

## Review of Pharmacy Remuneration and Regulation Questionnaire

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### Your Details

Name

- Christine Nunn

Organisation

- Goulburn Valley Alcohol and Drug Service, Goulburn Valley Health

Email:

- [REDACTED]

Which of the following categories best describes you?

- Other: Goulburn Valley Alcohol and Other Drugs Catchment Planner

Do you consent to your response being made publicly available through the Review website?

- Yes

Please Note: given the timeframe for submissions it was not possible to provide a combined endorsed response from members of the Goulburn Valley AOD Advisory Network.

## Chapter 2: Consumer Access and Experience

Each Finding and Option presented by the Review Panel in the Interim Report can be found by clicking the blue drop-down text on the following pages. You can provide your responses to any Option by either clicking on the Agree/Disagree buttons, providing written comments or both. You can return to the contents page by scrolling to the bottom of the page and selecting the Continue button.

### OPTION 2-1: PRICING VARIATIONS

#### [Finding - PRICING VARIATIONS](#)

The variation in pricing for medicines due to pharmacy pricing discretion creates consumer confusion.

#### [OPTION 2-1: PRICING VARIATIONS](#)

Agree  Disagree

Make a comment

### OPTION 2-2: \$1 DISCOUNT

#### [Finding - THE \\$1 DISCOUNT](#)

The \$1 discount has not led to appropriate outcomes for consumers.

#### [OPTION 2-2: \\$1 DISCOUNT](#)

The government should abolish the \$1 discount on the PBS patient co-payment.

Agree  Disagree

make a comment

The \$1 discount may make competition between community pharmacies, where there is more competition more transparent (e.g. within Shepparton), however, this is unlikely to be provided in small rural towns where there is limited or no competition (e.g. Nagambie). Therefore, people in these communities will pay more.

### OPTION 2-3: PBS SAFETY NET

#### [Finding - PBS SAFETY NET](#)

The current PBS Safety Net system is not transparent and is difficult for consumers to document and understand. The lack of transparency and understanding also results in the Safety Net not being utilised to the extent possible, which disadvantages the more vulnerable consumers.

#### [OPTION 2-3: PBS SAFETY NET](#)

In relation to the PBS Safety Net, the government should:

- a. require the PBS Safety Net to be managed electronically for consumers. This expectation should be automatic from the consumer's perspective
- b. investigate whether the PBS Safety Net scheme can be adjusted to spread consumer costs over a twelve-month period
- c. provide sufficient transparency in the way a patient's progress towards the PBS Safety Net is collated, including information on any gaps in how it is calculated
- d. investigate and implement an appropriate system which allows payments for opiate dependence treatments to count towards the PBS Safety Net.

Agree  Disagree

make a comment

The purpose of the PBS Safety Net system in Australia is to protect individual consumers and families who require a large amount of prescription medications. Manual record keeping, either by the individual or the pharmacy they attend means significant burden for vulnerable groups such as those participating in opioid replacement therapies, especially if they need to access medication from different pharmacies. It would be much simpler if there were a national recording system like the Medicare Safety Net system.

People can take many months before the Safety Net threshold is reached which means that some struggle to start or maintain treatment, because they are financially unable to sustain several months of co-payments until the safety net threshold is reached. It may be fairer to develop a system which spread costs to individuals over the 12-month period particularly for people with many co-morbidities.

Patients on methadone and other treatments for opioid dependence are unduly burdened by the cost of accessing essential treatment. These treatments fall under section 100 of the *National Health Act 1953* (Cth), with differing government funding arrangements. There are numerous anomalies in the PBS funding model for supplying pharmacotherapy services. One of which is that payments made by consumers to access opioid dependence treatments do not count towards the PBS Safety Net Funding should be aligned with other similar medicines and should include funding for the supply component, which reflects the complex nature of the service.

A typical dispensing fee in the Goulburn Valley is \$5.00 per dose or \$30 per week, which has remained the same for more than two decades<sup>1 2</sup>. Research cited by the Centre for Research in Injecting Drug Use in 2014 indicated that the daily MATOD dispensing fee can range from \$1.50 to

<sup>1</sup> Tim Griffiths Hume Area Pharmacotherapy Network Coordinator, 2015, Hume Pharmacotherapy Providers Spreadsheet and discussion held 10 September 2015

<sup>2</sup> Victorian Pharmacotherapy Area Based Networks, 2016, Submission to the Pharmacy Remuneration and Regulation Review, 2016 from the Victorian Area Based Pharmacotherapy Networks Submission #262; 23-Sep-2016

\$10 (median = \$4.65 for methadone and \$5 for buprenorphine preparations) and that the average cost for 12 months could exceed \$1,800 and be as high as \$3,640<sup>3</sup>.

It is reasonable for a patient legitimately seeking treatment for opioid dependence to expect that they should be able to access this treatment, at reasonable cost, without undue burden. The Disability Discrimination Act 1986, The Australian Charter of Healthcare Rights, and the World Health Organisation Essential Medicines List, all support this expectation.

Medications taken continuously to treat chronic disease (e.g. diabetes or depression) are provided with at least one month's supply of medicine for a single patient co-payment, and in most cases, the patient's contribution will count toward the PBS safety net<sup>4</sup>.

This does *not* apply for opioid dependence treatments, and additionally, the ad-hoc fee-for-service does not count toward the PBS safety net, no other medication is dispensed or charged for in this way<sup>5</sup>.

Section 100 Opiate Dependence Treatment programs are administered by state and territory governments and are therefore seen as separate from general PBS arrangements by the Australian Government, this system unfairly discriminates against patients requiring opiate dependence treatment, and must be changed.

## OPTION 2-4: LABELLING

### [Finding - LABELLING](#)

The label is a vital part of the supply of PBS medicines. It is relied on by patients and health professionals for the proper identification, dosage, categorisations and monitoring of medicines.

### [OPTION 2-4: LABELLING](#)

All PBS medicines provided to Australians should be appropriately labelled and dispensed. Where there is a system in place that involves 'remote' dispensing or 'bulk supply' then this system will require appropriate monitoring to ensure the quality of medicine supply.

Agree  Disagree

Make a comment

<sup>3</sup> Sarah Lord, Jenny Kelsall, Amy Kirwan and Trevor King, 2014, Opioid pharmacotherapy fees: A long standing barrier to treatment entry and retention. POLICY BRIEF No. 8: September, 2014 in Centre for Research in Injecting Drug Use <http://hrvic.org.au/wordpress/media/Policy-Brief-Lord-Kelsall-PDF.pdf>

<sup>4</sup> The following PBS co-payment and safety net amounts changes are effective from 1 January 2016:

- the general patient co-payment will increase from \$37.70 to \$38.30
- the concessional patient co-payment will increase from \$6.10 to \$6.20
- the general patient safety net will increase from \$1,453.90 to \$1,475.70
- the concessional patient safety net threshold will increase from \$366.00 to \$372.00

2016 PBS co-payment and safety net amounts webpage

<http://www.pbs.gov.au/info/news/2016/01/2016-pbs-co-payment-safety-net-amounts>

<sup>5</sup> Victorian Pharmacotherapy Area Based Networks, 2016, Submission to the Pharmacy Remuneration and Regulation Review, 2016 from the Victorian Area Based Pharmacotherapy Networks Submission Submission #345; 23-Sep-2016

**OPTION 2-5: PHARMACY ATLAS**

[Finding - CONSUMER INFORMATION ON MEDICINES AND PHARMACY SERVICES](#)

Information about pharmacy services is inconsistent and inadequate to provide sufficient consumer awareness and choice.

[OPTION 2-5: PHARMACY ATLAS](#)

There should be an easily accessible and searchable ‘atlas’ of all community pharmacies in Australia that provides key patient information, including the services and programs offered by that pharmacy, the opening hours of the pharmacy and any specific accessibility services of the pharmacy (e.g. multilingual staff). The 'atlas' should be easily accessible to consumers (e.g. through mobile-friendly applications).

Agree  Disagree

Make a comment

Some pharmacies also offer specialist programs and services such as treatments for opioid dependency. Promotion of specialist services such as MATOD is often limited. This can be for a range of reasons in relation to MATOD including a desire/need to maintain patient privacy and concern about potential numbers of MATOD clients and the perceived or actual impact on other patients and/or the perceived/actual response of other patients/potential patients if they knew about this specialist service being provided.

**OPTION 2-6: CONSUMER MEDICINES INFORMATION**

[Finding - CONSUMER MEDICINES INFORMATION \(CMI\)](#)

While Consumer Medicines Information (CMI) leaflets are generally available, there are variances in how these are provided to consumers. Some consumers may be unaware of the availability of a CMI and there is a risk that these may not be provided, which could impact on quality of care.

[OPTION 2-6: CONSUMER MEDICINES INFORMATION](#)

A Consumer Medicines Information (CMI) leaflet should be offered and made available to consumers with all prescriptions dispensed in accordance with Pharmaceutical Society of Australia (PSA) guidelines. The PSA guidelines and the distribution of CMIs to consumers need to be audited and enforced to ensure compliance. Pharmacists and the pharmacy industry should continue to work on the improvement of CMIs and the use of technology to make medicines information more available to consumers.

Agree  Disagree

Make a comment

**OPTIONS 2-7: ELECTRONIC PRESCRIPTIONS**

[Finding - ELECTRONIC PRESCRIPTIONS](#)

The current paper-based system of prescriptions used in Australia is outdated. It inhibits the creation of a universal medication record for Australians, creates excessive administration, is less convenient for consumers, and presents significant challenges in meeting the standard required for quality use of medicines.

[OPTIONS 2-7: ELECTRONIC PRESCRIPTIONS](#)

The government should initiate an appropriate system for integrated electronic prescriptions and medicine records as a matter of urgency. Under this system the electronic record should become the legal record. Participation in the system should be required for any prescriber of a PBS-listed medicine, any pharmacist wishing to dispense a PBS-listed medicine and any patient who is seeking to fill a PBS prescription.

Agree  Disagree

Make a comment

An e-prescription system with linkage into a comprehensive electronic health records system would provide patients, including MATOD patients.

To be most effective the system should enable patients to pick up their medicines with appropriate identification from any pharmacy and would enable real time monitoring.

Non-PBS medicines such as those dispensed for MATOD clients should also be included on this system, if a change is not made as per OPTION 2-3: PBS SAFETY NET above

**OPTION 2-8: ELECTRONIC MEDICATIONS RECORD**

[Finding - ELECTRONIC RECORD KEEPING](#)

Australia lacks an integrated and effective universal health record system. This reduces consumer access to best-practice care and continuity of care between providers.

[OPTION 2-8: ELECTRONIC MEDICATIONS RECORD](#)

The electronic personal medications record should cover all Australians and ensure appropriate access by, and links between, community pharmacy, hospitals and all doctors. This record should also include a vaccines register.

Agree  Disagree

Make a comment

An integrated and effective electronic health record system through which all health professionals

(including community pharmacies and hospitals) can access comprehensive patient health information, including medicine records is essential in order to support MATOD patients, many of whom have multiple-morbidities.

All prescribers should be required to record any prescriptions that they issue on the electronic medicine record. Pharmacists should similarly be required to record any medications (including vaccines) that they dispense on the electronic medicine record.

Real time updating is essential to ensure continuity of care and the avoidance of medical misadventure.

Whether this is using the current MyHealth Record system or something different needs to be investigated to ensure all prescribers and dispensers can participate without technological issues based on system compatibility or internet access issues.

Additionally, the development of an app that enables the patient to have their prescription and go to a pharmacy of their choice should be considered.

#### **OPTION 2-9: ELECTRONIC PRESCRIPTIONS – CONSUMER CHOICE**

##### [Finding - MANAGING RISKS ASSOCIATED WITH 'CHANNELLING' PRESCRIPTIONS](#)

The introduction of a compulsory electronic prescription record could introduce risks of inappropriate behaviour, such as channelling of prescriptions, that will need to be managed appropriately.

##### [OPTION 2-9: ELECTRONIC PRESCRIPTIONS – CONSUMER CHOICE](#)

The choice of where a consumer has an electronic prescription dispensed should remain a decision for the consumer. The consumer can request that the electronic prescription be directed to a particular community pharmacy for dispensing (including an online pharmacy if that is the consumer's choice). For avoidance of doubt, a prescriber may not direct an electronic prescription to a particular community pharmacy for dispensing. This will require appropriate oversight and enforcement by professional bodies.

Agree  Disagree

Make a comment

#### **OPTION 2-10: MANAGING MEDICINE RISKS FOR PATIENTS UPON DISCHARGE**

##### [Finding - MANAGING MEDICINE RISKS ASSOCIATED WITH HOSPITAL DISCHARGE AND READMISSION](#)

The lack of a robust framework for the management of medicines between hospitals and community pharmacies creates risks for patients on discharge.

### [OPTION 2-10: MANAGING MEDICINE RISKS FOR PATIENTS UPON DISCHARGE](#)

Hospitals should work closely with community pharmacies to ensure patients have access to the medicines they require upon discharge. Consistent policies and procedures are required to ensure each patient has access to the medicines they require as well as appropriate education and information relating to their medications. This may involve the hospital providing a 'discharge pack' with an appropriate level of patient medication to allow the patient to safely access a community pharmacy and their community health practitioner without running short of medication.

Agree  Disagree

Make a comment

## Chapter 3: The Role of Community Pharmacy in Medicine Supply

### **OPTION 3-1: COMMUNITY PHARMACIES – MINIMUM SERVICES**

#### [Finding - THE ROLE OF COMMUNITY PHARMACY](#)

There are certain minimum services that all community pharmacies should provide in order to meet consumer and government expectations about the level of consistency that is required from a national pharmacy network.

#### [OPTION 3-1: COMMUNITY PHARMACIES – MINIMUM SERVICES](#)

The government should establish a process to determine the set of minimum requirements that a community pharmacy must meet in order to receive remuneration for dispensing. The government should initiate procedures to enforce these requirements and to have them updated at regular intervals. These requirements should be promoted by being incorporated within the Community Pharmacy Service Charter.

Agree  Disagree

Make a comment

Minimum requirements need to include dispensing to MATOD patients.

This would enable these patients to live in the community of their choice, which would support their recovery.

### **OPTION 3-2: COMPLEMENTARY MEDICINES – SUPPLY FROM PHARMACIES**

#### [Finding - COMPLEMENTARY MEDICINES](#)

Consumers value access to complementary medicines in the community pharmacy setting, where they can receive advice on their selection and use that is backed by an appropriate level of evidence.

### OPTION 3-2: COMPLEMENTARY MEDICINES – SUPPLY FROM PHARMACIES

Community pharmacists are encouraged to:

- a. display complementary medicines for sale in a separate area where customers can easily access a pharmacist for appropriate advice on their selection and use
- b. provide appropriate information to consumers on the extent of, or limitations to, the Therapeutic Goods Administration (TGA) role in the approval of complementary medicines. This could be achieved through the provision of appropriate signage (in the area in which these products are sold) that clearly references any limitations on the medical efficacy of these products noted by the TGA.

Agree  Disagree

Make a comment

### **OPTION 3-3: PLACEMENT OF PHARMACY ONLY AND PHARMACIST ONLY (SCHEDULE 2 AND SCHEDULE 3) MEDICINES WITHIN A PHARMACY**

#### [Finding - PHARMACY ONLY AND PHARMACIST ONLY MEDICINES \(SCHEDULE 2 AND SCHEDULE 3 MEDICINES\)](#)

Complementary medicines pose a risk to consumers when they are not clearly separated from Pharmacy Only and Pharmacist Only (Schedule 2 and Schedule 3) medicines.

#### [OPTION 3-3: PLACEMENT OF PHARMACY ONLY AND PHARMACIST ONLY \(SCHEDULE 2 AND SCHEDULE 3\) MEDICINES WITHIN A PHARMACY](#)

Access to Pharmacy Only (Schedule 2) and Pharmacist Only (Schedule 3) medicines should be clearly separated from complementary medicines within a pharmacy. Options to achieve this might include:

- a. ensuring that all Pharmacy Only (Schedule 2) and Pharmacist Only (Schedule 3) medicines only be accessible from 'behind the counter' in a community pharmacy so that a consumer must always seek assistance or advice in obtaining these medicines
- b. requiring that complementary medicines are not displayed 'behind the counter' in a community pharmacy.

Agree  Disagree

Make a comment

### **OPTION 3-4: SALE OF HOMEOPATHIC PRODUCTS**

#### [Finding - PHARMACY ONLY AND PHARMACIST ONLY MEDICINES \(SCHEDULE 2 AND 3 MEDICINES\)](#)

There are unacceptable risks where community pharmacies are allowed to sell homeopathic products.

#### [OPTION 3-4: SALE OF HOMEOPATHIC PRODUCTS](#)

Homeopathy and homeopathic products should not be sold in PBS-approved pharmacies. This requirement should be referenced and enforced through relevant policies, standards and guidelines issued by professional pharmacy bodies.

Agree  Disagree

Make a comment

## Chapter 4: Community Pharmacy Remuneration by Government

### **OPTION 4-1: ACCOUNTING INFORMATION**

#### [Finding - SOURCES AND TRANSPARENCY OF PHARMACY REMUNERATION](#)

The extent and quality of data and information is currently not adequate to inform decisions and determinations about the costs related to an efficient dispensing service.

#### [OPTION 4-1: ACCOUNTING INFORMATION](#)

As soon as possible following the completion of this Review, the government in consultation with the Pharmacy Guild and other stakeholders should:

- a. determine a set of accounting principles that will apply for community pharmacies in order to provide the relevant information needed to determine the best practice benchmark cost of a dispense (as these terms are defined in the Interim Report)
- b. require community pharmacy (as a condition of being approved to dispense PBS medicines) to provide the necessary accounting information to inform consideration in the development of each Community Pharmacy Agreement (including as a basis for the determination of a best practice pharmacy). The relevant accounting information should be provided for each financial year, and no later than December 31 of the following financial year (beginning with December 31, 2018)
- c. designate a body within the government (although potentially an existing independent statutory authority with the relevant expertise such as the Pharmaceutical Benefits Remuneration Tribunal, or, more broadly, the Australian Competition and Consumer Commission) to provide a recommendation to the government on the best practice benchmark cost of a dispense as required over time by the government. The first such advice is to be provided as soon as practical and certainly before the end

of 2019. The timing of later determinations will depend on the process used in the future by the government to set the remuneration for dispensing PBS medicines

d. the information and advice submitted to the government should form the basis for the average remuneration for a 'dispense' to community pharmacy in the future and certainly from the expiration of the Sixth Community Pharmacy Agreement. The provision of appropriate accounting information should be an ongoing requirement to support the development of each Community Pharmacy Agreement

Agree  Disagree

Make a comment

#### **OPTION 4-2: REMUNERATION TO BE BASED ON EFFICIENT COSTS OF DISPENSING**

##### [Finding - BASIS OF EFFICIENT DISPENSING COST / REMUNERATION](#)

Remuneration should be based on the efficient costs of dispensing within a best-practice pharmacy.

##### [OPTION 4-2: REMUNERATION TO BE BASED ON EFFICIENT COSTS OF DISPENSING](#)

The remuneration for dispensing paid by government and consumer co-payments to community pharmacy should be based on the costs of dispensing for an efficient pharmacy.

Agree  Disagree

Make a comment

#### **OPTION 4-3: BENCHMARK FOR AN EFFICIENT DISPENSE**

##### [Finding - BASIS OF EFFICIENT DISPENSING COST / REMUNERATION](#)

Remuneration should be based on the efficient costs of dispensing within a best practice pharmacy.

##### [OPTION 4-3: BENCHMARK FOR AN EFFICIENT DISPENSE](#)

On the basis of the information that has been made available to the Panel, and the given data limitations, the Panel considers that the current benchmark for a best practice dispense be set within a range of \$9.00 to \$11.50. This should be reflected in the average remuneration paid to a pharmacy for a dispense.

Agree  Disagree

Make a comment

#### **OPTION 4-4: REMUNERATION FOR DISPENSING – FORMULA**

##### [Finding - THE COSTS OF DISPENSING](#)

Remuneration for dispensing should be based on the incremental costs of dispensing rather than fully distributed or stand-alone costs.

##### [OPTION 4-4: REMUNERATION FOR DISPENSING – FORMULA](#)

The remuneration for dispensing should be a simple dispense fee based on the efficient, average, long run incremental cost of a dispense in a community pharmacy.

Agree  Disagree

Make a comment

In 2014-2015 there were 23 dosing points in the Goulburn Valley<sup>6</sup>, reducing to 20 in 2015-2016<sup>7</sup>. All dosing points in the Goulburn Valley are community pharmacies. This represents 51.3% of the 39<sup>8</sup> community pharmacies in the Goulburn Valley which is above Victoria as a whole. While this indicates broad coverage, in some areas of the Goulburn Valley the level of servicing is not sufficient for people's needs, particularly in Shepparton and Yarrawonga.

Until August 2016 there was only one of the ten pharmacies in Shepparton dispensing pharmacotherapy to 40% of all patients in the Greater Shepparton area, when pharmacotherapy dispensing at this pharmacy was reduced to around 5% of all pharmacotherapy clients in Greater Shepparton. It was the intent of the proprietor to sell the pharmacy. The Hume PABN Coordinator negotiated with another two Shepparton pharmacies to take a limited number of patients, while a pharmacy in Mooroopna agreed to take the majority of these patients which resulted in it becoming the largest dispenser in Greater Shepparton (approximately 45%).<sup>9 10</sup> The Balanced Health and Priceline Marketplace both dose a small number of patients but they are not actively taking on new patients<sup>11</sup>.

A pharmacy in Cobram services 75% of Moira patients<sup>12</sup>. It is argued that this pharmacy draws people from the surrounding areas, especially Yarrawonga where neither of the two pharmacies provide dispensing services.

<sup>6</sup> Data supplied by Tim Griffiths Hume PABN Coordinator September 2015

<sup>7</sup> Data supplied by Andrew McPherson Consultant to the Murray Primary Health Network May 2016

<sup>8</sup> Victorian Pharmacy Authority, 2017, Registered Pharmacy Premises and Licensees as at 17 January 2017

<sup>9</sup> Tim Griffiths, 2016, Pharmacists and pharmacotherapy services in Greater Shepparton for the Hume PABN August 2016

<sup>10</sup> Tim Griffiths Hume PABN Coordinator discussion 12 January 2017

<sup>11</sup> Tim Griffiths Hume PABN Coordinator email 2 February 2017

The pharmacies in Shepparton, Mooroopna and Cobram report being at or very close to capacity and cannot service the growing demand<sup>13</sup>.

Other pharmacies in Shepparton and those in Yarrawonga, whilst sympathetic to the issue are unwilling to participate and cite lack of financial incentive as the reason they do not become dispensers.<sup>14</sup>

The cost of pharmacotherapy substitution drugs and dispensing of them is covered by the following mix of sources:

- The Commonwealth Government which funds the medications (i.e. methadone, buprenorphine and Buprenorphine - naloxone) under section 100 of the National Health Act 1953 and may provide Pharmacy Practice Incentives to some pharmacies;
- The Victorian government which provides funding for specialist groups (i.e. prisoners' dispensing fees are subsidised for the first 4 weeks post release and all young people under 19 years are fully subsidised), public clinics (i.e. metropolitan only), regulatory services (e.g. management of dispensing permits) and other costs, including initial training for pharmacists, clinical updates and refresher courses.; and
- MATOD consumers who are charged program or dispensing fees by pharmacies which dispense pharmacotherapy medications<sup>15</sup>

Normally, where a person is accessing drugs which are part of the PBS (Pharmaceutical Benefits Scheme) the Commonwealth government uniformly provides a dispensing fee, and where appropriate a dangerous drug fee, to the pharmacy and a consistent fee is charged to the consumer, on a "per script" rather than a "per dose" basis as occurs with <sup>16</sup>.

A typical fee in the Goulburn Valley is \$5.00 per dose or \$30 per week, which has remained the same for more than two decades<sup>17 18</sup>. Research cited by the Centre for Research in Injecting Drug Use in 2014 indicated that the daily MATOD dispensing fee can range from \$1.50 to \$10 (median = \$4.65 for methadone and \$5 for buprenorphine preparations) and that the average cost for 12 months could exceed \$1,800 and be as high as \$3,640<sup>19</sup>.

As a result dispensing related costs for MATOD services are considerably higher than those for any

<sup>12</sup> Tim Griffiths Hume PABN Coordinator discussion 12 January 2017

<sup>13</sup> Tim Griffiths Hume Pharmacotherapy Area Network Coordinator, discussions held 10 September 2015 and 12 January 2016

<sup>14</sup> Tim Griffiths Hume Area Pharmacotherapy Network Coordinator, 2015, Hume Pharmacotherapy Providers Spreadsheet and discussion held 10 September 2015

<sup>15</sup> Sarah Lord, Jenny Kelsall, Amy Kirwan and Trevor King, 2014, Opioid pharmacotherapy fees: A long standing barrier to treatment entry and retention. POLICY BRIEF No. 8: September, 2014 in Centre for Research in Injecting Drug Use <http://hrvic.org.au/wordpress/media/Policy-Brief-Lord-Kelsall-PDF.pdf>

<sup>16</sup> Sarah Lord, Jenny Kelsall, Amy Kirwan and Trevor King, 2014, Opioid pharmacotherapy fees: A long standing barrier to treatment entry and retention. POLICY BRIEF No. 8: September, 2014 in Centre for Research in Injecting Drug Use <http://hrvic.org.au/wordpress/media/Policy-Brief-Lord-Kelsall-PDF.pdf>

<sup>17</sup> Tim Griffiths Hume Area Pharmacotherapy Network Coordinator, 2015, Hume Pharmacotherapy Providers Spreadsheet and discussion held 10 September 2015

<sup>18</sup> Victorian Pharmacotherapy Area Based Networks, 2016, Submission to the Pharmacy Remuneration and Regulation Review, 2016 from the Victorian Area Based Pharmacotherapy Networks Submission #262; 23-Sep-2016

<sup>19</sup> Sarah Lord, Jenny Kelsall, Amy Kirwan and Trevor King, 2014, Opioid pharmacotherapy fees: A long standing barrier to treatment entry and retention. POLICY BRIEF No. 8: September, 2014 in Centre for Research in Injecting Drug Use <http://hrvic.org.au/wordpress/media/Policy-Brief-Lord-Kelsall-PDF.pdf>

other condition. Furthermore, this is a financially disadvantaged group already, who are doubly penalised by the treatment model (i.e. daily supervised dosing) as well as the method of payment (i.e. daily dispensing fee).

It is important to note that cost benefit modelling demonstrates that, although expensive, paying for MATOD program and dispensing fees would have a net benefit for the consumer and the community. A modelling project undertaken by the Drug Policy Modelling Program (DPMP) concluded that if the Federal government were to cover all MATOD costs (approx. \$4 million per month) the cost would be more than offset by the economic benefits to the community including health and social benefits such as reductions in health care utilisation and crime.<sup>20</sup>

The evidence indicates that MATOD dispensing fees are a major barrier to treatment retention, represent a significant financial burden particularly for the 65 -75% of pharmacotherapy clients on fixed incomes or welfare support<sup>21</sup> and may be the source of conflict between consumer and pharmacist. This, in turn, can jeopardise the therapeutic relationship that is ideally established through ongoing provision of opioid replacement therapies. Reports from advocacy services for consumers, payment issues are the most common issue of concern, with up to 80% of consumers contacting services for this reason.<sup>22</sup> This reinforces and builds on findings from research with 120 Victorian consumers in 2008 which found that many MATOD consumers faced hardship with fees and this led to adverse outcomes. Some of the key findings of the report were that:

- clients often prioritise the payment of dispensing fees over basic necessities, including food and accommodation
- income poor clients are compelled to rely on emergency relief services to meet food and accommodation needs
- a significant minority of clients engage in illicit sex work and acquisitive crime to meet the financial obligations of their treatment (i.e. dispensing fees)
- the difficulties meeting the financial obligations of opioid maintenance treatment often contributes to a deterioration in the relationship between dispensing pharmacist and client
- the accumulation of debt through the inability to pay dispensing fees is a primary reason for the involuntary discontinuance of treatment
- dispensing fees are the single greatest obstacle to retention in a MATOD program
- the withholding of MATOD encourages illicit heroin and/or other opioid use
- involuntary discontinuance of treatment is invariably followed by a return to problematic heroin use

#### **OPTION 4-5: REMUNERATION LIMITS**

##### [Finding - STRUCTURE OF REMUNERATION FOR DISPENSING](#)

<sup>20</sup> Chalmers J, Ritter A. Subsidising patient dispensing fees: The cost of injecting equity into the opioid pharmacotherapy maintenance system. *Drug and alcohol review*. 2012;31(7):911-7.

<sup>21</sup> Sarah Lord, Jenny Kelsall, Amy Kirwan and Trevor King, 2014, Opioid pharmacotherapy fees: A long standing barrier to treatment entry and retention. POLICY BRIEF No. 8: September, 2014 in Centre for Research in Injecting Drug Use <http://hrvic.org.au/wordpress/media/Policy-Brief-Lord-Kelsall-PDF.pdf>

<sup>22</sup> Rosmanith 2011, in Pennington institute, 2014, Opioid Replacement therapies (ORT) Fees: Consultation Paper <http://www.pennington.org.au/wp-content/uploads/2014/08/ORT-paper-for-consultation.pdf>

The current formula for the remuneration for dispensing paid by the government to community pharmacy is overly complex and opaque. The formula should be simplified to improve the transparency and simplicity of government payments.

[OPTION 4-5: REMUNERATION LIMITS](#)

If the government does not place an upper limit on the wholesale payment for a medicine by a community pharmacist, then the government should adopt a two-part tariff payment for the remuneration (i.e. a payment that involves a fixed payment per dispense plus a payment that varies with the relevant cost of the medicine to the pharmacist).

Under either a flat fee or two-part tariff, the average payment for a dispense should equal the required fee determined by the government, following the acceptance of Option 4-4.

Agree  Disagree

Make a comment

**OPTION 4-6: REMUNERATION FOR OTHER SERVICES**

[Finding - REMUNERATION – ALTERNATIVE SERVICE CHANNELS](#)

Government is currently paying different amounts through different mechanisms for the same service supplied by different primary health professionals.

[OPTION 4-6: REMUNERATION FOR OTHER SERVICES](#)

Government should require that if the same service is offered through alternative primary health outlets, then the same government payment should be applied to that service, regardless of the specific primary health professional involved.

Agree  Disagree

Make a comment

## Chapter 5: The Regulation of Pharmacy for Medicine Supply

**OPTION 5-1: LOCATION RULES – REMOVAL AND REPLACEMENT**

*Given the Government’s recent commitment in the 2017/18 Budget to continue the current pharmacy location rules, the Panel considers that options 5-1, 5-2 and 5-3 are no longer immediately*

*relevant to this Review. They have been presented but will not be considered further by the Panel. However, the Panel will continue to consider options to modify the location rules that have been put forward on the assumption that the current location rules will be retained*

[Finding - REFORMS TO PHARMACY LOCATION RULES](#)

Certain aspects of the pharmacy location rules are limiting competition and are unnecessary in some areas.

[OPTION 5-1: LOCATION RULES – REMOVAL AND REPLACEMENT](#)

The government should remove the location rules for community pharmacies. It should replace the location rules with one of the alternatives presented in Options 5-2 and 5-3.

Agree  Disagree

**OPTION 5-2: LOCATION RULES – ALTERNATIVE 1 FOR URBAN LOCATIONS**

*Given the Government’s recent commitment in the 2017/18 Budget to continue the current pharmacy location rules, the Panel considers that options 5-1, 5-2 and 5-3 are no longer immediately relevant to this Review. They have been presented but will not be considered further by the Panel. However, the Panel will continue to consider options to modify the location rules that have been put forward on the assumption that the current location rules will be retained*

[Finding - REFORMS TO LOCATION RULES](#)

Certain aspects of location rules are limiting competition and are unnecessary in some areas.

[OPTION 5-2: URBAN LOCATION RULES – ALTERNATIVE 1](#)

**5.2. ALTERNATIVE 1:** The government will undertake an analysis (as per Option 4-2) to determine and implement efficient remuneration for the dispensing of PBS medicines. Following the implementation of efficient remuneration and a suitable transition period (no later than 31 December 2020), the government should remove any restrictions to limit the ability of any qualified pharmacist or pharmacists to establish a pharmacy to dispense PBS medicines at any location in urban areas.

Agree  Disagree

Make a comment

## OPTION 5-2: LOCATION RULES – ALTERNATIVE 2 FOR URBAN LOCATIONS

*Given the Government’s recent commitment in the 2017/18 Budget to continue the current pharmacy location rules, the Panel considers that options 5-1, 5-2 and 5-3 are no longer immediately relevant to this Review. They have been presented but will not be considered further by the Panel. However, the Panel will continue to consider options to modify the location rules that have been put forward on the assumption that the current location rules will be retained*

### [Finding - REFORMS TO LOCATION RULES](#)

Certain aspects of location rules are limiting competition and are unnecessary in some areas.

### [OPTION 5-2: ALTERNATIVE 2](#)

The government should replace the location rules in urban areas in two stages:

1. For the first five years, the government should:
  - a. establish an independent statutory authority (the Pharmacy Location Board (PLB)) of five members, at least two of whom are persons who have been, but are no longer, engaged either directly or indirectly in community pharmacy. No PLB member may be a current pharmacy owner. Any pharmacist who wishes to establish a new pharmacy in an urban location must apply to the PLB for a provider number. The PLB will assess the application, 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
  - b. undertake an analysis (as per Option 4-2) to determine and implement efficient remuneration for the dispensing of PBS medicines.
2. Prior to the end of the five year period, the government should assess whether the PLB is required in urban areas, or whether consumer access to PBS medicines would be appropriately served by removing any remaining restrictions that limit the ability of any qualified pharmacist or pharmacists to establish a pharmacy to dispense PBS medicines at any location in urban areas.

Agree  Disagree

Make a comment

## OPTION 5-2: LOCATION RULES – ALTERNATIVE 3 FOR URBAN LOCATIONS

*Given the Government’s recent commitment in the 2017/18 Budget to continue the current pharmacy location rules, the Panel considers that options 5-1, 5-2 and 5-3 are no longer immediately relevant to this Review. They have been presented but will not be considered further by the Panel. However, the Panel will continue to consider options to modify the location rules that have been put forward on the assumption that the current location rules will be retained*

### [Finding - REFORMS TO LOCATION RULES](#)

Certain aspects of location rules are limiting competition and are unnecessary in some areas.

#### [OPTION 5-2: LOCATION RULES – ALTERNATIVE 3](#)

New pharmacy location rules should be introduced based on existing rules. This includes:

- a. retention of the prohibition within the location rules relating to the co-location of approved pharmacies in supermarkets
- b. the establishment by the Department of Health and the Guild of a joint working group, with the aim of identifying and addressing any anomalies that have arisen over time, to ensure the location rules remain responsive to the evolving needs of the community.

Agree  Disagree

Make a comment

#### **OPTION 5-3: LOCATION RULES – ALTERNATIVE 1 FOR NON-URBAN LOCATIONS**

*Given the Government’s recent commitment in the 2017/18 Budget to continue the current pharmacy location rules, the Panel considers that options 5-1, 5-2 and 5-3 are no longer immediately relevant to this Review. They have been presented but will not be considered further by the Panel. However, the Panel will continue to consider options to modify the location rules that have been put forward on the assumption that the current location rules will be retained*

### [Finding - REFORMS TO LOCATION RULES](#)

Certain aspects of location rules are limiting competition and are unnecessary in some areas.

#### [OPTION 5-3: ALTERNATIVE 1](#)

The government should replace the pharmacy location rules in non-urban areas by establishing an independent statutory authority (the Pharmacy Location Board (PLB)) of five members, at least two of whom are persons who have been, but are no longer, engaged either directly or indirectly in community pharmacy. No PLB member may be a current pharmacy owner. Any pharmacist who wishes to establish a new pharmacy in a non-urban location would be required to apply to the PLB for a provider number. 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.

The PLB will also work with the local Primary Health Network (PHN) in any relevant region to determine areas where there is a lack of appropriate pharmacy services and work with the PHN to initiate a tender to seek options by pharmacists to provide the identified services. The government will appropriately fund the PHNs and the PLB to carry out these tenders and, where relevant, to provide any subsidy determined through the tender process.

Agree  Disagree

Make a comment

Given limited access to dosing points for MATOD services in some parts of the Goulburn Valley, consideration has been given to development of a “friendly society” pharmacy in the area like those operating in Eaglehawk<sup>23</sup> and Bendigo<sup>24</sup> by the Hume PABN. There are 100 Friendly Society pharmacies around Australia.

Although the Shepparton community may be able to meet the requirements of being a Friendly Society licensee, it is difficult to obtain approval to open a new PBS dispensing pharmacy in a developed area such as Shepparton. This is because there are stringent rules governing location in relation to existing pharmacies. Most ‘new’ pharmacies are existing pharmacies which have moved location within the rules governing moving a pharmacy with the exceptions being genuinely new pharmacies in greenfield development sites which are supporting a new population and other amenities such as a major shopping centre.<sup>25</sup> The full rules are available in the [Department of Health Pharmacy Location Rules Applicant's Handbook 2015](#).

We are aware that there is some work being undertaken to determine the feasibility of creating dedicated dosing points. However, similar to the establishment of a new pharmacy these would require special State and Federal approval to exist as it is also not within the rules to open pharmacies with very limited services.<sup>26</sup>

To enable equitable access to MATOD services either all pharmacies should be required to provide these services as part of their minimum service delivery requirements or the location rules need to change in order to allow the establishment of a new pharmacy willing to offer these services

The involvement of the PHN would ensure local knowledge could be applied to this decision.

### **OPTION 5-3: LOCATION RULES – ALTERNATIVE 2 FOR NON-URBAN LOCATIONS**

*Given the Government’s recent commitment in the 2017/18 Budget to continue the current pharmacy location rules, the Panel considers that options 5-1, 5-2 and 5-3 are no longer immediately relevant to this Review. They have been presented but will not be considered further by the Panel. However, the Panel will continue to consider options to modify the location rules that have been put forward on the assumption that the current location rules will be retained*

#### [Finding - REFORMS TO LOCATION RULES](#)

Certain aspects of location rules are limiting competition and are unnecessary in some areas.

#### [OPTION 5-3. ALTERNATIVE 2](#)

New pharmacy location rules should be introduced based on existing rules. This includes:

<sup>23</sup> <http://www.eufs.com.au/>

<sup>24</sup> <https://bendigoufs.com.au/about-us/>

<sup>25</sup> Adapted from email received from Tim Griffiths Hume PABN Coordinator 17 June 2016

<sup>26</sup> Ibid

- a. retention of the prohibition within the location rules relating to the co-location of approved pharmacies in supermarkets
- b. the establishment by the Department of Health and the Guild of a joint working group with the aim of identifying and addressing any anomalies that have arisen over time, to ensure the location rules remain responsive to the evolving needs of the community.

Agree  Disagree

Make a comment

#### **OPTION 5-4: LOCATION RULES – POLICY OBJECTIVE**

##### [Finding - REFORMS IF THE LOCATION RULES ARE RETAINED IN SOME PARTS OF AUSTRALIA](#)

The policy in respect of pharmacy location rules is unclear. This results in different interpretations of their purpose and intent and reduces the ability to monitor performance and the achievement of outcomes.

##### [OPTION 5-4: LOCATION RULES – POLICY OBJECTIVE](#)

If the government retains the location rules (or some version of these rules) following the end of the Sixth Community Pharmacy Agreement then the policy objective of these rules should be clearly stated and the rules modified to ensure that the desired outcomes are achieved over the medium term.

The objective of the pharmacy location rules should be to assist the Australian consumer to ensure equitable and affordable access to medicines for all Australians, consistent with the National Medicines Policy, with evidence to demonstrate the achievement of this objective.

Agree  Disagree

Make a comment

#### **OPTION 5-5: LOCATION RULES – OWNERSHIP & LOCATION**

##### [Finding - OVERLAPPING OWNERSHIP AND LOCATION OF PHARMACIES](#)

The pharmacy location rules have not established robust competition between independent pharmacies in some locations. Rather, in some locations, either individual pharmacists or small

groups of pharmacists have been able to monopolise some or all pharmacies. This is inconsistent with the objective of Australia’s competition laws.

[OPTION 5-5: LOCATION RULES – OWNERSHIP & LOCATION](#)

In areas where the location rules are maintained, any group of two or more pharmacies each of which is located within 1.5 km 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 nominal ‘location’ of this single pharmacy would be the location of the pharmacy within the group that had the smallest turnover (in terms of the number of PBS prescriptions dispensed) in 2016.

For avoidance of doubt, a group of pharmacies is considered to have an overlapping ownership if any individual, or set of individuals have ownership of at least 20% of the equity in each of the community pharmacies in that group.

It is also considered that this option be implemented five years after this review, in order to allow an appropriate timeframe for transition.

The oversight of this option should be undertaken by the Australian Competition and Consumer Commission.

Agree  Disagree

Make a comment

**OPTION 5-6: INFORMATION ON PHARMACY OPENING HOURS**

[Finding - PHARMACY ACCESS AND OPENING HOURS](#)

In urban Australia, there are pharmacies currently operating with extended hours (from around 7 am to 11 pm); however, consumers often lack information about these pharmacies and they are not evenly spread through urban areas.

[OPTION 5-6: INFORMATION ON PHARMACY OPENING HOURS](#)

The Pharmacy Atlas (refer Option 2-5) should include information on pharmacy opening hours.

Agree  Disagree

Make a comment

## OPTION 5-7: 24 HOUR PHARMACY INFORMATION AND RELATED SERVICES

### [Finding - PHARMACY ACCESS AND OPENING HOURS](#)

In urban Australia, there are pharmacies currently operating with extended hours (from around 7 am to 11 pm); however, consumers often lack information about these pharmacies and they are not evenly spread through urban areas.

### [OPTION 5-7: 24-HOUR PHARMACY INFORMATION AND RELATED SERVICES](#)

The government should investigate the feasibility of a 24-hour telephone and/or internet 'pharmacy hotline' to provide medicine information to consumers Australia-wide.

Agree  Disagree

Make a comment

## OPTION 5-8: RURAL PHARMACY MAINTENANCE ALLOWANCE

### [Finding - THE RURAL PHARMACY MAINTENANCE ALLOWANCE](#)

There are a number of anomalies in the administration of RPMA payments that serve to reduce the effectiveness of the program.

### [OPTION 5-8: RURAL PHARMACY MAINTENANCE ALLOWANCE](#)

In situations where there is more than one pharmacy within a 10- kilometre area that is receiving the Rural Pharmacy Maintenance Allowance (RPMA), the government should:

- a. only make payments to a single pharmacy in the area
- b. ensure that the pharmacy that receives the RPMA is based on the services offered by that pharmacy, including services, opening hours and location (centrality and ease of access)
- c. ensure that the selection process is transparent.

Agree  Disagree

Make a comment

If this allowance is provided then as part of minimum service levels MATOD services should be provided as a requirement of receiving the payment.

Additionally, it is essential that the community and service providers understand which community pharmacy receives this allowance and all the services that it goes towards supplying.

Where community pharmacies are not providing MATOD services and there are no alternatives in the township, this is exclusionary and discriminating practice which should not be supported.

People who are prescribed MATOD have made a decision to change their life and need to be supported to do this. Taking this step means that they are more likely to have positive health outcomes as well as re-engage in their community and engage/re-engage in employment

#### **OPTION 5-9: HARMONISING PHARMACY LEGISLATION**

##### [Finding - VARIATIONS AMONG STATE AND TERRITORY REGULATORY ARRANGEMENTS RELATING TO COMMUNITY PHARMACY](#)

The community pharmacy sector is subject to a complex array of regulations under state and territory governments, as well as the Australian Government.

##### [OPTION 5-9: HARMONISING PHARMACY LEGISLATION](#)

As early as practicable, the Australian Government through the Australian Health Minister's Advisory Council, should seek to harmonise all state, territory and commonwealth pharmacy regulations to simplify the monitoring of pharmacy regulation in Australia for the safety of the public.

In the long term a single pharmacy regulator should be considered. As an interim measure, state and territory registering bodies need to coordinate with Australian Health Practitioner Regulation Agency to ensure that pharmacy regulations are being adequately monitored for the best practice of pharmacy and the safety of the public.

Agree  Disagree

Make a comment

##### [OPTION 5-10: TRANSPARENCY](#)

It is important that for each program that involves public funding, there is sufficient transparency as to the amount of funding provided by the government and the amount of funding provided by the recipient of that service.

Agree  Disagree

Make a comment

#### OPTION 5-11: EVALUATION MECHANISMS

The government should require the establishment of appropriate evaluation mechanisms to measure compliance and performance.

Agree  Disagree

Make a comment

## Chapter 6: The Distribution of Medicines to Community Pharmacy

**NB: I have not answered any questions in this section**

### **OPTION 6-1: COMMUNITY SERVICE OBLIGATION REMOVAL, RETENTION OR REPLACEMENT ALTERNATIVE 1**

#### Finding - ENSURING TIMELY MEDICINE ACCESS

Current supply chain arrangements (terms of trade and supply conditions) involve unnecessary regulation, as well as Community Service Obligation payments that appear unconnected with relevant distribution costs and may be leading to wholesale margins that are higher than necessary for an effective and efficient supply chain.

#### OPTION 6-1: COMMUNITY SERVICE OBLIGATION REMOVAL, RETENTION OR REPLACEMENT ALTERNATIVE 1

The Government should remove the Community Service Obligation (CSO) and suppliers of PBS listed medicines should be placed under an obligation to ensure delivery to any community pharmacy in Australia within a specified period of time (generally 24 hours), with standard terms of trade offered to the pharmacy (such as four weeks for payment) using one or more of a specified panel of wholesalers as follows:

- a. an initial Panel of around five wholesalers would be approved. It is expected that these will include the existing three national CSO wholesalers.
- b. the relevant terms of trade and other supply conditions may vary between medicines. For example, for high-cost medicines or medicines that have cold-chain supply requirements, the supply conditions may differ from those for low-cost medicines, to ensure that there is not an unreasonable risk or cost placed on either community pharmacy or consumers
- c. a cap should be placed on the amount that a community pharmacy contributes to the cost of a medicine. This cap should be in the range of \$700 to \$1,000.

Agree  Disagree

Make a comment

**OPTION 6-1: COMMUNITY SERVICE OBLIGATION REMOVAL, RETENTION OR REPLACEMENT ALTERNATIVE 2**

[Finding - ENSURING TIMELY MEDICINE ACCESS](#)

Current supply chain arrangements (terms of trade and supply conditions) involve unnecessary regulation, as well as CSO payments that appear unconnected with relevant distribution costs and may be leading to wholesale margins that are higher than necessary for an effective and efficient supply chain.

[OPTION 6-1: CSO REMOVAL, RETENTION OR REPLACEMENT ALTERNATIVE 2](#)

The government should retain the current CSO arrangements, but ensure all service standards, such as the 24 hour rule, are uniformly implemented.

Agree  Disagree

Make a comment

**OPTION 6.1: CSO REMOVAL, RETENTION OR REPLACEMENT ALTERNATIVE 3**

[Finding - ENSURING TIMELY MEDICINE ACCESS](#)

Current supply chain arrangements (terms of trade and supply conditions) involve unnecessary regulation, as well as Community Service Obligation payments that appear unconnected with relevant distribution costs, and may be leading to wholesale margins that are higher than necessary for an effective and efficient supply chain.

[OPTION 6-1: COMMUNITY SERVICE OBLIGATION REMOVAL, RETENTION OR REPLACEMENT ALTERNATIVE 3](#)

The government should conduct a separate review of the CSO to ensure current arrangements demonstrate value for money. A review would also present an opportunity to potentially streamline existing or remove unnecessary regulation. Such a review would require the full cooperation of the CSO Distributors which would provide financial data and other relevant information to government.

Agree  Disagree

Make a comment

### **OPTION 6-2: SUPPLY OF HIGH COST MEDICINES**

#### [Finding - PROCEDURES AND REMUNERATION FOR THE SUPPLY OF HIGH COST MEDICINES](#)

The supply of complex and high cost medicines does not sit well within existing supply chain and pharmacy remuneration arrangements. Stocking these medicines is of significant concern for a number of pharmacies.

#### [OPTION 6-2: SUPPLY OF HIGH-COST MEDICINES](#)

In line with Option 6-1, patients should be able to receive high-cost medicines from the community pharmacy of their choice. A cap should be placed on the amount that a community pharmacy contributes to the cost of a medicine. This cap should be in the range of \$700 to \$1,000, so that all PBS-approved community pharmacies can supply all PBS medicines required by the public.

Agree  Disagree

Make a comment

## Chapter 7: Future Community Pharmacy Agreements

**NB: I have not answered any questions in this section**

### **OPTION 7-1: SCOPE OF COMMUNITY PHARMACY AGREEMENTS – DISPENSING**

#### [Finding - THE COMMUNITY PHARMACY AGREEMENT PROCESS](#)

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.

#### [Option - OPTION 7-1: SCOPE OF COMMUNITY PHARMACY AGREEMENTS – DISPENSING](#)

The scope of discussions under future Community Pharmacy Agreements should be limited to the remuneration and associated regulations for community pharmacy for the dispensing of medicines under PBS subsidy and related services, including the pricing to consumers for such dispensing.

Agree  Disagree

Make a comment

**OPTION 7-2: SCOPE OF COMMUNITY PHARMACY AGREEMENTS – WHOLESALING**

[Finding - THE COMMUNITY PHARMACY AGREEMENT PROCESS](#)

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

[OPTION 7-2: SCOPE OF COMMUNITY PHARMACY AGREEMENTS – WHOLESALING](#)

The government should ensure that the regulation and remuneration of wholesaling of PBS listed medicines should not form part of future Community Pharmacy Agreements.

Agree  Disagree

Make a comment

**OPTION 7-3: SCOPE OF CPA – PROGRAMS AND SERVICES**

[Finding - THE COMMUNITY PHARMACY AGREEMENT PROCESS](#)

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

[OPTION 7-3: SCOPE OF COMMUNITY PHARMACY AGREEMENTS - PROGRAMS AND SERVICES](#)

The regulation and remuneration of programs offered by community pharmacies should not form a part of future Community Pharmacy Agreements.

Agree  Disagree

Make a comment

**OPTION 7-4: COMMUNITY PHARMACY AGREEMENTS – PARTICIPANTS**

[Finding - THE COMMUNITY PHARMACY AGREEMENT PROCESS](#)

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

[OPTION 7-4: COMMUNITY PHARMACY AGREEMENT PARTICIPANTS](#)

The parties invited to participate in future Community Pharmacy Agreements must include the Pharmacy Guild of Australia (as a representative of the majority of approved pharmacists), the Consumers Health Forum of Australia (as the peak representative consumer body in Australia on health-related matters) and the Pharmaceutical Society of Australia (as the peak representative body for pharmacists in Australia).

Agree  Disagree

Make a comment

## Chapter 8: Health Programs Offered by Community Pharmacy

**OPTION 8-1: DOSE ADMINISTRATION AIDS – STANDARDS**

[Finding - LEVERAGING PHARMACY AND PHARMACIST CAPABILITY](#)

Significant opportunities exist for the better use of community pharmacy and pharmacist programs and services in improving the health of Australians.

[OPTION 8-1: DOSE ADMINISTRATION AIDS – STANDARDS](#)

The government should establish clear, enforceable minimum standards for the supply of medicines by community pharmacies, including for Dose Administration Aids (DAAs). There should be appropriate compensation provided to community pharmacies for the dispensing of medicines using DAAs (in recognition that this tends to be a higher cost activity than dispensing in manufacturer’s packaging).

Agree  Disagree

Make a comment

## **OPTION 8-2: COMMUNITY PHARMACY PROGRAM – KEY PRINCIPLES**

### [Finding - LEVERAGING PHARMACY AND PHARMACIST CAPABILITY](#)

Significant opportunities exist for the better use of community pharmacy and pharmacist programs and services in improving the health of Australians.

### [OPTION 8-2: COMMUNITY PHARMACY PROGRAM – KEY PRINCIPLES](#)

The range of programs offered by community pharmacy should be underpinned by the following principles:

- a. be based on evidence of effectiveness
- b. may or may not involve government paying for some or all of the cost of the service to some or all patients
- c. may in some cases be offered on the basis of each community pharmacy choosing whether or not to offer the program (with all community pharmacies being eligible to offer the program). In other cases the program will only be available (with government payment) through pharmacies/pharmacists that are selected by the government (for example, through a tender process, or as a result of negotiation between the government and the relevant pharmacies or pharmacists)
- d. for some programs, government remuneration for the program will be channelled through the users of the program (or their representatives) so that the users will decide which community pharmacies (or pharmacists) to use to deliver the program
- e. adequate funding for the above needs to be found outside PBS expenditure.

Agree  Disagree

Make a comment

If MATOD services are to continue not being included in the PBS

## Chapter 9: Indigenous Medicine Access

### **OPTION 9-1: ACCESS TO MEDICINES PROGRAMS FOR INDIGENOUS AUSTRALIANS**

### [Finding - s100 REMOTE AREA ABORIGINAL HEALTH SERVICES PROGRAM](#)

Access to medicines for Indigenous Australians under the section 100 RAAHS Program and the CTG PBS Co-Payment Measure has created a number of challenges in ensuring a consistent level of care to the intended patient group.

#### [OPTION 9-1: ACCESS TO MEDICINES PROGRAMS FOR INDIGENOUS AUSTRALIANS](#)

The access to medicines programs for Indigenous Australians under the section 100 RAAHS Program and the Closing the Gap PBS Co-payment Measure should be reformed so that the benefits to the individual follow that individual, regardless of where the prescription is written or dispensed.

Agree  Disagree

Make a comment

#### **OPTION 9-2: ABORIGINAL HEALTH SERVICE PHARMACY OWNERSHIP AND OPERATIONS**

##### [Finding - PHARMACY OWNERSHIP AND OPERATIONS BY ABORIGINAL HEALTH SERVICES](#)

The current inability of an AHS to operate a community pharmacy poses a significant risk to patient health in some rural and remote areas of Australia.

#### [OPTION 9-2: ABORIGINAL HEALTH SERVICE PHARMACY OWNERSHIP AND OPERATIONS](#)

All levels of government should ensure that any existing rules that prevent an Aboriginal Health Service (AHS) from owning and operating a community pharmacy located at the AHS are removed. As a transition step, these changes should first be trialled in the Northern Territory, and governments should work together with any AHS that wishes to establish a community pharmacy.

Agree  Disagree

Make a comment

Consideration should also be given to trialling these in a rural/regional settings such as Shepparton/Mooroopna.

While the local AHS has a partnership agreement with a local community pharmacy to enable dispensing of some medications at the service, the capacity to own and operate a community pharmacy would facilitate access and information in culturally appropriate ways as well as address affordability issues for ATSI members of the community, some of whom go without essential medications, despite them being prescribed.

## Chapter 10: Specific Issues

### **OPTION 10-1: s100 HIGHLY SPECIALISED MEDICINES**

#### [Finding - SECTION 100 HIGHLY SPECIALISED MEDICINES](#)

The distinction between highly specialised and other PBS medicines is causing administrative inefficiencies and unnecessary risks to patient health.

[OPTION 10-1: s100 HIGHLY SPECIALISED MEDICINES](#)

The Highly Specialised Medicines (HSD) Program under s100 of the *National Health Act 1953* (Cth) should be reformed to remove the distinction between s100 (Community Access) and other medicines listed within section 100 HSD arrangements. This should include, for example, harmonising access and fees regardless of where the medicine is dispensed.

Agree  Disagree

Make a comment

However, MATOD medicines need to be included on the PBS. This would ensure pharmacists are remunerated in line with other highly specialised medicines they dispense.

It is essential that appropriate training is provided for dispensing MATOD medications and managing a MATOD service.

**OPTION 10-2: CHEMOTHERAPY COMPOUNDING – PAYMENTS**

[Finding - CHEMOTHERAPY COMPOUNDING - PAYMENTS](#)

The rationale for differential payments for compounding of chemotherapy preparations is not substantiated on the basis of patient risks or health outcomes for medicines that must meet an appropriate level of quality, whether prepared at a TGA licensed or non-TGA-licensed facility.

[OPTION 10-2: CHEMOTHERAPY COMPOUNDING – PAYMENTS](#)

There should be no difference in the remuneration paid by the government for the compounding of chemotherapy medicines in any facility that meets the minimum quality and safety standards. In particular, there should be no additional payment for medicines that are prepared in a facility that exceeds the minimum standards.

Agree  Disagree

Make a comment

**OPTION 10-3: CHEMOTHERAPY COMPOUNDING - UNIFORM MINIMUM STANDARDS**

[Finding - CHEMOTHERAPY COMPOUNDING - PAYMENTS](#)

The current standards for the compounding of chemotherapy medicines in community pharmacy and other facilities appear to be overly complex. The oversight currently includes legislation, codes and guidelines. The overlap and inconsistency of these across Australia do not provide clear rules or guidance for compounders.

[OPTION 10-3: CHEMOTHERAPY COMPOUNDING - UNIFORM MINIMUM STANDARDS](#)

There should be a clear, uniform set of minimum quality standards for all approved chemotherapy compounding facilities based in a hospital, a community pharmacy or elsewhere. These minimum standards should:

- a. not require that a compounding facility be Therapeutic Goods Administration (TGA) licensed to meet the minimum requirements
- b. mean that a TGA-licensed facility clearly satisfies the minimum standards
- c. reflect the variety of settings that are appropriate for the preparation of chemotherapy medicines, including 'urgent' preparation in a hospital setting or a community pharmacy setting.

Agree  Disagree

Make a comment

**OPTION 10-4: CHEMOTHERAPY COMPOUNDING PRACTICE MODELS**

[Finding - CHEMOTHERAPY COMPOUNDING PRACTICE MODELS](#)

There are a number of good practice chemotherapy compounding models that can be leveraged to improve existing compounding arrangements.

[OPTION 10-4: CHEMOTHERAPY COMPOUNDING PRACTICE MODELS](#)

Existing practice models in place in public hospitals for limited trade of medicines prepared onsite, such as radio pharmaceuticals, should be considered for providing greater access to chemotherapy arrangements.

Agree  Disagree

Make a comment

## OPTION 10-5: GENERIC MEDICINE - LISTING ARRANGEMENTS

### [Finding - TIGHTENING THE LISTING OF GENERIC MEDICINE](#)

A more targeted approach to listing PBS medicines can improve supply chain efficiency and reduce costs to the Australian community.

### [OPTION 10-5: GENERIC MEDICINE - LISTING ARRANGEMENTS](#)

When an 'original' (or 'branded') medicine comes off patent then the government should hold a tender for the listing of generic versions of the medicine. The government should limit the number of generic versions of a particular medicine to be listed to a relatively small number that is still sufficient to allow for patient choice (e.g. four generics and the original brand of the medicine). The chosen generics should be those best able to meet the distribution and other conditions required by the government at the least cost to the PBS.

Agree  Disagree

Make a comment

## OPTION 10-6: MACHINE DISPENSING

### [Finding - MACHINE DISPENSING](#)

Overseas experience has demonstrated advantages in the use of remote dispensing machines.

### [OPTION 10-6: MACHINE DISPENSING](#)

The government should trial the use of machine dispensing in a small number of relevant secure locations in communities that are not currently adequately served by community pharmacy. Such machine dispensing should be appropriately supervised and allow real-time interaction with a remote pharmacist. The range of PBS medicines available through machine dispensing also needs to be limited and should be based on an assessment of risk.

Agree  Disagree

Make a comment

Dispensing machines provide an opportunity to provide equitable access especially in rural areas.

It would be desirable that this access is extended MATOD medications.

Necessarily there would need to be mechanisms to ensure the medication is provided to the appropriate person and that there is capacity for appropriate advice and support either through telephone/skype like applications, as with all medications.

The development of a telephone app could assist this.

