Submission on Pharmacy Remuneration and Regulation Interim report

I request an extension in order to fully examine the Report. The Interim Report at 220 pages was provided on 23 June, a week before community pharmacies do the annual stocktake, additionally our pharmacy is preparing for a QCPP review at the end of July and I do not have sufficient time before the deadline to adequately study and respond.

Some comments about those parts I was able to read, comments in quotes are paraphrased from the Interim Report for brevity.

1. On Page 26, "community pharmacies that increase the payments above the dispensed price, likely raise the pharmacies profits" but p.25 states it is most likely remote pharmacies in PHARIA 3-6 (generally the least profitable) that are most likely to raise prices. The proposal to remove additional, optional fees may decrease the price to patient but the inability of the pharmacy to compensate for increased costs in remote areas may ultimately lead to inefficiencies through loss of access if the pharmacy closes.

The suggestion that PBS pharmacies because they receive payments from the government, should not be able to charge above a Government fixed fee is at odds with the MBS, where the Government pays a fee based on the service, recommends a patient co-payment and then the doctor is free to charge an additional fee. The government does not limit charges above the statutory fees for the MBS so it does not follow that it should do so for the PBS.

2. Page 34 suggests pharmacy remuneration could be reduced because some pharmacies are able to bear the $1 Copay discount. Presumably pharmacies offering the $1 discount do so in the expectation of increased script volume of increased front of shop sales; if all pharmacies offered the discount then no one could benefit from increased script volume and all would have reduced margins. It does not argue that the existing remuneration is too high to because some pharmacies are able to fore go it.

3. Page 60 suggests a minimum schedule of products all pharmacies be required to stock. The Panel considers pharmacies are agents of the government but the government bears no cost of holding required stock or has no economic risk if the stock goes out of date or has windfall price drops under Price Disclosure. If the suggested schedule of products is required and is always to be held then it would be reasonable for the government to make a on off payment to own that stock.

There would need to be variations in products held by location eg for accessibility PHARIA 3-6 may need a broader range but have less ability to fund them than a metropolitan pharmacy.

4. Option 4.1 onerous ongoing requirements for every pharmacy to provide accounting information to establish best practice benchmark cost of dispensing would seem to be a return to the inefficiency and inequality under the PBRT that made remuneration decisions 6 months in arrears and resulted in 6 monthly variations to the dispensing fees and markups. This lack of certainty in projecting income led to the replacement by the 5 year CPA Guild-Government Agreements. Annual benchmarking would seem to me to be a return to a system rejected due to its inherent inefficiencies

5. I have not had time to review Option 6.2 but agree with the panels observations that GST on high cost medications causes difficulty. In my earlier submission I suggested that items over a certain price point eg $1500 could be GST free throughout the supply chain. I would like to now suggest that all PBS medications be GST free throughout.

Currently GST is charged and reclaimed at each step in manufacture and distribution. Pharmacies pay GST on purchases of medication but do not charge GST on the sale, recouping the tax through monthly or quarterly BAS.

In my pharmacy for example we do quarterly BAS, so GST on January purchases is paid through wholesaler statements in early February but recouped and into our bank account late April or May. As this occurs each quarter the ATO permanently holds a significant amount of money that is unavailable for the pharmacy to use.

When the GST was introduced small businesses were intended to have positive cash flow form GST and this was to be used as compensation for the additional accounting required. Pharmacies have a significant negative cash flow due to GST and this is inequitable. It is also inefficient in that all tax collected is ultimately refunded, presumably less the 20% the Report quotes as the cost of collecting tax.

The Government ultimately repays all of the GST but effectively has permanent loan from community pharmacy that is inequitable and inefficient. When GST was introduced certain items were classified as GST free throughout the supply chain by Ministerial determination eg Folic Acid tablets and some bandages and dressings. There is no reason that all PBS items could be treated equally by another Ministerial determination. (by GST free I mean no no GST on purchase or on sale).

6. The Panel is concerned on Page 75 about the large number of micro and small pharmacies as described by RSM. However small business tax concessions apply by government definition to businesses with a turnover of less than $2 million……on this basis 42% of pharmacies are not small. Similarly the 4% of pharmacies with turnover exceeding $10 million could be considered outlier with little relevance.

7. I find the RSM table 6 on Page 85 to be arbitrary. It may well argue for a flat fee but it clearly shows that $10 is insufficient and could not be used to justify the lower end of the Panel's range of $9 to $11.50.

A previously I request an extension of time to fully examine the Interim Report as my reading to this point has highlighted issues of concern to me.

Your sincerely

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Pharmacy Regulation and Remuneration Interim Review Submission Pt 2

Many thanks for providing additional time to add to my earlier submission of 23/7/17. I agree to this submission also to be published.

1. Option 2-3. I agree that the PBS Safety Net should include payments for opioid dependence treatments by allocating a PBS code; failing that they could be included in the Medicare Safety Net (with an MBS code) which is already administered by Medicare. Presumably dosing at a doctor's clinic is already funded by an MBS service..... as per Option 4-6 the Panel proposes that the same service provided by different providers should receive the same remuneration. This would mean that funding would be transferred from states to federal government.

2. Option 2-5, 5-6, 5-7. The details proposed for the Pharmacy Atlas are largely available from current sources eg the Guild, marketing groups, white and YellowPages Online and also via Apps like MedAdvisor. Most people are sufficiently tech savvy to find required information currently, an additional resource is unlikely to improve access.

Well targeted advertising programs may be more suited than the Atlas to increasing consumer knowledge of programs eg influenza vaccination over winter months , DAAs or medical certificates.

3. Option 2.6. Auditing the provision of CMIs is an additional administrative task with a cost of time involved and detracting from time available to interact with the patient about their medication. As previously submitted it would be an additional onerous task to interrogate the patient as to whether the doctor had supplied a CMI or it was obtained online or through an App like MedAdvisor , whether the patient is just too sick to be bothered or if they are happy with the information provided orally by their doctor and pharmacist.

Technology has largely moved on from paper based CMIs already or will do so soon and again an advertising program would be more suitable to increase uptake by patients. An advertising program could promote electronic access to CMIs via the nps.org.au website and created or existing Apps like MedAdvisor and also contact details on the various consumer medication and poison hotlines, and also the availability of CMI in other languages.

Another failing of an audit is that it would monitor delivery of CMIs rather than comprehension by patients, the relevant outcome.

4. Page 48 uses an example of how electronic prescribing could improve 'equity of access' for a client living 50kms from a pharmacy showing a $34.05 saving for each script purchased from an online pharmacy.

The example has a number of deficiencies, the first being this would argue for REMOTE prescribing via phone or computer link between doctor and patient rather than electronic prescribing replacing a paper script. (online consultations already exist with scripts being faxed and then posted but the AMA could probably best argue if this is a suitable alternative to a face to face examination for other than routine script refills or uncomplicated conditions)

Accepting that the Panel is considering only electronic prescribing then if urgent the patient would need to drive to the doctor and would then see a nearby pharmacy- the $43 travel cost would be allocated to visiting the doctor- the real reason for the trip. If non-urgent, say a $6.30 regular medication, most likely the patient would wait until a regular town visit say for $400 bulk groceries and $100 of petrol.....travel cost for the prescription is now 54 cents, reduced again when including the doctor visit. If the example patient is prepared to wait for an online pharmacy to deliver then they are probably organised enough to wait for the next visit to town.

Of course remote patients already use online pharmacies to access prescription medicines but this may be for cost savings or convenience. In the case of electronic prescribing there would only be a saving of $1 postage in not sending the paper prescription but no increased equity of access.

To me it seems the cost is less than 54 cents in driving time as the example assumes the medicines are non-urgent versus $8.95 delivery fee (unchanged for paper or electronic script) less a dollar postage ie in the example the online option is $7.41 more expensive, not $34.05 cheaper.

The final paragraph states the consumer would save $34.05 for EACH script dispensed online- clearly, even if there was any saving rather than a $7.41 loss, it would only be a single saving per delivery of multiple items not for each item as stated.

The amounts in my example are arbitrary but no more than that provided in the example. The example seems to me to be contrived to promote online pharmacy and irrelevant to a discussion of equity of access re electronic prescribing and I trust the deficiencies are obvious enough that it would not be included in the Panel's final report. I am not arguing about the benefits of electronic prescribing, just the example which is more used to justify online rather than community pharmacy.

The Panel is aware of the ageing population, increased health issues including mental health and suicide in the bush and separately aware of the difficulties of remote dispensing in achieving quality use of medicines and in providing additional services; the patient may well receive health and social benefits in maintaining face to face contact with their 'local' pharmacy discussing side effects, compliance, allergies, etc rather than an online service.

Equity of access could be better served by providing more and better services rather than promoting faceless online delivery.

5. Option 2-8. Electronic Medication Records are desirable but would require the complete replacement of the PBS and MBS which are designed as federal government payment systems and not as condition and medication tracking programs for State Health departments. There is currently no real time evaluation to report on interactions with medications dispensed at other pharmacies, doctor shopping, contraindications , etc.

Rather than writing good health maintenance programs to improve QUM, pharmacies pay fees to software vendors to rewrite their programs to accomodate pricing changes. I suggest the Government provides an open source minimum pricing/ payments program that leaves software vendors free to provide programs that would benefit patients rather than just facilitate payment.

6. Page 112. The Panel notes many supermarket chains have expanded their offering of complementary medicines and vitamins and recommends collocation of pharmacies with supermarkets. The Panel previously expressed concern that Pharmacy legitimised the sale of some dubious CMs- this would be an even greater issue if pharmacies collocated with unregulated supermarkets, particularly since many consumers currently believe products sold in supermarkets must be safe despite health risks of promoted products like paracetamol, ibuprofen, aspirin, acyclovir,etc.

7. Option 7-3. I don't agree that the CPA only determine dispensing remuneration. Most of the Professional Payments relate directly to dispensing eg staged supply, DAAs, clinical interventions, MedsChek and it is reasonable to include them with dispensing remuneration rather than be determined by separate Advisory Councils.

Current PPI payments may be inadequate as suggested by the Panel on Page 137 but only exist because of previous CPAs. Advisory Councils are likely to result in duplication of analysis and delayed decisions in seeking agreement of multiple bodies, with little recourse to fix problems that may become obvious later.

An example would be DAAs provided to eligible Veterans and widows that took, from memory as I participated in the trials, about 3 years to start; the fee for payment established in 2008 (again from memory) has not been adjusted since. Similarly the government funded Return of Unwanted Medicine RUM program has run for I believe nearly 2 decades with no payment to community pharmacy ever. A more recent example of the failure of external bodies to provide adequate remuneration to community pharmacy is the 2015 6CPA $1 token payment for National Diabetic Supply Scheme NDSS which does not compensate for required stock holding, time involved and an accounting arrangement that is almost impossible to track.

Adequate payment for NDSS should be a topic for the Interim Review but I cannot find it as an Option.

While Option 8-2e suggests funding for non dispensing programs should be found outside of the PBS but this is unlikely given Government's current Budgetary crisis.

Option 8.2d permitting funds to be channelled through user groups resulted in the Diabetes Australia/ NDSS token payment.

8. Option 7-4 to include the Consumer Health Forum as a signatory to future CPAs. As the CHF is government funded there is an issue that it could remain truly independent in negotiations. It is appropriate that the CHF is included in discussions as it is currently but not as a signatory.

Thank you once again for the opportunity to comment on the Interim Review

Sincerely

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