of limiting the costs of the pharmacy network. That simplicity and transparency is achieved through the use of relatively straightforward distance rules.

An administrative cost of $2-3 million would also be considered relatively modest when compared to alternatives such as the Pharmacy Location Board (PLB) contemplated by the Panel. As a newly constituted independent authority consisting of five members, the PLB would need to be supported by appropriate personnel. The scope and associated costs of disputes could also be expected to rise, given the discretion that would be afforded to the PLB (P.105):

> *The PLB would assess all such applications and engage in relevant consultation as it sees fit. The PLB would issue a provider number if (and only if) in the opinion of the PLB, this would materially improve consumer access to PBS medicines.*

How many Government boards, making hundreds of decisions upon which hang maybe hundreds of thousands of dollars – of the kind that the PLB would make – operate on a budget less than $2 million per year? And will there be appeal mechanisms, on matters of fact or interpretation? These are all factors that will invariably increase the costs of regulations far beyond what is currently the case. One might reasonably have expected these questions to be discussed, with a proposed budget and costing for the PLB, rather than a glib assertion that the existing system imposes an undue burden.

The Panel states that the existing pharmacy Location Rules are based on 'arbitrary' distances and proxies for consumer 'traffic flow' (P. 96). It is certainly possible to think of more complex criteria for pharmacy locations that may better achieve the 'ideal' distribution that the Panel appears to have in mind, although the Panel does not put forward such an option. For instance, it is theoretically possible to adjust the distance rules by some metric of socio-economic characteristics (such that more pharmacies could be established in areas with poor socio-economic outcomes). However, greater complexity will invariably reduce the transparency of the regulation, and will correspondingly increase the scope for and associated costs of disputes.

Option 5-2 (Alternative 3b) is for a working group to identify and address any anomalies that have arisen over time, to ensure the Location Rules remain responsive to the evolving needs of the community. This should be sufficient to deal with a major objection that the Panel makes to the existing Rules, which is that they do not take account, or sufficient account, of the fact that many PBS scripts are more conveniently filled near the place of a person's employment, than near to home. However, this solution is merely an alternative to what has happened in the past to the Location Rules. There is, in other words, no reason to believe that even without implementing this option, the Location Rules would be subject to periodic review.

The Interim Report claims that the Location Rules create both observable and hidden costs by preventing new pharmacies from locating in areas that are already well-served. This claim rests on two assumptions:

- that consumers who already have good access to a community pharmacy may find themselves with a (slightly) reduced travel distance if an additional pharmacy is opened, and that the corresponding benefits from reductions in travel time are material; and

- that the increased costs of maintaining the pharmacy network in an unrestricted entry scenario are not material.

The first of these assumptions is implausible, given that new entry will almost certainly occur in locations that are already well-served. In the capital cities, the average resident is located 1 kilometre from the nearest pharmacy; 95 percent of consumers are no further than 2.5 kilometres from a pharmacy. Outside of capital cities, country residents are 6.5 kilometres on average from the nearest pharmacy, with 72 percent having a pharmacy within 2.5 kilometres.

The second of these assumptions is at odds with the outcomes that have been observed overseas, including recently in the United Kingdom. These cost impacts on the pharmacy network accounts for the decision on the part of the UK Department of Health to tighten substantially the 'control of entry' rules in England in 2012 after these rules had previously been relaxed. The earlier relaxation of pharmacy entry restrictions in England immediately resulted in a rapid rise in applications that led to clustering of pharmacy outlets, what the Department of Health (2012) referred to as 'speculative' applications, as well as an acceleration of industry consolidation trends. The Department's Impact Assessment accordingly presents the rationale for tightened controls on pharmacy locations as arising from the need to control the costs of medicines distribution by the National Health Service (NHS, P.1):

> *The current regulatory system ... may stimulate provision in areas already well-served, without ensuring the benefits of any increased provision outweigh the costs incurred. More chemists produce more fixed costs. Either the NHS bears these costs or, with no funding increase, all chemists bear the costs, reducing the income each receives. Whichever route is followed, these are costs to society.*

As described by the Department of Health, an outcome whereby overall funding for community pharmacy was not increased to match the greater number of pharmacies would lead to secondary impacts. A decrease in average funding provided to each pharmacy would lead pharmacies in areas of lower demand or serving wider population catchments (in more rural areas) to either reduce their services, or to

close. Ultimately, accessibility for certain segments of the population would be reduced. The Department further noted that, while greater restrictions on pharmacy locations would have a negative impact on patient access in well-served areas (which had not been costed), these costs would be more than outweighed by other benefits arising from better aligning entry to local needs, and in increases in the provision of local enhanced services and the quality of all pharmaceutical services.

It is finally worth noting the Department's comments on the option of entirely removing all entry restrictions, which it elected not to cost in the Impact Assessment, and which corresponds to the Panel's preferred recommendation of removing the Location Rules:

> *It is exceptionally difficult to make plausible assumptions regarding the costs and benefits of allowing the market forces to determine market entry and exit. This is mostly due to the unprecedented nature of such a change, which results in an unparalleled uncertainty in any entry and exit predictions. The necessary step change in legislation, combined with lack of certainty of meeting any of the policy objectives renders this option unsatisfactory and therefore it has not been quantified.*

Competition

At P.108, the Panel claims that the Location Rules 'have not established robust competition between independent pharmacies in some locations'. Among other things, a lack of competition in community pharmacy is said to lead to higher prices for consumers, lower quality service (such as reduced opening hours), or increased travel costs. Cross-ownership of pharmacies is said to be a particular concern, with the Panel citing submissions suggesting that this contributes to 'increased pricing' for the local population. As a result, the Panel recommends Option 5-5: that 'in areas where pharmacy Location Rules are maintained, any group of two or more pharmacies, each of which are located within 1.5 kilometres of another pharmacy in the group, that have an overlapping ownership should be considered to be a single pharmacy for the application of the location rules'.

The Panel's conclusion in respect of the claimed 'lack of competition' contradict the empirical evidence, including from overseas, and do not take into account the pricing structure around PBS medicines. More broadly, the Panel fails to consider the implications of its recommendations for competition in the counterfactual.

First, the Panel offers no evidence that a lack of competition as a result of the concentrated ownership of community pharmacies is a material concern.

The MacroPlan Dimasi research referenced above found that Australians typically have a choice of local pharmacies, so that the Location Rules do not materially detract from effective competition. 92 per cent of consumers in the capital cities live within 2.5 kilometres of at least two pharmacies, while 69 per cent of non-metropolitan consumers live within no more than 5 kilometres of at least two pharmacies. Overall, accessibility to at least two pharmacies within 2.5km (at 92 per cent) is significantly better than for banks (80 per cent), and marginally better than for supermarkets (89 per cent) and medical centres (91 per cent). MacroPlan Dimasi's analysis also shows that community pharmacies are highly accessible in terms of their opening hours. 55 per cent of consumers shop at a pharmacy that is open 7 days, with a further 32 per

cent shopping at a pharmacy that is open on Monday to Saturday but is closed on Sunday.

Second, there is no basis for the claim that a purported lack of competition has resulted in a lower quality of service, as indicated by a survey conducted by the Institute of Choice for the Guild in 2014 (Guild 2014). The survey results show that:

- 36.1 per cent of respondents said that they waited 5 minutes or less to have their script filled, whilst 40 per cent said that they waited between 6-10 minutes; and

- the overwhelming majority of survey respondents place a high degree of trust in the ability of their local pharmacy to provide the best service and advice.

Third, the claim that the Location Rules result in a lack of effective price competition reflects a misunderstanding of the PBS remuneration arrangements, and is also not consistent with the overseas experience:

- Any effects of a single owner-pharmacist owning multiple community pharmacies in a particular area will be essentially limited to non-PBS medicines. The pharmacy remuneration arrangements regulate the maximum retail price that may be charged for PBS medicines. For these products, community pharmacies that are in the position of being a sole supplier may elect not to offer a $1 discount or to forego certain elements of dispensing fees. There is also some price flexibility for drugs with a cost below the relevant co-payment. However, such discounting arrangements are only relevant for customers who do not hold concession cards and are not safety net customers.

- At least in Europe, the deregulation of community pharmacy has not been found to reduce prices (Vogler 2014). As is the case for PBS medicines, the prices of medicines that are subsidised by Governments are regulated in most European countries. The analysis of price impacts post-deregulation therefore focused on OTC medicines that do not require a prescription. However, studies of the impact of deregulation on the prices of OTC medicines could not confirm a consistent decrease in OTC medicines prices, and the additional competition on prices was generally found to be limited.

RSM (2017) advance an alternative hypothesis, namely that pharmacies exploit the 'market power' they have in relation to the right to dispense PBS medicines by placing the dispensing desk at the rear of their premises, to 'divert' customers past shelves of non-PBS goods, similarly to supermarkets who locate milk at the back of the store (P73). Milk is at the back of supermarkets to preserve the cold chain, given that it is a perishable and high volume item that needs to be constantly replenished. There are similar logistical issues to be managed with medicines: PBS medicines may not be stored within reach of customers, medicines storage requires space for shelves, fridges and a safe for dangerous drugs, and a pharmacy requires space for filing and documentation. More broadly, the notion that pharmacies have any degree of significant 'market power', relative to very large players such as supermarkets, seems absurd. As for the notion that 'market power' could be materially enhanced by placing dispensing at the back of the retail premises, it is not easy to take seriously, and to the best of our knowledge, has never been raised in any previous study.

Finally, the Panel fails to consider competitive outcomes in the counterfactual; that is, if its recommendations were accepted and the Location Rules removed. The current regulation framework that applies to community pharmacy has preserved a diffuse ownership structure. This outcome can be contrasted with substantial horizontal and vertical industry consolidation in the pharmaceutical industry in European countries where community pharmacy has been deregulated, and where competition concerns have, in fact, emerged (Lluch and Kanavos 2010, Vogler 2012, 2014):

- In both Iceland and Norway, the deregulation of community pharmacy resulted in horizontal mergers and coalitions between pharmacies and, in Norway, vertical integration between pharmacies and wholesalers. The distribution of pharmaceuticals was rapidly transformed into an oligopoly. As of 2011, four major pharmacy chains own more than 85 per cent of all pharmacies in Norway.

- In England, new dominant players, including supermarkets, emerged after the Location Rules were removed. In 2002, 40 per cent of pharmacy outlets belonged to big chains and supermarkets; by 2003 the percentage of pharmacy chains had increased to 53 per cent. As of 2011, 58 per cent of pharmacies were owned by large chains.

Inevitably, such a structure, were it to evolve in Australia, would be able to exercise a degree of market power not only with respect to consumers but also and especially in setting the charges the Commonwealth would bear to obtain dispensing services. That would both tend to reduce the level of pharmacy services that could be provided and increase the cost to taxpayers of any given level of access to pharmacy, increasing the deadweight losses of taxation which the Panel itself has emphasised.

Location rules and pharmacies in regional and remote areas

The Panel suggest that there is some causal connection between the Location Rules and (P.97) "*too few pharmacies being present in some regional and remote areas*".

The provision of all forms of health and social services, including pharmacy services, in remote parts of Australia remains a long-standing public policy problem that is separate from the effects of the Location Rules. The Location Rules place minimum distance requirements on new entrant pharmacies. As such, the rules overwhelmingly limit new entries in urban areas and cities. There is no sense in which the Location Rules would prevent pharmacies from opening in regional or remote areas where there is an unmet need for dispensing services.

To the contrary, the geo-spatial analysis prepared on behalf of the Guild (2014) shows that the community pharmacy model provides better access than a deregulated model would in regional areas. That is, in regional areas of Australia:

- the proportion of people having access to at least one pharmacy is significantly higher (81 per cent) than is the case for supermarkets (76 per

cent) and banks (72 per cent), and marginally below medical centres (83 per cent);[11] and

- the proportion of people having access to at least two pharmacies (69 per cent) is higher than for supermarkets (65 per cent) and banks (66 per cent), and again marginally lower than for medical centres (70 per cent).

The Guild's submission to the Interim Report furthermore presents analysis compiled by Lange and Franzon (2016), which shows that over 200 communities have secured the services of a new pharmacy as a result of locational restrictions in more densely populated areas. Thus, pharmacy numbers in large population centres (CAT A) reduced from 3,745 from 1990 to 3,464 in 2014, while numbers in less populous centres (CAT B and CAT C) increased from 1,833 to 1,990 over the same period.

We finally note that under the current system of pharmacy remuneration, government outlays to support rural and remote pharmacies are relatively modest. Hence 6CPA, provides for funding of $6.9 million for the Rural Pharmacy Workforce Programme to strengthen and support the rural pharmacy workforce, and $14.3 million for the Rural Pharmacy Maintenance Allowance to support improved access to PBS medicines and pharmacy services in rural and remote parts of Australia. In comparison to the recommendation to establish a new PLB (discussed in Section 4.2.3), which would essentially adopt a central planning role, the current direct funding arrangements are also likely to be more cost-effective.

4.2 Panel recommendations

This section discusses the Panel's broader regulatory approach to determining the size and distribution of the community pharmacy network. While the Panel acknowledges that the community pharmacy network is 'good', it has nonetheless elected not to consider an incremental approach to reform (P.104):

> *Rather than try to modify the existing rules, the Panel has considered that it is more appropriate to remove the existing rules and, if required, replace them with a different, simpler system that directly deals with the issues of consumer access.*

The Panel's central recommendation is therefore that the Location Rules should be eliminated (Option 5-1). The Location Rules should then be replaced by one of the alternatives described under Option 5-2 and Option 5-3:

- Option 5-2 relates to urban areas:
  - Under Alternative 1 (no Location Rules), the overall number of community pharmacies would solely be determined on the basis of dispensing fee paid. No restrictions would be placed on the location of new pharmacies.

[11] In this study, medical centres were broadly defined to include some that are either not open 7 days per week or may not have a qualified GP present on a full-time basis. As such, the percentages are likely to represent overestimates.

- Alternative 2 (no Location Rules) is to establish the PLB, followed by a review after five years to decide whether remaining restrictions should be removed.

- Alternative 3 is to introduce new Location Rules 'based on existing rules', with a joint DOH/Guild working group to address any identified anomalies.

- Option 5-3 relates to non-urban areas:

  - Alternative 1 is to establish the PLB as a permanent body. This recommendation also includes an initiative to work with the local Primary Health Network to improve regional access to pharmacy services where needed.

  - Alternative 2 is to introduce new Location Rules 'based on existing rules', with a joint DOH/Guild working group as above.

4.2.1 The Panel's agenda for community pharmacy

The Panel states at P.104:

> *.. the information available to the Panel strongly indicates that removal of the location rules with appropriate behavioural regulation to remove any economic rents and protect against excessive entry will lead to a desirable distribution of community pharmacies.*

What constitutes 'appropriate behavioural regulation' is explained in Appendix D of the Interim Report and on P.96: "*.. if there is an issue of too many or too few pharmacies overall then this should be dealt with by a change in government remuneration for pharmacies*". In other words, what the Panel has in mind is that the level of dispensing fees would become the central mechanism for determining the overall number of pharmacies.

The practical issues involved in varying the level of dispensing fees so as to achieve the 'perfect' location pattern the Panel has in mind are nowhere discussed. Indeed, it does not take much thought to see that dispensing fees are a relatively blunt instrument; the notion that they could be 'fine-tuned' to secure, with any accuracy at all (much less laser-like precision), a particular number and geographical pattern of community pharmacy appears far-fetched. Moreover, it is equally obvious that the possibility of that kind of fine-tuning occurring would materially increase the commercial risk pharmacies face, raising their cost of capital and hence the long run cost of the PBS.

While eliding these issues, what the Panel does suggest (as discussed in Section 3.3 above) is that a flat dispensing fee of $10 be applied, which, RSM (2017) conclude, would force the closure of a large number of small pharmacies. RSM then argue that (P.61-63):

- while "*there are a large number of micro pharmacies in major cities that would potentially be adversely affected by any reduction in the amount of remuneration provided by the government*", this would not be of great consequence, since these consumers would still have access to a many other pharmacies; and that

- while 84 and 98 per cent of pharmacies in remote and very remote regions of Australia, respectively, are small and the closure of those pharmacies would have a disproportionally greater adverse impact on accessibility, this issue could be addressed by increasing the amount of remuneration provided to these pharmacies.

The idea that emerges is of a system whereby a central planning body determines the level of dispensing fees so as to achieve a 'desirable' number of community pharmacies, and where the associated geographical distribution of community pharmacies would be the result of purely commercial considerations.

The starting point for the Panel is that the network has too many pharmacies, and in particular, far too many very small pharmacies that, it is claimed are the 'least efficient' and in need of the highest 'rates of assistance' (P.82). A significantly reduced level of remuneration would force small local pharmacies to close, while unrestricted entry would lead to a new and significantly larger pharmacies in commercially attractive areas. In other areas, the government would intervene to maintain those pharmacies whose ongoing operation is deemed by government to be desirable.

As discussed in previous sections of this report, the various statement by the Panel referenced above have no foundation. The Interim Report unambiguously concludes that pharmacies are not earning economic rents.[12] In Section 3.3 we explain that the Panel's application of the concept of 'effective rates of assistance' and the associated claim that small pharmacies are receiving higher effective rates of assistance is devoid of economic content.

The broader implication of the Panel's approach to removing the Location Rules is that accessibility objectives have no place in an urban environment. Yet as the experience with relaxing entry restrictions in England (discussed below) illustrates, unrestricted entry has not resulted in better or more equitable health outcomes for consumers, but has merely placed significant additional financial pressure on existing pharmacies that serve an identified community need. Combined with the proposed significant cut in pharmacy remuneration, the outcome of the Panel's recommendation would be to facilitate new entry by large and very large pharmacies in an urban or commercially attractive setting, while simultaneously forcing the closure of large numbers of small pharmacies. The consequences for accessibility and the corresponding costs for consumers of removing a significant share of small pharmacies are not discussed.

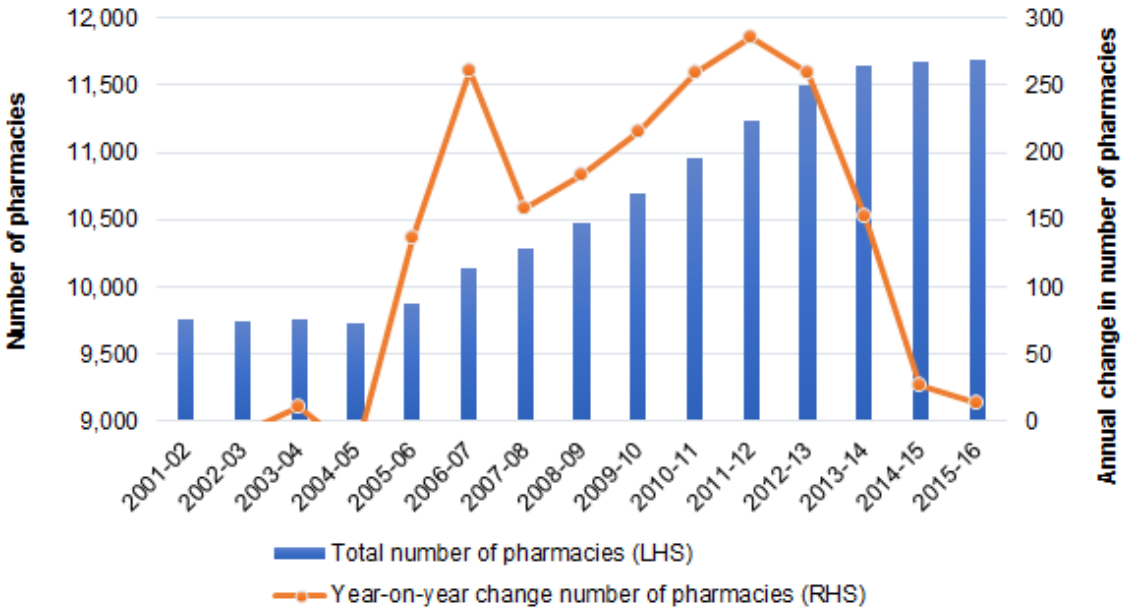
4.2.2 'Control of entry' relaxation in England

The following is a case study of the effects of relaxing the 'control of entry' restrictions on pharmacies in England. In broad terms, the results of removing these restrictions mirror those that occurred in other countries where community pharmacy has been deregulated. The most recent survey by Vogler et al. (2014), where community pharmacy was compared across nine European countries, consistently found 'urban clustering' in all deregulated countries. At the same time, accessibility of prescription-only medicines in rural and sparsely populated areas remained unchanged. In this respect, the outcomes in England are representative of the broader experience.

[12] See Footnote 5.

Following a review by the then Office of Fair Trading (OFT), new regulations were introduced in England in 2005, which substantially loosened the previous 'control of entry' regulations in order to promote more competition (NHS Digital 2016). Among other things, the new Location Rules introduced four classes of 'exemptions' whereby certain types of pharmacy applications would be automatically approved. The most important of these was for pharmacies opening for at least 100 hours a week. The result of weakening the restrictions was rapid new entry (Figure 4-1). On average, 212 new pharmacies opened every year from 2005-06 to 2013-14.

Figure 4-1. Number of community pharmacies on the pharmaceutical list (England)



Source: ATKearney, 2012. NHS Digital 2016.

Rapid new entry did not result in improved *overall* accessibility, however. A 2008 Pharmacy White Paper and subsequent Impact Assessment concluded that the revised arrangements had resulted in (Department of Health 2008, 2012):

- pharmacies locating in places that were already served by pharmacies, at the expense of locating in areas where there were identified unmet patient needs;
- the clustering of new pharmacies close to each other or around income sources, and an increase in 'speculative' applications;
- a lack of control on the part of local primary care trusts as to where such pharmacies located; and
- a lack of correspondence between better access and the need for such an improvement locally.

Overall, the Department concluded that (DOH 2012, P.12):

Whilst the existing regulatory system may continue to improve access and choice, such improvements would be neither equitably available to all nor related to identified patient needs. Benefits derived from increased competition would most likely continue to be localised in areas where there is already adequate existing provision.

The Department of Health's Impact Assessment noted that unlike in other industries, consumers would not benefit from increased price competition, given that prescriptions are dispensed at a fixed price. While there were some benefits to having more pharmacies, these would need to be set against the additional (fixed) costs of the new pharmacies. Analysis commissioned by the Department then found that these costs amounted to £143,000 (AU$ 243,000) per new entrant pharmacy. 'Doing nothing' (i.e. leaving the entry restrictions unchanged) would lead to (P.12):

.. continued and possibly increased over-provision of services, most likely in areas already well served, and to greater financial pressures. These would need to be met either by increased payments by the NHS, or by pharmacies if funding remained unchanged ..

4.2.3 Pharmacy Location Board

One of the options that has been put forward by the Panel is to eliminate the Location Rules and instead establish a PLB. In urban area, the PLB would initially adjudicate on pharmacy location requests on a temporary basis. In rural areas, the PLB would become a permanent fixture.

It is, in principle, possible, that a PLB may deliver outcomes that better reflect the Government's public health policy objectives than the existing Location Rules, provided that the PLB's charter reflects these public policy objectives. That is, in making its recommendation to allow or disallow a pharmacy to locate or relocate in an area, the PLB would need to be required to evaluate consumer accessibility and cost trade-offs in a manner that supports broader policy goals. However, as described in the Interim Report, Options 5-2 and 5-3 do not envisage that a PLB would need to consider such trade-offs, and state as the sole criterion for approving an application "*if (and only if) in the opinion of the PLB, this would materially improve consumer access*". This wording appears reminiscent of the Panel's view that any new entrant pharmacy is to be welcomed, since it would, by definition, reduce travel costs for a subset of people, if only minimally.

It is not clear why the Panel believes improved consumer access ought to be the sole criterion – indeed, that flies in the face of its other recommendations, which seem to involve reducing the number of pharmacies in the interests of reducing budget outlays. Nor is it clear why essentially unbridled administrative discretion would do a better job in achieving that goal (or any other) than would clear rules. While there are unavoidable trade-offs in the design of any administrative system, clear rules are generally held to have advantages in terms of transparency, simplicity and accountability; indeed, Australian experience with discretionary arrangements in areas such as liquor licensing has almost invariably been extremely poor, and over the years, the trend of policy has been away from such arrangements to systems based on rules.

There are also other concerns. As noted earlier, more discretion implies greater incentives on the part of would-be entrants to lobby the PLB in their favour or to

submit speculative applications as occurred in the UK, as well as a greater scope for disputes with associated costs. Further, to date, community pharmacies have invested considerable human and physical capital in their businesses in the expectation that they will be able to recoup these investments through future dispensing activities. That expectation is in large part anchored in the existence of the Location Rules. The creation of a PLB with the powers to approve pharmacy locations by applying other criteria may then leave some existing pharmacies with stranded investments and may more generally reduce the incentive to invest in community pharmacy in the first place. By thus increasing the risks of ex-post opportunism, in which the PLB effectively expropriated the sunk investments made by pharmacists, the cost of capital to pharmacy would rise, increasing long run costs to consumers, taxpayers and the community.

The potential role of a PLB becomes even more problematic in non-urban areas, where it seems at least plausible that such a body would morph into an additional regional planning body with responsibility for approving pharmacies, but also putting in place separate remuneration arrangements for certain pharmacies.

It seems unlikely that merely removing the Location Rules would lead to significant new entry in sparsely populated regions, such as remote and very remote parts of Australia; indeed, to the extent it increased the commercial risk pharmacies bore, it might deter it. The main effect on pharmacies located in these regions, as predicted by RSM (P.61) would arise from the cut in dispensing remuneration. Here, RSM suggest that (P.63): "*.. it may be necessary to consider increasing the amount of remuneration provided to more remote pharmacies if a flat dispensing fee was to be introduced ..".* Whichever body is tasked with identifying those pharmacies requiring additional funding (to compensate for the cut in pharmacy remuneration recommended by the Panel), the effect is the same: the need for a new regulatory body to distribute assistance payments with all of the consequences that entails.

4.3 Removal of supermarket co-location rules

The Interim Report suggests that there is little public support for eliminating the restriction that prevents pharmacies from co-locating inside supermarkets. Representative bodies, such as the Guild and the Pharmaceutical Society of Australia are in favour of retaining the restriction. A study commissioned by the Panel on the overseas experience with co-locating pharmacies in supermarkets was inconclusive, and a consumer survey commissioned by the Panel found that the great majority of respondents do not favour pharmacies inside supermarkets.

The Panel selectively refers to consumer preferences where it suits its agenda (to eliminate the Location Rules), but not where it does not, as in the case of supermarkets. The Panel then concluded that '*.. there is no reasonable rationale for maintaining the current co-location restrictions,'* (P.113).

The restriction on pharmacies locating in supermarkets is explicitly stated in the Location Rules,[13] but is fundamentally anchored in the rules governing pharmacy

[13] Schedule 2, Section 212 of the Location Rules generally prohibit pharmacy premises from being accessible to the public from within a supermarket. This requirement must be met, irrespective of which of the Location Rules is invoked. That is, while Rules 130, and 132 through 134 define various criteria for a new pharmacy or a pharmacy

licensing and ownership. In the context of the Location Rules, the entry of supermarkets into the pharmacy space raises similar concerns as unrestricted entry does more generally. Entry would predominantly take place in commercially attractive locations; given that Coles and Woolworths are often co-located in shopping centres, such entry would also lead to clustering and the duplication of infrastructure costs. Moreover, the Location Rules have meant that there are pharmacies in many, maybe most shopping centres that contain one or more supermarkets: thus, any improvement in access would be minimal, were supermarkets permitted to contain pharmacies.

The rules around pharmacy ownership are defined at a jurisdictional level and vary in the detail (Hattingh 2011). Broadly speaking, however, pharmacy ownership is restricted to pharmacists, corporate entities controlled by pharmacists, or friendly societies. As such, supermarkets are prohibited from owning and operating community pharmacies. As we discuss in the following, two features of the pharmacy ownership rules are relevant to the question as to whether supermarkets should be permitted to own and operate pharmacies:

- the implications of the rules for the structure of the community pharmacy sector, which affects both the Government's bargaining position in relation to negotiating dispensing fees and the broader competitive dynamics within the sector; and
- the re-enforcement of quality requirements, where the ownership rules currently unambiguously hold the owner-pharmacist responsible for the quality of dispensing outcomes.

4.3.1 Industry structure and competition

To date, the pharmacy ownership rules have preserved a dispersed industry structure in community pharmacy. In particular, the requirement that the owner of a pharmacy must be a registered pharmacist have, at least to an extent, limited the growth of major players or chains who are capable of dominating the market (Ibisworld 2016). Such a structure provides crucial benefits to the Commonwealth, as it prevents a situation from emerging where the Commonwealth, to meet its objectives, would have to purchase dispensing services from suppliers with substantial market power. It is inevitable – and consistent with any economic theory of bargaining – that in any concentrated ownership scenarios, players with a predominant position in dispensing services would have a high degree of bargaining power vis a vis the Government. As a result, it is likely that they would ultimately secure monopsony rents at taxpayers' expense.

The broader implications for competition in the supply of non-PBS products if new and dominant players (such as supermarkets) emerge are unclear. It is possible to envisage various scenarios with different numbers or combinations of large pharmacy groups and different competitive dynamics, with correspondingly differing outcomes for consumers. At least in Europe, however, the experience with competition post-deregulation has been mixed at best. Vogler et al. (2012) found that in the five

relocation that involve a supermarket being nearby, the pharmacy premises in question must not be accessible from within the supermarket.

deregulated countries studied, the removal of ownership rules led to the establishment of pharmacy chains and vertical integration with large international wholesalers. In Iceland and Norway, the deregulation of pharmacy ownership resulted in horizontal mergers and coalitions between pharmacies and, in Norway, vertical integration between pharmacies and wholesalers. In these countries, the distribution of pharmaceuticals was rapidly transformed into an oligopoly. At the same time, no price decreases for over-the-counter products in countries that have deregulated community pharmacy have been reported in the literature (Vogler et al. 2014).

Overall, and while comparisons of pharmaceutical sectors between countries can be problematic, a clear trend of industry consolidation has been observed in countries that have relaxed their pharmacy ownership rules. In some countries, this has been a gradual and ongoing process; in others, the industry landscape changed very rapidly. Eliminating the ownership rules therefore risks putting the Australian pharmacy sector on a path to greater concentration of ownership, be it in the hands of the major supermarkets, upstream wholesalers, or large pharmacy chains. It is worth emphasising that these are trends that are difficult or impossible to reverse once they have been set in motion. Given the relatively small size of the market and existing concerns about market power in retailing in Australia, the consequences of ownership deregulation as it relates to pharmacies co-locating in supermarkets would therefore need to be carefully assessed.

4.3.2 Quality in dispensing

In combination with the remuneration arrangements, the ownership rules re-enforce quality incentives because the agent relationship may be terminated if quality standards are breached. Pharmacists invest considerably in human and physical capital to operate their businesses, which is usually their principal asset.[14] Because the rules limit dilution of equity, pharmacists cannot spread the risk associated with that asset to other investors in the way a listed entity would. By placing the pharmacist and his or her professional reputation at the centre of the distribution relationship, a position that the pharmacist stands to lose if quality standards are not met, the Government effectively 'raises the stakes' for non-performance. Owner-pharmacists therefore have an enhanced incentive to conduct themselves and their pharmacies ethically and professionally, so as to not risk loss of registration and, therefore, loss of value in the pharmacy.

The ownership rules therefore contribute to the trust consumers undoubtedly have in community pharmacy, which in turn helps achieve the Commonwealth's public health objectives of ensuring access to safe and effective medicines. The empirical evidence supports this claim:

- The Institute of Choice survey commissioned by the Guild (2014) found that on a scale from 1 to 5, over 50 percent of consumers gave their pharmacy a trust score of 5, which corresponds to trusting it 'completely', with an additional 37 percent giving it a trust score of 4. Some 90 percent of consumers surveyed said that pharmacies should be owned by pharmacists.

[14] As of June 2012, the average Australian pharmacy held around $1.1 million in assets and had around $1.7 million in debt (Guild Insurance 2013).

- The qualitative research prepared by Hall & Partners (2016a) on behalf of the Panel highlights very similar outcomes. Hall & Partners state that the overall perception of the position of the pharmacist is '.. *imbued with a sense of clinical trust, or trust in clinical knowledge and care* ..' (P.12), particularly among older people or people with chronic conditions. While Hall & Partner note that participants who only visit pharmacies sporadically may view pharmacy as more of a commoditised service, pharmacists are '*widely considered to be a positive component in the care of people's health*' (P.12).

The European experience correspondingly suggests that the quality of dispensing outcomes may suffer post deregulation. Vogler et al. (2014) report markedly increased workloads and reduced professional training in three countries where community pharmacy has been deregulated: Norway, Sweden and England. Swedish studies additionally reported a deteriorated environment for counselling and advice, and lower consumer satisfaction, including a negative effect on safety.

4.3.3 Quality in dispensing and supermarkets

Both of the surveys referenced above furthermore show that while consumers place a high degree of trust in their local pharmacy, this trust does not extend to supermarkets. The Institute of Choice survey found that the great majority of respondents did not think that supermarkets should provide health services, would not wish to have their prescriptions filled in a supermarket, and did not want supermarkets keeping their personal health information.

The findings by Hall & Partners are very similar. In a questionnaire survey, only 15 per cent of respondents to a said that they would like to access pharmacy dispensing services in a supermarket (Hall & Partners 2016). Hall & Partners' qualitative survey (2016a) additionally found that many respondents questioned whether it was necessary to permit the co-location of pharmacies and supermarkets, given that there is typically a pharmacy in the same shopping strip or complex as most supermarkets. Hall & Partners' qualitative research also noted that consumers were concerned about the effect that supermarkets offering pharmacy services would have on local community pharmacies if the Location Rules were removed (P46):

> *The two major concerns relate to service delivery and the power that the supermarkets giants such as Coles and Woolworths are already perceived to have. People worry that if supermarkets are allowed to offer pharmacy products and services as well, they could take the opportunity to undercut prices and drive out the smaller community pharmacies. This could eventually erode the number of available pharmacies – and possibly at that point supermarkets might take the opportunity to raise prices. Beyond these practical concerns, many like the idea of supporting local, small businesses and maintaining variety in the community.*

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