

Review of Pharmacy Remuneration and Regulation

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Dear Mr King and Panel Members,

I appreciate the time and effort you put in this report to review the pharmacy industry in Australia and Ask the right questions to create a better future for the industry and offer better value for customers (Patients).

First, I would like to mention this statement “I am a community pharmacist and a member of PSA but the current submission made by PSA doesn’t represent me and it doesn’t represent many of its members. PSA submission represents PSA and their alliances and agendas which doesn’t necessarily represent the best for the profession or the customers and taxpayers”

I am [REDACTED] a senior pharmacist, registered in Australia since [REDACTED] Practised overseas in [REDACTED] as a pharmacist, pharmacy manager and worked in the industry. I have studied finance, economics, marketing and other subjects as part of my MBA degree at [REDACTED] based on that I believe I know about the ins and outs of this industry.

The Interim report has come up with many valuable questions. I regards to this matter I have done a bit of research to make my comments more valuable.

Also, I have read Rhodes Management reports [1](#) and [2](#) on “The Future of Pharmacy Industry in Australia” among other reports Mainly [Kordamentha Report 2014](#) and National Commission of Audit [NCOA – PBS](#)

Pharmaceutical Society of Australia (PSA) and Pharmacy Guild Submissions (PGA) and Media publications are irrelevant to me and the consumers Because of the following:

- 1- Pharmacy Guild of Australia represents only the interest of its members and that is clear in Monopoly laws “Ownership and Locations rules”
- 2- PSA supports PGA and believe that the community needs more services, this service their relevance as and RTO – The more services a pharmacist can offer, the more trainings they can provide i.e. service their relevance.

I support the idea that CPA “Community Pharmacy Agreements” should not be there. The PGA claim that they provide the framework that delivers PBS services to customers but the truth is “Any Pharmacy MUST provide PBS services to Customers because it is a PBS registered Pharmacy”

In any agreement, customers must have the highest representation, followed by employee pharmacists, doctors, then pharmacy owners – I strongly believe that PSA should not be there in any agreement why? This is because the PSA work for employee pharmacists “We” send them what we need and they should design the required trainings and related materials but not the other way around.

Now, I will try to follow the same sequence in the Questionnaire provided.

1- PRICING VARIATION

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

- A- Pricing should follow a different model and structure. In other countries, we have decided to approve generics only if their price falls below the price of the original Product and if a second generic wanted to enter the market, their price should be less than the price of the previous generic and so on. This will drive generic companies to compete to offer their best price until they reach “Equilibrium Price”
- B- ***Variation in Pricing creates customer confusion and that is true.*** I strongly recommend that if a pharmacy group can sell any of their products at or less than concession co-payment price then this medication should not be subsidised by PBS **BUT** It should still count against patient’s Safety Net e.g. At chemist warehouse Atorvastatin 10mg is \$5.30 “Private script price” if dispensed as Concession it will be \$5.30 and the government will pay the difference which is \$6.56 in this case.
- C- ***I do not agree with \$1 discount*** – the way it is done is not proper. Because patients need to hit 72 scripts to reach their safety net, so they are still paying the same money. Also, many pharmacies do not do it. BUT I can be done by reducing dispensing fees by \$1 then ***“It will be mandatory to all pharmacies to discount it”***
- D- ***General Patient Price “Maximum price” Should be the same as “Maximum Safety Net Price”*** there is no reason to charge more than the max safety net price.
- E- We should also compare our approved prices with Prices in Middle East, Gulf and India. It does not make sense that Harvoni “Hepatitis C treatment” is sold in Egypt for \$280 “three months’ course” and India around \$1000 “Three months’ course” and Here is for approx. \$22,000 for ONE month treatment.

2- Safety Net Recording

It is better to have a national recording system. Rhodes Management reports 1 and 2 they advised ***“Digitisation from Consultation to Collection”***

I believe a National ERP “Enterprise Resource Planning” System should be implemented. This system will improve the following:

- Easier identification of customers,

- Better and easier collaboration between Healthcare professionals
- Avoid duplications,
- Less wasted time especially in communication after patient discharge from hospitals.

Therefore, all dispensing software companies should adjust their software to record patients' data on the cloud as a first step.

- 3- **Labelling is important**, remote dispensing is a great idea especially for those who live in rural and remote areas and do not have access for medicines. We can use other countries experience, German dispensing robots companies have tried this model in Europe and Here in Australia.

All S8 "Opioid pain killers" ***MUST have Label ONE PRINTED on the boxes.*** There is no point to keep sticking it EVERY time we dispense them.

- 4- **CMI printing** – a simple solution can solve the problem; whenever indicated by Dispensing software that it is the first time for a patient to take a certain medication – the software prints CMI without asking the dispensing pharmacist.
- 5- **Electronic Prescriptions** are mandatory in the 21 Century – CPAs are stopping innovation in Pharmacy Industry. A central ERP system connected to All dispensing and consulting software will make it easier to everyone. PGA will oppose most of that because Electronic scripts means that customers can go to any pharmacy but within the current system patients can keep their prescriptions at their nearby chemist "Monopoly". ***Monopoly is also facilitated by "myPharmacyLink" software provided by Guild and MedAdvisor software. These softwares are adjusted to send customers messages to dispense scripts after 20 days i.e customers will get their 6 repeats in 4 months instead of 6 – this means more GP visits and more prescriptions paid for by the government.***

- 6- **REMUNERATION:** the current remuneration system is not fair for taxpayers. Every time prices goes down "PBS price cuts" PGA and PSA try to find more services to get remunerated for. It is not right.

The current pharmacy model in Australia is no Efficient – Location and Ownership rules need to be removed so other companies and supermarkets can enter the competition, offer cheaper prices to

customers, bring innovation to the industry and add a real societal value.

Remuneration MUST be to the PHARMACIST not to the Pharmacy, the pharmacist is the person who does the job, dispensing, counselling, interventions and all services that are done in the chemist. It is done under his name and liability. So, the pharmacist MUST share part of the dispensing FEES (Paid directly to the pharmacist) and paid for the services they do.

The government should not pay for the drop-in number of scripts like this year's budget 2.14% drop in scripts volume falls within accepted statistical variation.

- 7- Location Rules** they MUST be removed to allow more pharmacists open pharmacies. It will never happen that pharmacies will be everywhere because of that but ONLY efficient business models will be able to open and compete. Competition brings prices down, offer more services to customers, longer opening hours i.e. better value and better accessibility. The current location rules restrict supply and inflate prices. Many rural pharmacies do not have all medicines available especially expensive LOW GP items – That is supply restriction. Medicines prices vary from one pharmacy to another – rural and remote pharmacies sell their medicines at higher prices.
- More Pharmacies means better competition, lower prices and longer opening hours (better accessibility).
 - Rhodes Management in their reports 1 and 2 has introduced two Ideas VABESMA and VABEAMA for better SUPPLY and ACCESS in Australia.
 - CSO agreements should not be there. Taxpayers should not fund inefficiency.
 - If supermarkets to enter the market, it will be great for the customers. Supermarket will have an efficient supply chain, better inventory management, can negotiate better prices with pharma companies, open more hours, and will bring innovation to the industry because they have the money to invest on innovation. This in return will be better prices (cheaper – better value), longer opening hours and more pharmacies (better accessibility).

- The Pharmacy Guild can only be consulted on how to implement new location rules because the PGA aim is to keep the current rules in place so any consultation with them regarding changing the current rules will be irrelevant.
- PGA support MONOPOLY – They must sign an agreement with the government to not do nor support any act that may lead to monopoly “myPharmacyLink” is a new monopoly related software released by Guild.
- Pharmacy Atlas is a great idea.
- A pharmacist should not own more than 3 pharmacies in total, this will allow more pharmacists to be pharmacy owners or partners (diversity).
- The Survey about supermarket pharmacies – I believe it was not relevant because we don’t have supermarket pharmacies in Australia – it was more like asking people about mobile phones before having one. If the survey was in the format of “do you trust your pharmacist irrespective of the pharmacy setting, they work at ‘supermarket or private’ then we can find better answers”.
- Rural Pharmacy Allowance: it is ok for the government to support more than rural pharmacy – otherwise the competition will not be fair.
- Transparency in Pharmacy Programs: All pharmacy programs should be run by the government. There is no need for PGA to be in the middle. PGA collects the data and manipulates it to get more funding for services. PGA has created the accreditation QCPP idea so ONLY accredited pharmacies can access government Funds. That is neither right nor fair. All PBS pharmacies MUST be treated the same.

8- **CSO must be removed**

- o Pharmacy wholesalers supply chain in Australia are not efficient – they must bring innovation in – **it is not right not accepted that taxpayers fund inefficiency.** The vast majority of rural pharmacies have early cut off times and will never receive all their orders next day.
- o **Supply of high cost medicines:** supplying high cost and \$100 medicines by community pharmacies has affected cash flow dramatically. I believe if government reimburses Pharmacies their profit/percentage directly and pay the wholesaler the cost of the medicine **BUT a better solution is consignment stock** – consignment stock will be based on bringing in

innovative technologies to wholesalers there can be a national portal for suppliers they can measure stock use in real-time for any suburb, pharmacy or state in Australia.

9- Future of Community Agreements CPAs must be removed and replaced with a new agreement with Patient and Pharmacist at heart. **Consumers and Pharmacists MUST be presented.** PSA doesn't represent Pharmacists "they are a peak body based on a tender but not because they are a peak body" PSA is an RTO – their job is TRAINING ONLY – They should only provide Training when asked by Pharmacists or Pharmacy Board of Australia. PGA represent Pharmacy Owners who are GUILD members but not ALL Pharmacy OWNERS.

○ **Any Agreement Must have Consumers Rep, Pharmacists Rep, Doctors Rep, Pharmacies Rep and Pharmacy Board of Australia(PBA).**

○ The PBA should monitor workload – pharmacies have decided to have one pharmacist and a tech instead of TWO pharmacists – they try to cut back on expenses BUT this can CREATE serious PROBLEMS.

○ **Rhodes Management Report 2 has addressed workloads and the myth of pharmacy services.**

10- Pharmacy Services:

○ **DAA** : I am not sure who provided the data to the government that a single webster pack would cost around \$17.00 but I am ready to take the panel advisors to visit pharmacies randomly to make them check how many packs they pack in a week and the time spent by pharmacist, tech and assistant in packing and checking.

○ **Most consumers pay for webster packs – so why does the government pay for the service again?!!**

○ PSA and GUILD together push to get more services funded so PSA can provide training and PGA help pharmacies get more money.

○ The government should reimburse the **PHARMACIST directly** for the service provided by them, the same like doctors. Bringing more money to an inefficient pharmacy model doesn't serve the patients.

- We have seen and will see how these services are being abused.
- Pharmacy Services MUST be audited by the Government NOT PGA.

11- Indigenous Medicines Access: I agree with the Panel recommendations. Our indigenous people need more care and health services be delivered properly to them. I worked in an indigenous community and there were many barriers.

Specific Issues : I will comment on Machine Dispensing – I believe it is important for RURAL areas where community pharmacies are not available. This should ensure proper access of medicines and can be trialled in a few towns “in all the states to ensure that we get the proper statistical results”

Finally, I would like to thank the panel for the time they put in reading my submission – I will be more than happy to help or meet with the panel if needed.

Kind Regards,

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