Review of Pharmacy Remuneration and Regulation
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2017

The Future of the Pharmacy Industry Part 2a

AN INDEPENDENT PERSPECTIVE – PART 2A –
THE COMPELLING NEED FOR CHANGE – SUBMISSION TO THE KING REVIEW

MICHAEL RHODES – JULY 2017

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The approximate reading time for this document is 120 minutes.

1 Executive Summary

1.1 Context

In June 2017, this document was published as Part "2" (without the Executive Summary) and was authored sight unseen of The King Review (TKR) interim report. This is in addition to the first report we published as an overview commentary on the pharmaceutical industry back in April 2017 (Part "1"). That first report can be found here http://bit.ly/2t9M2Sn. Data and commentary from both of these reports have been quoted in various digital media news sites and publications.

Now THIS report known as Part "2a" is in response to having reviewed TKR interim report (along with the Hall Partners Open Mind Analysis) on the pharmaceutical industry, hence this Executive Summary section is the ONLY addition to the original version 2 report we published.

1.2 Our Summary Response to the Interim King Review

To aid in our contribution of the debate our recommendations are listed below however for the full context of these recommendations both our first report and this report from the Introduction section onward (next) should be read in detail. Many of the recommendations we have made are also in response to the original questions posed by The King Review.

We are in full agreement with many of the recommendations of TKR. As we read the TKR we were somewhat surprised at the information uncovered and the similar nature of the recommendations made, completely independently of each other. However, it should be noted that we go somewhat further in some areas of the debate than TKR does. We do so because we are not constrained by terms of reference that bind us or constrict us and we are not answerable to any pharmacy or retail related body whom wishes to push their agenda. We are also not answerable to any political agenda or pre-disposition that may also restrict our analysis or commentary and have taken the position that the most important consideration in both the debate and commentary is that of societal value and our definitions on this are clear in both our first report and this report.

Our summary of recommendations is noted below, however this is not a substitute for what we have advocated throughout this whole report:

1. **Scrap the CPA and introduce VABESMA (VS1) and VABEAMA (VA1) in May 2020**. We fully agree that the current CPA arrangements do not serve the industry or consumers well and need to be replaced. We also agree that the PGA should not be the only body that represents to government this industry. We advocate the introduction of the consumer centric (VABESMA) Value Based Efficient Supply of Medicines in Australia (supply side agreement) and the (VABEAMA) Value Based Efficient Access to Medicines in Australia (demand side agreement) to replace the outdated CPA model.

2. **Supermarkets should be permitted to enter the market**. In our first report, we called out the fluffy evidence provided by the PGA[i] in the 2014 pre 6CPA submission that asserted a level of distrust exists between consumers and supermarkets entering the pharmacy industry. However, when the PGA survey was conducted by the pharmacists representing the Guild the question was "who is best to trust to dispense medicines pharmacies or supermarkets?" Needless to say the answer was predictable. The analogy we drew was that is like asking consumers of your local barber shop, do you trust them to do the dry-cleaning? Of course, they wouldn't because there are no dry cleaners in the shop! We stated however that if the consumers surveyed were asked (and they were not) "if a registered, qualified and highly trained pharmacist who is subject to the ethical and professional standards all pharmacists are subject to, dispensed medicines from a specially configured portion of the store in a supermarket, would you trust them to do so?", we ascertain that in this scenario the answer would be predictable in the affirmative. We caution both the government and The King Review on any so-called consumer representation that might occur about any lack of support for supermarkets entering the industry because those asking the questions are simply 1) not asking the right question and 2) have a vested interest to ensure supermarkets don't enter the industry. An example of this is the Hall and Partners Open Mind (HPOM) review which outlined a perception of limited support from consumers for supermarket entry (though some did think this was a good idea), however their focus group approach elicited a qualitative perception from consumers instead of a fact-based insight had they'd been given the right information and options. This perception is further compounded as the HPOM review readily stated that most consumers were close to clueless about what services they can expect from pharmacists. So the average consumer ability to ascertain whether supermarkets can or should enter the pharmaceutical market is not centred on a fact based perspective, that we argue would alter those perceptions.

3. **Prices need to reduce**. The price both governments (whom reimburse) and consumers pay for PBS medicines is expensive and structurally this is flawed. The government has a limited budget and this funding should not be endless. We agree with TKR on this. Allowing supermarkets to enter the industry would assist to reduce the supply price of PBS medicines due to the negotiating power they have and the increased competition. We also advocate that international best price should be the norm for pricing and that subject to manufacturing quality checks all branded and generic drugs should be able to be sourced internationally as well as locally. We also advocate for a national price monitoring body for the supply of prescription medicines. This body should serve as an aid to the industry in sourcing and negotiating best price drugs globally. We also advocate that consignment stock be an industry best practice for all community pharmacies so that consumers are not impeded in being able to get the medicines they need, no matter how expensive or specialised they are. This approach also benefits pharmacy owners so that they are not short on cash and pay for inventory once it has been sold. It then shifts the mantra of efficiency back to the suppliers instead of pharmacy owners. We do however not agree with TKR on the price setting mechanism across all pharmacies and would offer that perhaps a price ceiling mechanism is acceptable (i.e. similar to a recommend retail price or RRP). We advocate that government should not be in the business of price setting or competition regulation as it simply makes markets inefficient.

4. **Access to medicines needs to increase through the removal of location restrictions**. The notion that the current arrangements are efficient and serving the needs of consumers is not founded in fact or proof. In fact it is otherwise. TKR research revealed that location loyalty applies to only 30+% of all prescriptions dispensed and thus makes a mockery of research that suggest location restrictions were the be all of efficient industry functioning. Consumers value convenience and relationships well above location access. Our recommendation to allow supermarkets to enter the industry will no doubt increase the number of locations as well as convenience to consumers whom can access medicines – we *estimated* a net result of at least 1000 additional locations, probably more. We also noted in our first report that some community pharmacies will no longer exist or will fail and we stated that this would happen anyway. And consistent with TKR observations it is not the government's responsibility to endlessly fund inefficient business models. We also noted suggested rules whereby supermarkets and pharmacy owners would have certain parameters with which to approach, negotiate and sell with or between each other so as to protect the community pharmacy owners. We would also add to this by stating that no pharmacy should be sold for less than any current debt on that pharmacy business (subject to auditing etc) so as to protect community pharmacy owners.

5. **Allow general practitioners to operate *within pharmacies***, without restriction as a trade-off for supermarkets entering the industry. This would mean that community pharmacies as they exist now would be able to open up their pharmacies (subject to space and configuration) so that practising GP's can consult within them. This would enable the current locations that these pharmacies operate within to ostensibly share the major fixed costs and utilities between 2 businesses and revenue streams.

6. **General practitioners should be allowed to enter the market pending the size of their operation**. We also recommend that certain medical centres should be allowed to open pharmacy operations subject to the size of the operations. For *example* 10 or more practicing GPS' whose medical centre operates 24/7/365.

7. **Pharmacists need certainty**. The industry is losing pharmacists whom are leaving due to poor pay and conditions (more on this later). The current owner centric approach that constricts pharmacy locations to a privileged few needs to change and once and for all existing pharmacy owners need certainty as to the inevitability of supermarkets entering the industry. While the industry will eventually normalise, and perform after the forming and storming stages of opening up the market, it will at least set a framework of certainty for the next 50+ years.

8. **Innovation and digitisation needs to occur from consultation to collection**. Every patient has a unique Medicare number (and other forms of unique identification like passports, driver's licences, national identity cards or mobile phone numbers etc…) and it is simply palpable that this is not used between the doctor at ailment consultation to the pharmacist at medicine collection in one single national portal. All prescriptions for all medicines between all doctors and all pharmacists in all locations should be able to be accessed from such a portal so that the consultation is recorded and the prescription (or repeat) is digitised at the source and eventually the collection of medicines is available at a pharmacy anywhere in Australia through this portal. Extension of this portal would include access to consumer medicines information as well as TGA medicines information.

9. **Innovation and digitisation needs to occur across the supply chain** between suppliers and pharmacies. We agree that the CSO funding should be removed. The amount allocated recently to fund this inefficiency could have been dedicated to fund the consultation to collection national portal. We also advocate for an inter/national buy and supply portal that tracks all pharmaceutical medicines supply (and returns) to pharmacy outlets in Australia. This portal can be further developed for the return of unused medicines management.

10. **Innovation should be encouraged, tracked and rewarded**. We have recommended this in our VABESMA and VABEAMA framework and have linked it to how this innovation supports the national medicines policy (NMP).

11. **Managing inventory working capital must be improved across the whole supply chain** providing greater levels of certainty for pharmacies, manufacturers, wholesalers, payment terms and ultimately the Commonwealth. Importantly it provides transparency. Our recommendations here are centred on consignment stock management and the presumption of having portals for consultation to collection and supply chain management. This includes for high cost or highly specialised medicines.

12. **In order to attract and retain pharmacists, their remuneration should increase** in addition to their base salaries now through the minor and partial direct reimbursement of the services they provide. As the AHI fee now tops $10 we recommend between $0.50 - $1.00 be directly paid to the pharmacist dependent on experience (particularly given the recent increase only occurred in May 2017). Pharmacists directly bear the responsibility and liability of providing the dispensing and advice services and thus should also receive some of the reward to do so. As the PGA continue to push for the reimbursement of more services, which as we have demonstrated in this report many pharmacists simply cannot do with a quality of service approach to support a quality use of medicines outcome, many of these services represent pure profit for the pharmacy owner (whom increasingly do not work in their pharmacies), at the expense of the employee pharmacists.

Our list here is not exhaustive but it is topical and important. It is not a substitute for reading our Part 1 report (http://bit.ly/2t9M2Sn) and this full Part 2a report. We advocate change for consumers and those 25,000+ *employee pharmacists* whom provide most of the services. Nowhere in recent analysis and debate have employee pharmacists been able to have their voices heard, yet they're the ones doing most of the work, hence our complimentary involvement from April 2017.

Michael Rhodes – Director, Rhodes Management

2 Introduction

As a favour to employee pharmacist colleagues we were requested to independently review the pharmacy industry and provide a perspective for public comment. This resulted in our first report, which for many was controversial and confronting. That controversy started because it challenged the inefficiency of the pharmacy industry and the perpetuation of that inefficiency by the Pharmacy Guild of Australia (PGA) under the auspices of the Community Pharmacy Agreements (CPA), currently 6CPA. I rightly called the CPA a "PORPA" - Pharmacy Owners Restriction and Penetration Agreement. The term "Community Pharmacy Agreement" is an oxymoron because these words simply do not reflect the current operational reality. The term PORPA is more appropriate because until the CPA opens up supply and access to medicines to the whole community through supermarkets and other outlets they will only ever be Pharmacy Owners Restriction and Penetration Agreements or "PORPA".

Since completing the first report[ii] in April 2017 we received overwhelming support, particularly from employee pharmacists. The report garnered a mention in news.com.au and the AJP[iii] and the most common theme of feedback has been "thank goodness somebody is telling it like it is without fear, vested interest or undue influence".

The first report generated over 1200 downloads and is still growing daily. We dare say this report will generate even more interest. Clearly the first report struck a chord across the whole industry sector. We make no apology for calling out the inadequacies of the obvious restrictions in the supply of medicines and the high price of those medicines which are born by the most economically disadvantaged in society. Somewhere amongst the debate, commentary, vitriol on social media and the vested interests of all parties, this seems to have been lost. We were accused of targeting the PGA. We have targeted nobody intentionally or specifically. We did not have to as the facts are simply overwhelming. The societal value that the PGA claims to deliver is simply not supported by the evidence under the present CPA arrangements.

Responses from the PGA predictably defended their position, but no response got to the heart of the matter of better supply, better competition, more outlets, better pharmacist pay and cheaper medicines or in broad simple terms societal value. Some claim the societal value are the health benefit outcomes. Wrong; societal value is the reduced taxpayer funded inputs and how efficiently they go to achieve the health benefits. The PGA advocate the status quo and recent activities and lobbying by the PGA have extracted further money for pharmacy owners out of the health budget while still not addressing high costs, low employee pharmacist wages and no increases in the supply and availability of PBS medicines.

One of the PGA responses[iv] referred to the 17-year-old National Medicines Policy[v] (NMP), which we thought was interesting. In our first report, we made no mention of that and didn't have too. But we note the NMP drew distinctly clear parallels with the document we authored and the recommendations we made. From the NMP, they are as follows:

Objectives of the policy (page 1)

- "give better value for taxpayers' dollars;"
- "In line with this agreement, the overall aim of the National Medicines Policy is to meet medication and related service needs, so that both optimal health outcomes and economic objectives are achieved."
- "timely access to the medicines that Australians need, at a cost individuals and the community can afford;"

Access to medicines (page 2)

- "Cost should not constitute a substantial barrier to people's access to medicines they need. Therefore normal market mechanisms may be tempered in access arrangements, to increase the affordability of important medicines. For example, the Pharmaceutical Benefits Scheme (PBS) facilitates access to certain prescribed medicines by subsidising costs, and subsidies also occur when hospitals supply medicines to patients. Such subsidies are not costless, and the community as a whole must bear them."
- "all partners take adequate responsibility for achieving value for money;"
- "access processes are made as simple and streamlined as possible, so that subsidisation of medicines is timely, mechanisms are understood, and unnecessary administrative barriers and expenses are avoided;"
- financing arrangements for medicines avoid incentives for cost-shifting between levels of government or other funders, or other perverse incentives;
- efficient and effective distribution and supply networks (distributors, hospital, and retail) exist; and
- a fair distribution of costs and savings between the partners is achieved.

In response to these points, this is precisely why our report outlined opening up the supply of medicines to the community through supermarket chains. It is somewhat fortuitous that the 9 points all mentioned above have economic value, fair pricing and access to

medicines as their key tenets. The current CPA arrangements hinder this and any argument that states otherwise is nonsense. This is also supported by recent research. In 2015 "The Review of Competition Policy", chaired by Professor Ian Harper, recommended pharmacy medicine supply restrictions be removed, finding they were imposing costs on consumers, limiting choice and thwarting the ability of suppliers to meet customer preferences[vi].

Our response and suggestion to the points above was the introduction of **VABESMA** or the **Value Based Efficient Supply of Medicines in Australia**. This addresses the industry and economic societal value. With respect to the NMP the a) Quality use of medicines b) A responsible and viable medicines industry in Australia, and c) Making the partnership work all requires trained and skilled pharmacists. With so many leaving the industry and even many more so lowly paid how are these objectives being met under the current CPA arrangements. Nothing was offered from the PGA, the Pharmaceutical Society of Australia (PSA) or the Professional Pharmacists of Australia (PPA) to correct this. With respect to the PGA and PSA this is to be expected as it suits their respective charters[vii] and thus lobbying to increase supply, open up the market, reduce prices and drive economic and societal value is an anathema to their existence.

It will never happen. It's a failure of respective governments whom have not woken up and smelled the roses, the tax payer and consumers are being fornicated with.

In the PGA response to our first report it was also referred that the market is a monopsony, however this definition is only partially correct. For those curious, a monopsony is where you have only one buyer and many sellers. As most are fully aware it is the millions of consumers, through the thousands of pharmacy outlets, whom buy the drugs, not the government. Government merely negotiates initial supply prices and reimburses in accordance with the PBS rules. A true monopsony would not permit the likes of major hospitals (through their tender processes) and discount pharmacy chains to have competitive prices for prescription medicines because they would have to be non-negotiable price takers which is not the case given the prices they offer and the rebates they're paid from suppliers.

Notwithstanding this, the fundamental economic flaw in the current arrangement is monopsony based "price taking" the government has to endure with drug suppliers instead of exposing these drug suppliers to international competition (as mentioned by the NMP and our first report) as well as increased local competition and group buying power. This monopsony like price taking is also perpetuated by the PGA whom for the recent budget extracted another $600M out of the Australian tax payer. This was meant to be provided for "new" services, but instead was allocated to existing services due to the 2.14% drop in prescriptions. Employee pharmacists actually struggle to provide these services anyway and for which the PSA usually has to provide and / or accredit some form of training (can you see the connection?).

Perpetuating the current arrangement will not change the competitive landscape, increase medicine availability and reduce current prices (which is why the government now requests greater transparency) and ultimately it is the consumers who bear the cost and pharmacists who are under paid.

This is not maximising societal health and value.

Pharmacy wages have hardly moved while the work load has increased. By definition pharmacists are being paid less for each unit of work they perform. We find it quite perverse that a small number of the most privileged ownership group of any industry in the country are directly reaping benefits at the tax payers expense and at the expense of the most underprivileged economic group in Australia.

We must ask why is it that Australia still pays higher prices for prescription medicines than the UK, Canada, USA and New Zealand. As it stands the current arrangement is neither adequately serving the consumer nor the economic objectives outlined in the NMP.

Approximately 26 years ago 1CPA came into place to mandate, control and ultimately restrict the penetration of pharmacies and medicine supply in the market. That model 26 years later is now wholly ripe for long overdue change and the CPA is a dinosaur of market waste and inefficiency.

Finally, both the industry and the media must stop referencing the industry as "pharmacists" and start articulating and delineating the difference between *owner* pharmacists and *employee* pharmacists. *In this document, our reference to "pharmacists" is generally referred to those whom are mostly employee pharmacists and are actually doing the work, unless otherwise clarified.*

The time for substantial change is now long overdue and hopefully The King Review will be the panacea for that and we are delighted to have been able to contribute independently and constructively to the debate. For the record, this report has been authored completely independent and sight unseen of the The King Review report (which we look forward to reviewing).

Michael Rhodes – Director Rhodes Management

3 Incomprehensible Waste and Inefficiency

In the closure of our first report we ended with … *Despite what ALL parties think there is actually a greater level of commonality than you realise, however each party must be prepared to trade off something to drive and strive for the greater good. This greater good comes in the form of:*

- ✓ ***Personal*** *– higher pay and higher standards to those actually advising and dispensing medicines for it is here where the work is actually done.*
- ✓ ***Business*** *– Increasing supply of prescription medicines and making those left even stronger and providing for those struggling an opportunity to sell up.*
- ✓ ***Industry*** *– Introduce VABESMA; the Value Based Efficient Supply of Medicines in Australia to replace the current CPA. All parties to submit their VABESMA outcomes.*
- ✓ ***Economic*** *– Driving for the greater good and societal value ensuring we can live within our economic means into perpetuity.*

These are still lofty yet achievable objectives, but not under the current CPA arrangements in place.

We must ask ourselves how many industry reviews, how many recommendations and how reports do we need before somebody in government listens and realises the current arrangements are economically and logistically unsustainable? The convenience of ignorance is no longer a reason for inaction.

3.1 Transparency and Supply Efficiency

Firstly, the inefficiency of the market is served by those who lobby hardest, the PGA, with respect to the pharmacy owners. However, the lack of transparency in this regard has been palpable[viii].

An auditors general report in 2015 prior to the 6CPA being enacted was damning in its appraisal of the lack of transparent conduct between the PGA and health department, criticising the arrangements as being opaque and not transparent. Delivering on 5CPA came in $600M short on the value promised and neither anybody in the health department nor the PGA was held to account. The $600M comes predominantly out of the pockets of the elderly and concession card holders.

Further to this is the $195M allocated during the funding term to eligible drug wholesalers under the CSO arrangement for 6CPA[ix]. It is done under the auspices of ensuring *approved pharmacists obtain timely support of section 85 PBS medicines irrespective of the size or location of the pharmacy, the breadth of the product range, the cost of the medicines and the cost of their distribution and supply to the physical pharmacy premises.*

This arrangement funds inefficiency in the supply chain, storage and procurement practices and is a waste of money. We recommend that if you are going to spend nearly $200M in the supply chain then direct those funds to innovation not inefficiency.

Why can't pharmacies and their wholesalers work on a consignment stock arrangement[x]. Distributing pharmacy medicines is not a weight or storage space intensive operation[xi]. The consignment stock arrangement carries low risk for the pharmacist because they're not paying for goods until they're sold and it also carries low risk for distributors given the predictive nature of "medicines to ailments" dispensing. It would also go a long way to ensuring the availability of PBS medicines for sale in the pharmacy as required by 6CPA[xii].

In supplying any product to any customer in any industry there are 7 key things that are required, they include 1) supplying the right product 2) with the right quality 3) and the right quantity 4) at the right price 5) to the right customer 6) at the right location 7) at the right time.

We call these the 7 "R's" of supply chain management[xiii]. With the plethora of information available today we can introduce business processes and forecasting methodologies[xiv] that optimise supply chain efficiency.

PBS medicines are the most tracked products on supply in Australia today. Given each product has a 12 digit UPC number or 13 digit EAN number coupled with the forecasting technologies available, wholesalers should be supplying pharmacies with the products they need, mostly on consignment stock, even *before* the pharmacy realises they need to order that product. It would be much better if this funding was allocated to drive digital renewal and innovation in the 21st century, so that it generated a societal value return on investment and ultimately delivers a better outcome to consumers and pharmacies alike.

And this funding is an oxymoron to clause 5.1.6 of the 6CPA[xv] to seek to obtain competitive business practices because funding inefficiency will never achieve it.

We don't fund wholesalers, manufacturers or distributors for the supply of baby formula, nappies, milk or water storage all which are essential elements to children's health so why should be fund the inefficiency of a wholesale supply chain that hasn't adequately digitised for optimal efficiency its business processes and supply methodologies.

It is also somewhat of a paradox that supermarkets in this regard do actually rely on the digitisation of their supply chains to be efficient and competitive otherwise they would be out of business.

Within the 6CPA under section 6 clause titled Community Pharmacy Programmes the PGA states it acknowledges that "the Australian Government requires the achievement of *real improvement* in patient access to community pharmacies (including through increased opening hours).[xvi]

Yet in the Guild 2015 submission to the 6CPA no mention is made of increased opening hours for pharmacies and the notion of *real improvement* is absent of any defined measures. In other words, it's a feel-good clause without any defined measures or accountabilities attached.

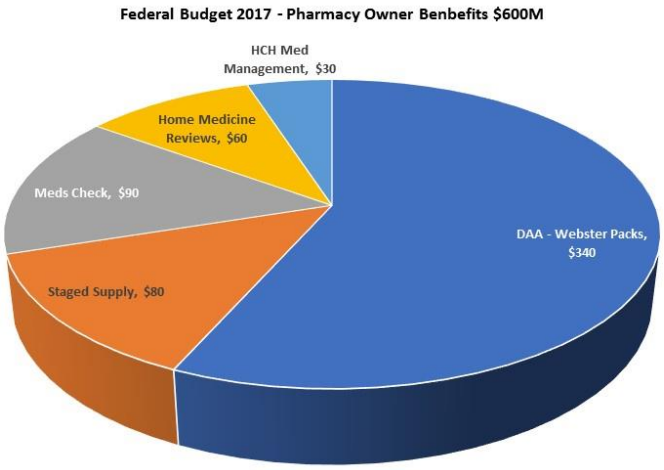
3.2 The May 2017 Budget and the Sixth Community Pharmacy Agreement (6CPA).

The 6CPA[xvii] states in its background[xviii] that both the Commonwealth and PGA have common interests in ensuring the sustainability, cost effectiveness, efficiency, viability, access and that appropriate resources are directed across the health system, to ultimately serve the needs of consumers at an affordable price as and when required.

How is it cost effective then to dump an additional $200M into the CPA until May 2020 only because the prescribed volumes were 2.14% "lower than expected"? This variation is within a statistical error of measurement.

One must ask what causal factors contributed to this *insignificant* drop. We would only hope people are getting healthier and if so why does the tax payer have to fund an inefficient business model in the process?

For the next 3 years until May 2020[xix] an extra $600M has been extracted from the federal budget. The breakdown is as follows:



Nobody denies these services are important and essential, but are they worth any more funding in the face of a minor drop in PBS descriptions? As the government continues to request greater price transparency and cost reduction through the use of generic medicines the PGA continues to scramble to extract greater reimbursement for services, which as we shall see later generally represents 100% pure profit and under current working arrangements is difficult to provide any way.

Further to this as outlined in the 6CPA pharmacists can charge consumers additional money for RPPB and EPPB medicines[xx] if the prices for medicines are below the co-payment threshold. Put simply pharmacy owners can charge the full price for a medicine even if the actual price of that medicine is below the co-payment level.

How does the maintenance of an unnecessarily higher price benefit the elderly or concession card holders? While we do not advocate government control or fix the retail prices of PBS medicines we do advocated greater competition to ensure the market pays for the best for those medicines.

3.2.1 Pharmacy Remuneration and Regulation Review (The King Review)

Stemming out of the 6CPA is the commitment to undertake a comprehensive review of pharmacy remuneration and regulation[xxi]. This is also known as The King Review and is being conducted by Professor (of Economics) Stephen King from Monash University. It is perhaps paradoxical that Professor King has borne the brunt of the PGA's pre-assessment of what will be in the review prior to it even being released. Perhaps given Mr. King' background they have cause for concern. Mr. King specialises[xxii] in micro-economic theory and has advised government and industry on reforms in this area, including competition policy. At the time of writing the critical parties have declared their hand and self-interest.

On September 7 2016 during a panel forum discussion there was compelling feedback on The King Review[xxiii] from the main parties in attendance. From our independent perspective, most of this feedback is entirely predictable.

The initial context was provided from panel members and included statements such as *"There are differing views across the sector and in the community on the appropriateness of the current pharmacy location rules," "Those that support maintenance of the existing pharmacy location rules, argue that they provide pharmacy businesses with the certainty and capacity to allow continued investment in providing a range of high quality pharmacy and related services to the community. "Others who favour a removal of the pharmacy location rules, argue that they prevent competition in the sector and stifle innovation and consumer choice". "They note that there are fewer community pharmacies in Australia today than there were in 1988, despite the considerable growth in population since that time."*

Defending their position, the PGA as an employer representative body, through president George Tambassis said one key question was omitted, being "should we take a system that is working well for consumers and taxpayers and dismantle it for the sake of an economic theory?" He stated no and opposes deregulation of the pharmacy sector for a range of "evidence" based reasons based on the best interests of our members but also the best interests of consumers.

We find it perplexing that the PGA president questions the very review which the PGA agreed to in 6CPA (clause 8) and defends a system he claims is working well, based on evidence. Our review and research simply finds the system is *not working well for taxpayers* and it could *work much better for consumers*. The "system" is inefficient, wasteful, perpetuates higher prices and limits supply to the elderly and concession card holders. We called that out in our first report and now this one.

It is not economic theory it is fact.

It is also interesting that the very nature of the questions being asked by Professor King seeks to understand this in much greater detail and if the PGA president had nothing to hide with the evidence he says exists then why pre-empt it with the comment to the contrary?

It was encouraging to see the PSA through CEO Dr Lance Emerson and National President Joe Demarte acknowledge questions being included in the review to address payment for the pharmacists' services linked to the MBS and to consider complexity. As we've said previously parts of these payments should *go directly to the pharmacists* whom provide the services.

Additionally, it was also encouraging to see the PPA CEO Dr Chris Walton state that "business as usual" was not an option when it comes to the future of the pharmacy industry, noting the remuneration was centred on what a pharmacists does (perhaps not surprising given the PGA has negotiated reimbursement of these services for the pharmacy owner members), versus what the consumer actually needs.

Given that employee pharmacists actually provided most of these services he was encouraged to see the debate finally opening up, no doubt to the behest of the PGA. Similar sentiments we echoed by Society of Hospital Pharmacists (SHPA) CEO Kristin Michaels.

3.2.2 Other Waste

Market inefficiency is also prevalent in the form of drug companies being able to charge ½ billion dollars per annum more than they should[xxiv] . The problem exists because there are consumers who are paying for more expensive alternative drugs instead of cheaper medications which provide the same benefits. This has found to be the case with statin drugs.

Put simply the cost (to both government and pharmacy owners) of all equivalent drugs should be pegged to the cheapest alternative available within the PBS.

So instead of being price takers in the market we become price makers by virtue of the buying power. It should also be asked why is it many large hospitals pay less for prescription medicines than current community pharmacies do and have been able to do so through their competitive tender processes.

With expenditure on health exceeding economic growth and continuing to do so from 15.7% (25 years ago) of taxation revenue to today's number of 24.1% and health expenditure as a proportion of total economic activity increasing from 6.5% to 9.7%[xxv] it is time to introduce measures and controls that curb this spending or as a minimum make it more efficient to achieve the similar or better outcomes.

While it's noted there were more pharmacies in 1988 than today the simple fact is the health budget at that time wasn't bleeding like it is now. All it proves is that as a function of health spending we are 54% more inefficient and 49% more inefficient as a proportion of total economic activity, all of it in a time when information and process efficiencies through information technology have substantially improved business practices across the end to end supply chain.

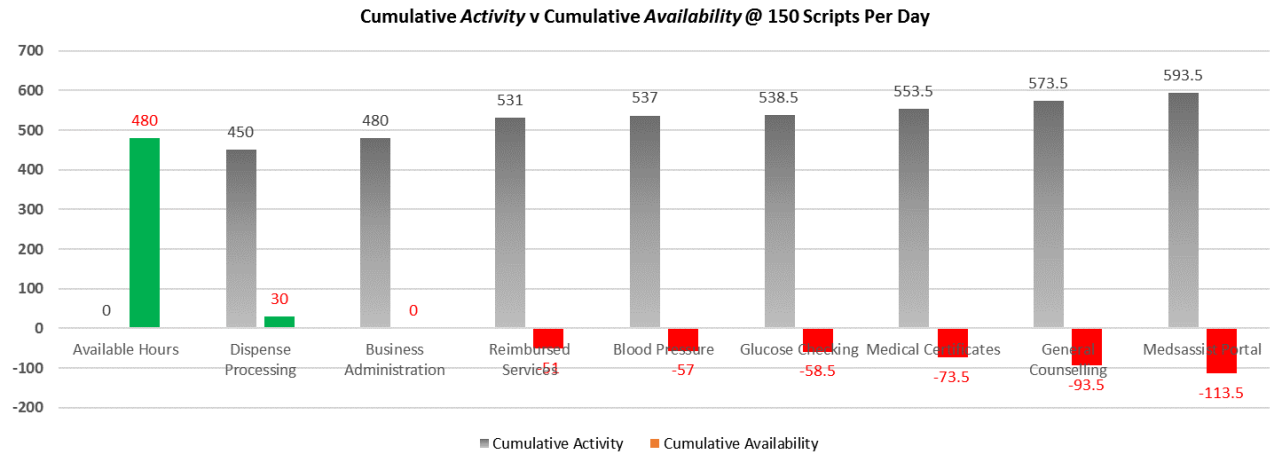
A culture of waste and inefficiency breeds further waste.

4 Pharmacists and the Myth of Pharmacy Services

4.1 Services

Getting to the heart of providing services we conducted research[xxvi] with a number of pharmacists to ascertain the time spent on providing these services. We did so because it was put to us that actually providing the services that pharmacists are being reimbursed for was at best "difficult" and at worst "misleading".

As a general guide, full time pharmacists work 480 minutes per day[xxvii] and many work longer and without a lunch break. With this in mind the breakdown in minutes per activity performed is denoted below. The graph shows available time in green, the cumulative activity time in grey and the cumulative deficit in red between the cumulative activity time and the available time.



Starting with 480 available minutes per day dispense processing, based on 150 per scripts per day, consumes:

1.	Dispensing	450 minutes[xxviii],
2.	Business administration	30 minutes
3.	Reimbursed services[xxix]	51 minutes
4.	Blood pressure checking	6 minutes
5.	Glucose checking	1.5 minutes
6.	General counselling	20 minutes
7.	Meds assist portal	20 minutes
8.	**Total**	**593.5 Minutes (9.9 hours per day)**

To explain clearly, after the core dispensing and business administration activities are completed there is *nearly a 2 hour per day deficit to provide even the most basic of reimbursed services*, let alone the plethora of other services (highlighted in red in the above graph). Points 4 to 7 are based on a monthly total, averaged to the minutes in the days performed. While the PGA extracts from government additional funding for services for pharmacy owners, employee pharmacists are struggling to provide those services.

Thing brings into question the notion of actually being able to provide a *quality of service*. Furthermore, many discount chains provide an incentive to their pharmacists in meeting *volume objectives* for reimbursable services irrespective of the validity of the service being provided; read this as an ignorant "she'll be right mate". As one commentator in the USA pointed out pharmacists should not be in a position to create patient problems by being subject to undue work pressure and risk when analysing and dispensing medications[xxx]. It appears the pressure to perform these services increases the risk to create such problems. Increasingly employee pharmacists are pressured to undertake training to provide the additional services (vaccinations being a good example) in order to meet the profitability required at both store and corporate level, due to the shrinking margins being endured as more generic drugs are being prescribed. How is this *quality of service*?

We deliberately chose the conservative number of 150 scripts per day as a cut-off point to illustrate the *time deficit of service provision*. Many of the single pharmacists we spoke to dispense more than 230 scripts per day and often over 300 on some days. Providing any sort of advice or counselling service in this instance is simply a fantasy. The reason the PGA and pharmacy owners push so hard for reimbursement of these services is because they represent 100% pure profit based on the absorbed fixed costs already in place (e.g. salaries and rent).

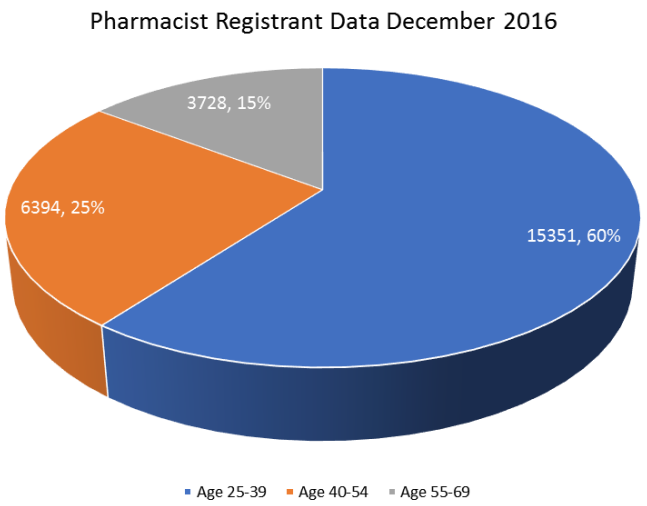
So, one must question the motivation of pharmacy owners and certainly the PGA to so vigorously want to provide these services. Pharmacists generally have a low motivation, due to time restrictions, to be able to provide these services in their busy daily schedules. At 200 scripts per day this is 1 script every 2.4 minutes in an 8-hour work day. Of course, most pharmacies don't have a linear dispensing work flow so often the problem is exacerbated. If the remuneration model changed to reflect some portion of direct payment to the pharmacist, the organisation, motivation and attention to provide these services would increase as would the profitability of the pharmacy itself even when part of that payment goes directly to the pharmacist.

By all means reimburse for the services but ensure a quality of service environment to do so. Perhaps the pharmacy business model needs to adjust so the environment exists to provide these services and less focus is placed on selling retail items like perfumes, vitamins and moisturisers. This would lower the retail footprint size and thus costs. We must ask is there room in the market for *predominantly* pharmacy only prescriptions and medicines and services? Possibly yes. This would allow for clear branding, consumer understanding and better service provision quality.

4.2 Registration and Remuneration

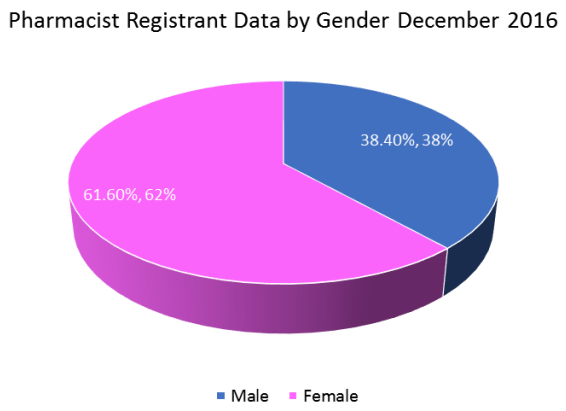
This report calls out 2 distinct "elephants in the room". The first is opening up the supply of PBS medicines to allow supermarkets and other bodies to enter the industry and the second is the absurdly low wages of pharmacists given their initial training, ongoing training and general responsibilities on the job. In this section, we address pharmacist registration and remuneration.

Below is the national pharmacy registration data across the prime working age groups from 25-69[xxxi].



As the data reveals 15,351 pharmacists comprise the majority of registrants in the 25-39 age group. This is 2.4 times larger than the 40-54 age group comprising 6394 pharmacists and 4.1 times larger than the 55-69 age group comprising 3728 pharmacists. The 25-39 age group is the prime age group for the pharmacy industry registrants[xxxii].

When broken up by gender the split is as follows.

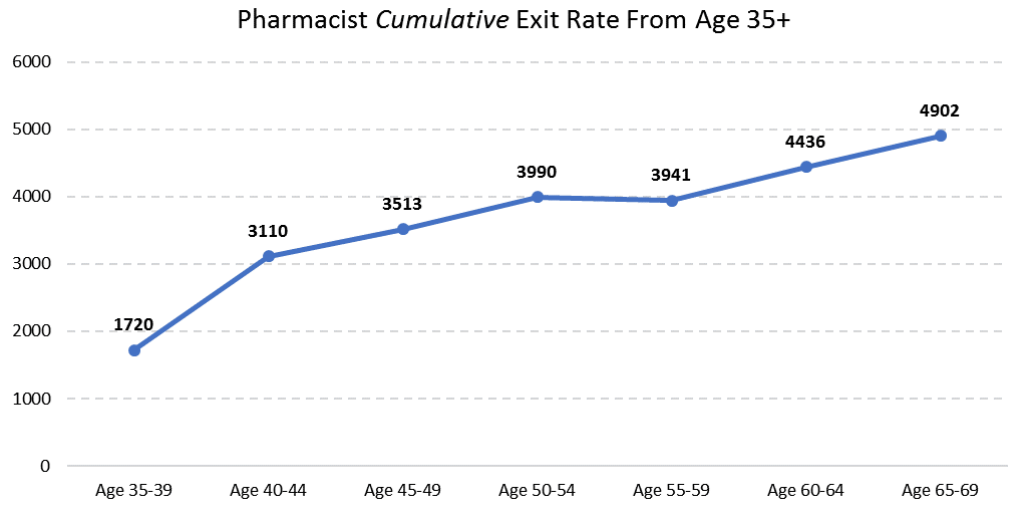


The industry is dominated by females at 62% of all pharmacist registrations. They also (predictably) dominate the list of non-practising pharmacists as well.

However, things begin to get interesting when we look at pharmacy turnover rates and the amount of people exiting the profession and not returning.

Our analysis revealed a cumulative loss of pharmacists is occurring when they are at the peak of their career knowledge and experience. The problem is further compounded when women leave to start families and in some cases, don't return to the profession.

The graph below highlights the cumulative loss trend by age group.



What the data shows is that year on year in the prime working age group of 25-69 the pharmacy profession has a 19% turnover[xxxiii]. While it is acceptable as the working age increases that more people leave the profession, most disturbing is the notion that 14% of the turnover occurs with pharmacists *whom are at the peak of their knowledge and experience* between the ages of 35 and 49.

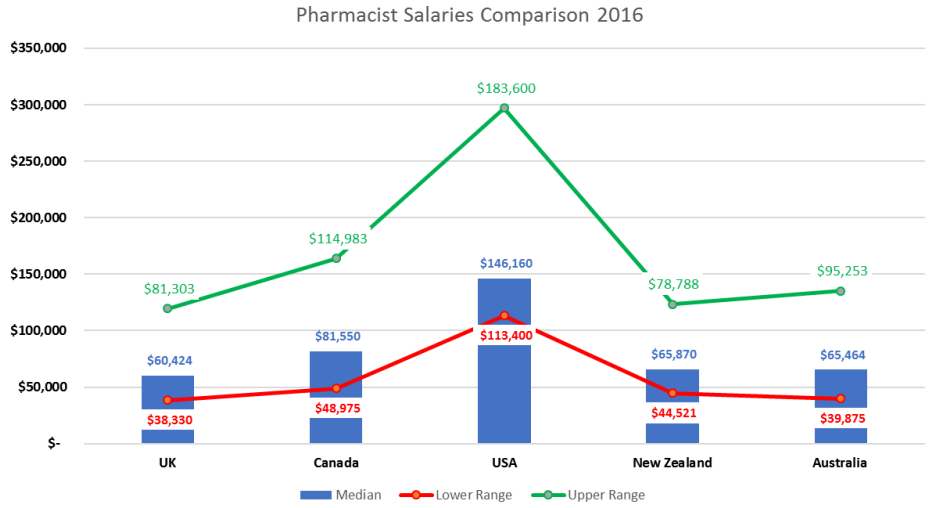
Our research reveals that 1) pay rates are simply too low to retain pharmacists in their profession 2) females leaving the profession to start families and not returning 3) change of career for pharmacists whom are seeking higher paid roles in either allied or similar industries 4) lack of recognition for what pharmacists do versus what they get paid. The remuneration level was the prime reason for leaving and was overwhelmingly the most prevalent reason amongst male pharmacists.

This does not bode well for the profession and the industry. Employee pharmacists comprise 6 times more active and working pharmacists than owner pharmacists yet it is the owner pharmacists whom are reaping the greatest benefits from the services provided.

This is acceptable but not at the expense of quality of service and fair remuneration outcomes. This is specifically why we recommend that portions of the dispensing services fees are paid directly to the pharmacists whom provide the service *in addition* to their normal salaries and daily retail outlet responsibilities.

As remuneration is a key concern for pharmacists our research shows Australia is behind global pay standards for pharmacists. The more open an industry is the greater the pay available to pharmacists and by and large the cheaper the prescription medicines are.

The following graph highlights this trend as evidenced by the salaries in the USA.[xxxiv]



The median pay scale for pharmacists in Australia is $65,464 per annum. This is less than experienced plumbers and electricians make whom have level 4 TAFE certifications and can choose their working days and working hours. For an industry that trains so much for its profession and endures ongoing training it is a woeful level of compensation. Further to this, pharmacists have to pay for liability insurance in order to do their jobs and it is them who are exposed if something goes wrong. If they're bearing this risk they should also have some portion of the reward in the form of direct reimbursement for services.

As we said in our first report, "we know of no other profession which is responsible for growing the top sales line of the business and to do so while not harming people in the process".

Is it somewhat coincidental in the USA whose market has no restriction on supply and pharmacy locations that they pay almost double that of Australia. The same goes for Canada whose salary ranges are 25% higher than Australia at the median level and 21% higher at the upper level. In markets where supply and locations have been restricted salaries for pharmacists have been kept low.

The entry level pay for Australian graduating pharmacists and interns is also desperately low at below $40,000 per annum which is actually 12% lower than the starting salary in New Zealand. Canada and the USA have entry level pay at 23% and 184% higher than Australia respectively.

We advocate simply that if pharmacist salaries were increased, turnover would reduce and quality of service would increase through experience retention to the benefit of the paying consumer.

Our research also revealed that pharmacists whom were best paid in the USA were actually done so from the supermarket chains. Any notion that the supermarket chains entering the market in Australia would harm the pharmacy profession are ill founded.

5 The Solutions

5.1 Value Based Efficient Supply and Access to Medicines in Australia (VABESMA & VABEAMA)

In this report, we have advocated for the introduction of 2 new concepts to replace the CPA agreement. This is broken down into the supply side and the demand (or access) side as both are fundamentally important and complimentary to each other. They are:

- ✓ **VABESMA** – The Value Based Efficient *Supply* of Medicines in Australia. Addressing the supply side of the industry.
- ✓ **VABEAMA** – The Value Based Efficient *Access* of Medicines in Australia. This is the demand or access side the industry.

The essence of the agreements is that they're a charter commitment with patients and the community at large. They are not agreements with employer bodies, training organisations or other industry representative bodies and their sole purpose is to ensure that everything done efficiently and effectively serves the needs of patients and the medicines consumer and is aligned to the NMP to the extent that this ensures best price and best access for consumers.

It is ostensibly operating policy.

By doing so this removes the vested and self-interest of any representative body in the pharmacy industry and puts ONLY at the centre of the agreement what is right for consumers.

The following list of recommendation points for each charter is not exhaustive but provides an indication as to what is possible. Our recommendations build generally on the answers we have provided to The King Review questions (see section 4.2) and our observations, research and analysis of the industry.

VABESMA **Value Based Efficient Supply of Medicines in Australia**	**VABEAMA** **Value Based Efficient Access of Medicines in Australia**
1. PBS Governance 1.1. Governance of the PBS should reside primarily with the government under the VABESMA framework independent of any industry body. This governance and any term related changes should be clearly documented. 2. PBS Trading Prices 2.1. All PBS prices should be dictated by a focus on global best price and be governed either under VABESMA or an independent pricing review and negotiation body. 2.2. What is agreed should form a separate schedule in the agreement. 3. PBS Reimbursement Schedule 3.1. We advocate a tightening of the reimbursement scheduled and a review of the products reimbursed for to ensure they actually deliver value to the community. Our general view is that they do but it is worth reviewing this. Again, this should be led by the pricing body mentioned above (or similar). 4. Services Reimbursement Schedule 4.1. We also advocated a tightening of the services reimbursement schedule to actually determine whether patient centric quality of service is being delivered and to what level. 4.2. The services agreed should be noted as a separate schedule in the agreement and also note changes from the prior term. 5. Entities to Trade	1. Entities who can sell pharmaceutical medicines 1.1. Community Pharmacies 1.1.1. Outline what a community pharmacy is 1.1.2. Who represents them 1.2. Supermarket Pharmacies 1.2.1. Outlined what a supermarket pharmacy is 1.2.2. Who represents them 1.3. Hospital Pharmacies 1.3.1. Outline what a public hospital pharmacy is and who represents them. 1.3.2. Outline what a private hospital pharmacy is and who represents them 1.4. General Practitioner Pharmacies 1.4.1. Outline what a GP pharmacy is, what the scale or size rules are for a GP pharmacy is and who represents them. This could be limited to 24-hour GP operations only whom have a size and scale to support a pharmacy dispensing business. 1.5. Pharmacy GP's 1.5.1. Outline how a Pharmacy can have GP consulting rooms in them, unrestricted and without segmentation. 2. Restrictions on selling 2.1. For example, requirement for accredited pharmacists in all outlets that sell pharmaceutical medicines. 2.1.1. Outline accreditation rules. 2.2. Location Restrictions (to be nil)

VABESMA
Value Based Efficient Supply of Medicines in Australia

5.1. All "entities to trade" should list all of the business types allowed to sell PBS pharmaceutical medicines
5.2. It should list any changes to this from the prior term.

6. No restriction to trade
6.1. It should list any restrictions to trade and where applicable make reference to the trade practices act.
6.2. Any state base jurisdiction should be noted also.

7. Rural governance and reimbursement
7.1. By exception any specific rural governance supply issues should be noted as should any specific product or services reimbursements.

8. Urban governance and reimbursement
8.1. By exception any specific urban governance supply issues should be noted as should any specific product or services reimbursements.

9. Entity requirements in this charter agreement.
9.1. PGA
9.1.1. The PGA should outline for each VABESMA it's specific employer body objectives and how they believe they contribute to the NMP.
9.1.2. A statement of key requirements for the PGA should be noted for reference.
9.2. PSA
9.2.1. The PSA should outline for each VABESMA it's specific training organisation objectives and how they believe they contribute to the NMP.
9.2.2. A statement of key requirements for the PSA should be noted for reference.
9.3. PPA
9.3.1. The PPA should outline for each VABESMA it's specific employee body objectives and how they believe they contribute to the NMP.
9.3.2. A statement of key requirements for the PPA should be noted for reference.
9.4. Pharmacy board
9.4.1. The Pharmacy Board should outline for each VABESMA it's specific objectives and how they believe they contribute to the NMP.
9.4.2. A statement of key requirements for the Pharmacy Board should be noted for reference.
9.5. Other
9.5.1. Any other non-government parties should be encouraged to submit their requirements to each VABESMA term and in doing so those requirements should be summarised here.
9.6. Declared Interests and Preferences
9.6.1. All declared interests and preferences from all bodies should be listed here.
9.6.2. All cross-office holder bearers should also be noted here as well to ensure completed transparency.

10. Price Scanning Entity
10.1. The notion of how prices and value is negotiated and delivered should be noted here.
10.2. International Supply and Sourcing Arrangement

VABEAMA
Value Based Efficient Access of Medicines in Australia

2.2.1. Outline any location restrictions to any pharmacy being in operation (for example a heavy industrial area, a mine site, a mobile arrangement etc…)
2.3. Opening hours Restrictions
2.3.1. Outline any hours of opening restrictions for any pharmacies – will generally be nil.
2.4. General Practitioner Size Restriction
2.4.1. Outline the size and scope of a GP practice before it can sell medicines. For example, a minimum number of consulting rooms and doctors.
2.4.2. Outline the rules of ownership in this regard.

3. Accredited 24 Hour Pharmacies
3.1. List conditions of 24 hours accreditation (and thus reimbursement)

4. Non-Accredited 24-Hour Pharmacies
4.1. List conditions of 24 hours operation for non-accredited pharmacies (and thus no reimbursement)

5. Pharmacy Ownership Rules and Guidelines
5.1. To be outlined for all pharmacy types.
5.2. Ownership rules should not require accredited pharmacist ownership but ALL pharmacies outlet must have accredited pharmacists.

6. Pharmacy Owner Obligations
6.1. These are to be outlined and include a focus on quality of services.

7. Pharmacist Obligations (Practicing and Accredited)
7.1. These are to be outlined

8. Service Level and Quality of Service Standards
8.1. Dispensing charter
8.1.1. These are to be outlined as minimum mandatory standards in the VABEAMA.
8.2. Services charter
8.2.1. These are to be outlined as minimum mandatory standards in the VABEAMA.

9. Communication and Patient Awareness Charter.
9.1. This is to be outlined across a range of media channels to ensure consistency of message and consistency of awareness.

10. Location Patient Awareness Guidelines
10.1. A guide to in pharmacy patient messaging should be made available and clear in all pharmacies for all patients and consumers.
10.2. It should be mandatory that this is displayed for all consumers.

VABESMA **Value Based Efficient Supply of Medicines in Australia**	**VABEAMA** **Value Based Efficient Access of Medicines in Australia**
10.2.1. All international supply and sourcing arrangements should be noted here for reference. 10.3. Local Best Price 10.3.1. Proof of local best price should be noted here for those PBS medicines that contribute to 80% of value of the PBS schedule over the term. 10.4. Internal Best Price 10.4.1. All medicines that deliver the same benefits as others should be pegged to the lowest best price. 11. Wholesaler Obligations 11.1. All wholesaler service and supply level commitment obligations should be clearly summarised in the VABESMA and form part of the participation to supply in the VABESMA. 12. Manufacturer Obligations 12.1. All manufacturer service and supply level commitment obligations should be clearly summarised in the VABESMA and form part of the participation to supply in the VABESMA. 13. Distributor Obligations 13.1. All distributor service and supply level commitment obligations should be clearly summarised in the VABESMA and form part of the participation to supply in the VABESMA. 14. Innovation 14.1. Innovation that clearly delivers value and efficiency in support of the NMP should be rewarded. 14.2. Non-Government Innovation Requirements 14.2.1. Innovation should be defined in specific terms 14.3. Non-Government Innovation Reimbursement Schedule (based on proven economic results or substantial projects to enable results) 14.4. Government Innovation 14.4.1. Current Innovation Projects and Expected Outcomes 14.4.2. Planned Innovation Projects and Expected Outcomes 15. National Medicines Policy (NMP) 15.1. How VABESMA meets or exceeds NMP requirements. 15.2. Recommended Changes to the NMP should outlined from each agreed VABESMA term. 15.3. Recommended Changes from the NMP should be documented in each VABESMA term. 15.4. How this agreement meets or exceeds the previous agreement in alignment with the NMP. 15.5. Outline what initiatives have achieved the NMP objectives. 15.6. Which ones are being carried over and from when (they were initiated). 15.7. Which ones are not being carried over and why. 16. Transparency in Negotiations 16.1. All parties should note how their commitment to transparency in negotiations has been met and ensure this transparency is auditable.	

VABESMA **Value Based Efficient Supply of Medicines in Australia**	**VABEAMA** **Value Based Efficient Access of Medicines in Australia**
17. Who does each party represent? 17.1. It should be clearly noted who each party represents 18. Declaration of cross entity representation 18.1. It should be clearly noted if parties have cross membership in their management or boards of governance structure.	

We believe these 28 points (and over 70 sub points) represent just the beginning when it comes to a patient centric commitment to best price and best access in the market for PBS medicines consumers.

The VABESMA and VABEAMA charter agreement framework promotes societal value as a core tenet and builds on what we said in our first report. It dilutes the self-interest and lack of transparency of any industry group so this can be achieved. As we advocate the entry of supermarkets into the industry we also advocate the integration of general practitioners into the pharmacy sector as well, but not into supermarkets. That is, we specifically recommend that pharmacies be allowed to have consulting rooms *within a pharmacy* so that general practitioner doctors can practice without physical hindrance or segmentation within a pharmacy location. This model further strengthens the community pharmacy as a trade-off for allowing supermarkets to enter the sector. It also builds on recommendations we made in our first report. Further to this we recommend that ownership of such a business be restricted to pharmacists only (who can hire GP's) or pharmacists and doctors (whereby pharmacists must have majority ownership 51%+), but not doctors in isolation to ensure integrity of not over-prescribing unnecessary medicines (the only exception to this is if a GP is also a qualified and accredited pharmacist). Needless to say, this recommendation will open up the medical practice sector by allowing more doctors to reach more patients in more locations. It will also strengthen the business model of pharmacies who choose take this route.

Being patient centric for societal value and community outcomes is not only a noble outcome it is the right outcome.

5.2 Answers to the King Review Questions

It is somewhat fortuitous that the King Review provides a concise and comprehensive set of questions for which to provide a series of responses and most importantly solutions. Our benefit in doing so is the independence with which we can answer without any vested interest at play. For the purposes of brevity, we have kept the responses per question as brief and relevant as possible[xxxv].

Question	**Rhodes Management Response**
1. In your opinion, is the ratio of community pharmacies to population optimal? What data would you use to support this opinion?	No – they should be increased by the addition of allowing supermarket chains to enter the industry. See our first report on this. Opening up to supermarket chains will add at least 1000 extra pharmacy outlets in the market and most importantly provide for additional regional coverage where otherwise pharmacies would not operate.
2. If it is desirable for the ratio of community pharmacies to population to increase or decrease in some areas, what in your opinion is the best way to encourage this?	The best way to increase access is via the adoption of VABEAMA or the Value Based Efficient Access to Medicines in Australia, predominantly through the addition of allowing supermarket chains to operate in the pharmaceutical sector. See our recommendations in section 4.1.
3. In your opinion, should there be a maximum ratio of retail space to professional area within pharmacies to maintain the atmosphere of a health care setting for community pharmacies receiving remuneration for dispensing PBS medicines?	No. Like all retail centric business this should be at the discretion of the business owner. Notwithstanding this, as service provision may increase inside pharmacies it should be at their discrete how they allocate the space appropriate to provide a service. We also recommend allowing doctors to practice in pharmacies. See our recommendation in 4.1.
4. Should Government funding take into account the business model of the pharmacy when determining remuneration, recognising that some businesses receive significant revenue from retail activities?	No. Those driving retails sales are a function of good business versus those whom are not and they should not be penalised for providing pharmacy services. Notwithstanding this perhaps a tiered funding arrangement could be reviewed so as to provide each business with the relevant level of funding in accordance with their size and commercial negotiating position.
5. Is the CPA process consistent with the National Medicines Policy? Is it consistent with the long-term sustainability and affordability of the PBS? Is it consistent with good government practice in terms of	No. Approximately 9 of the first initial points in the NMP advocates value and efficiency and the CPA achieves neither. The CPA first and foremost serves Pharmacy Owners whom are represented by their registered Employer Body the Pharmacy Guild of Australia (PGA), so any changes to the CPA under the current arrangement is incongruent with the very existence of the PGA. The CPA acts as a Pharmacy Owners Restriction and

Question	Rhodes Management Response
value for money (for both patients and taxpayers), clarity, transparency and sustainability?	Penetration Agreement (PORPA). It is somewhat perverse that the most privileged industry group in Australia is remunerated at the expense of the most under-privileged economic group in Australia comprising the elderly and concession card holders whom pay higher prices and have constricted supply of medicines and locations. The introduction of VABESMA should be introduced or the Value Based Efficient Supply of Medicines in Australia. See our recommendations in section 4.1.
6. What would be a preferable approach? Why would this be preferable? In particular why would this lead to better value for money and better meet the objectives of the NMP?	The principle of VABESMA opens up the market to better supply and better access to medicines by not constricting the market. Underpinning this principle is allowing the supermarket sector to enter the industry. VABESMA will also advocate allowing pharmacy practices to be collocated with general practices, subject to minimum size requirements and ownership accountabilities. Why restrict anything related to health care to a few privileged individuals. See section 4.1 for our recommendations on this.
7. Should the CPA be limited to dispensing and professional programs provided by community pharmacy only? If so, how can contestability and effectiveness be ensured in professional programs? If not, why not?	Yes. Certainty is important in any arrangement that provides for a professional service to patients (and the businesses that provide them). Depending on the scope, frequency and depth of the service these can be tendered for.
8. Is it appropriate that the Government continues to negotiate formal remuneration agreements with the Guild on behalf of, or to the exclusion of, other parties involved in the production, distribution and dispensing of medicines? If so, why? If not, why not, and which other parties should be involved? Is there currently an appropriate partnership with these other parties, including consumers?	No. **Categorically this is unacceptable**. Consumers are NOT represented. Employee pharmacists are NOT represented. Makers and distributors of drugs are NOT represented. VABESMA and VABEAMA should be introduced and administered by the department of health, albeit with external assistance. A VABESMA and VABEAMA program lead should by appointed whom is not a pharmacy owner, not a PGA member, not a PSA member, not a PPA member and not a member of the Pharmacy Board. Both agreements should be a statement of actions and measurable outcomes and reflected as an agreement and commitment with the patients / consumers signed by the minister. It should be *the charter of outcomes and operation* over each term of 5 years.
9. Should the Government move away from a partnership arrangement? If so, what would take its place? For example, should the Government move to a more standard contracting or licensing approach with individual pharmacies or groups of pharmacies? How would such alternative arrangements be implemented?	Yes. The arrangement needs to be broader and reflective of the whole industry. The PGA argument that their members have "skin in the game" is misleading. Individual employee pharmacists also have "skin in the game" from a professional liability perspective. Owners, like all small businesses, have skin in the game from a commercial perspective. Also, this notion of skin in the game is wholly incongruent with actual pharmacy board practice whereby the employee pharmacists bare the insurance liability risks and costs if they personally screw up. Pharmacy owners merely have to prove "the right processes were in place". So yes, the PGA should not be the only nor main body that represents the pharmacy industry, in fact it is hurting the industry because they are. The VABESMA charter for PBS medicines should be administered by an independent body (either new or existing – for example the TGA[xxxvi]) and the VABEAMA charter should again be led by an independent body but for which members of could comprise an *advisory only* board.
10. Is the current system of dispensing of medicines in Australia, that focuses predominantly on community pharmacies operating as small businesses, the best way to achieve the objectives of the NMP? Should there be alternative approaches for the dispensing of PBS medicines beyond a community pharmacy, such as through hospitals or different pharmacy arrangements? If so, what could these alternative approaches look like?	No. The CPA constricts market supply and this has been factually proven in a number of reports. **It is a 26-year-old dinosaur of market inefficiency**. Dispensing pharmacy medicines should be allowed from supermarket pharmacies which would open up at least another 1000-1500 location opportunities over time. Our first report called out the potential nature on how this can occur. The model of supermarket pharmacy in the first instance should be an "employed pharmacists" model and not a sub-lease. The main reason being that you cannot have the privileged of selling PBS medicines without the accountability to do so ethically and professionally at board level. Importantly it would open up the available hours of access too. Subject to certain ethical, practice and size conditions general medical practices should be permitted to dispense PBS medicines. In this case the medical business must be jointly owned by doctors and pharmacists and rules should be in place so that over-prescribing of medicines carries associated penalties. We also recommend allowing general practitioners to work in pharmacies (whom have the space and technology) without restriction, as a trade-off for allowing supermarkets to enter the industry. See our recommendation in section 4.1.
11. Is the 6CPA achieving appropriate 'access to medicines' as defined in the NMP? If so, why? If not, why not and how could access be improved?	Yes, but more can be done. Access to medicines is a function of time open and/or location and/or delivery convenience. This should be considered across the whole supply chain and the whole retail chain. Our recommendations throughout this report outline a number of options. In addition, the way medicines are prescribed (by the doctor), received (by the patient), processed (by the pharmacists), counselled (by the pharmacist

Question	Rhodes Management Response
	to the patient), collected (by the patient) or delivered (to the patient) and followed up (from the doctor or pharmacist) should be digitised. This will facilitate further access to medicines, access to medicine information as well as access to pharmacist counselling.
12. Do current arrangements under the 6CPA lead to the appropriate creation and distribution of information relating to the use of medicines? If so, how and why? If not, why not and how could the distribution of this information be improved?	No. There is not enough information transparency from consultation[xxxvii] to collection[xxxviii].
13. Is this requirement a significant impediment to online ordering and remote dispensing? If so, should this impediment be removed? In this scenario, what compensating arrangements would need to be implemented to ensure that there is appropriate oversight and control over dispensing and patient choice of pharmacy?	Yes. In the 21st century the paper script is an impediment to online efficiency. A myriad of technology exists to securely enable the digitising of the consultation to collection process for a patient. *A good yet simple example of this type of technology are boarding passes used by both Jetstar and Qantas which send a link via SMS to an app on a phone which is then securely downloaded and populates the app for permission to board the plane.* As a backup in case the phone is lost, stolen or not working the pharmacist can access a portal and search for a prescription using the patients surname, date of birth and consultation date and the Medicare card number can be the secure access. Processes can then be put in place once the patient acknowledges receipt of the medicine so that it cannot be dispensed again (unless it is a repeat). A good but still incomplete process is the eRX system currently in place[xxxix]. It should also be noted that any innovation in an online sense *sits at odds* with the recommendation of the pharmacy board in their dispensing guidelines[xl].
14. To what degree is it appropriate that community pharmacies be protected from the normal operations of consumer choice and 'protected' in their business operations? Is such protection required to achieve the NMP objective of access to medicines? If so, why? If not, why not?	This industry like all industries should be survival of the fittest, unless exceptional circumstances exist commercially that preclude the NMP access to medicines objectives (e.g. far remote areas). Protecting anything from normal operations and consumer choice only funds inefficiency and laziness and that is unfair to the tax payer and the community whom can benefit from a better use of those funds to achieve health objectives.
15. Is the 'swings and roundabouts' approach to remunerating pharmacists for dispensing appropriate? Does it lead to undesirable incentives?	It is appropriate. Pharmacists are always thinking when dispensing no matter how routine or complex the transaction is. There is no need to over engineer the uncomplicated.
16. Should dispensing fee remuneration more closely reflect the level of effort in each individual encounter through having tiered rates according to the complexity of the encounter? For example, should dispensing fees paid to pharmacists differ between initial and repeat scripts?	No. The dispensing fee should be standard. However, as the individual pharmacist bears the professional risks and liabilities and amount of up to $1 of the **dispensing fee should be paid directly to the dispensing pharmacists** and this should be based on years of practicing pharmacist experience in Australia. For example, less than 5 years' experience should be 50 cents, 6-10 years' experience should be 75 cents and above 10 years should be $1 per script. This would adequately compensate the pharmacist for the work they do and risks they bear in addition to their low base salaries.
17. Are the current fees and charges associated with the dispensing of medicine appropriate? In particular, do they provide appropriate remuneration for community pharmacists? Do they provide appropriate incentives for community pharmacists to provide the professional services, such as the provision of medicine advice, associated with dispensing?	The fees are appropriate for owners. In most cases the fees reimbursed for represent 100% pure profit for pharmacy owners. They are manifestly inappropriate for employee pharmacists. See response to question 16.
18. Currently community pharmacists have discretion over some charges. For subsidised PBS prescriptions, should community pharmacists be able to charge consumers above the 'dispensed price' for a medicine in some circumstances? Should community pharmacists be allowed to discount medicines in some circumstances? If so, what limits should apply to pharmacist pricing discretion? If not, why not?	Pharmacists should be able to charge what the market will bear. It will soon be apparent if their prices are too high through lost business. We do not advocate government setting any fixed retail selling price for medicines as again this funds inefficiency particularly when the supply and costs of medicines will reduce over time. Pharmacies most certainly should be able to discount as they see appropriate as well. There should be no limits to discounting, or maintaining higher prices because that only hurts the consumer. Their profitability will suffer if the discounting is too deep and thus would not be sustainable. In addition, online business sales should also facilitate discounting as well, and should specific advice be warranted for the medicines this can be documented and included with the goods.
19. Is the RPMA the best way to encourage pharmacies to operate in locations where they would	In simple terms yes, it is a way to encourage pharmacies to operate in locations where they may otherwise not be economically viable. Opening up the market to allow rural

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not otherwise be viable? Is community need a more appropriate measure than geographical location?	supermarkets to operate a pharmacy would spread the fixed costs of operating a pharmacy and provide access to consumers. This would also reduce the RPMA fees paid.
20. Is the Electronic Prescription Fee achieving its intended purpose of increasing the uptake of electronic prescribing and dispensing?	Not yet.
21. Is the Premium Free Dispensing Incentive achieving its intended purpose of increasing the uptake of generic medicines? Are there better ways to achieve this?	Yes. Branded medicines should be de-listed or supplied at generic prices to the pharmacy.
22. Should the timeframes for payment settlements for very high cost medicines be lengthened throughout the supply chain and mandated by Government?	Yes. However, if a consignment stock arrangement was in place for these medicines the supplier invoice would not to be paid until the medicine is dispensed. In addition, the government reimbursement time for those medicines should be shortened so that neither pharmacists or suppliers are at a disadvantage.
23. Are there better ways of achieving patient access to very high cost medicines through community pharmacy that reduce the financial risks to the supply chain and facilitate consumer choice?	Yes – consignment stock to ensure availability. Predictive forecasting analysis on products that are sold down to the pharmacy level to ensure pharmacies actually have the stock on hand for dispensing. A concept of location allocation of these medicines where by one pharmacy may have the product in stock and another pharmacy can access that product so it can be dispensed. From the suppliers' perspective, this would simply be processed as a return (from the pharmacy that had the product) and re-allocation (to the pharmacy that needs the product) for selling to the consumer.
24. Given that very high cost drugs are likely to become more common on the PBS, should this remuneration structure for hospitals change to more closely reflect the remuneration structure of community pharmacy?	No for public hospitals. Yes, for private. Facilitates access.
26. Should there be limitations on some of the retail products that community pharmacies are allowed to sell? For instance, is it confusing for patients if non-evidence based therapies are sold alongside prescription medicines?	No, let the market determine this. However, there is probably a business model waiting to be executed whereby predominantly only prescription medicines are dispensed and sold, along with associated (pharmacy and/or medical) services in a much smaller retail footprint. Confusion is only apparent if the consumer is not adequately informed.
27. Would a community pharmacy that solely focused on dispensing provide an appropriate or better health environment for consumers than current community pharmacies? Would such a pharmacy be attractive to the public? Would such a pharmacy be viable?	These models already exist oversees (UAE[xli]). They would be viable if the dispensing volume and associated services (pharmaceutical and/or medical) justified the rent and salaries paid.
28. More generally, is there a need for new business models in pharmacy? If so, what would such a model look like and how would it lead to better health outcomes?	Yes definitely. Opening up supply in the market. Digitising the process chain from consultation to collection. Allowing supermarkets and general practice to dispense medicines. Allowing GP's to work in pharmacies. See section 4.1.
29. Is it appropriate that the PBS links the remuneration for the provision of professional advice to the sale of medicines?	Yes, why else would the advice be provided if the direct patient need does not exist.
30. Would it be preferable when a medicine is dispensed if advice given to consumers is remunerated separately; for example, through a MBS payment? Would this be likely to increase the value consumers place on this advice?	It may be preferable but the current operations and time available in a pharmacy are incongruent to this advice being provided. Further the positioning of this service needs to be considered as some patients may or may not value it. In addition, the advice provided should be part of the dispensing fee itself which is why the dispensing pharmacist should receive some form of direct compensation.
31. If an MBS payment for professional pharmacy advice was introduced, what level of service should be provided? Should the level of payment be linked to the complexity of particular medicines? Should it be linked to particular patient groups with higher health needs?	This would change the transaction nature of the pharmacy business model of dispense/advise to one of consultation (a good thing). But before this question is even answered in detail an inventory of the professional advice should be outlined so as to clearly articulate precisely what advice is being given, for what reason, to what patient, for what medicines at what time.

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32. What are appropriate ways for pharmacies to identify and supply the health services most needed by their local communities?	The provision and publication of medicine and health data by region and suburb, condition, demographic etc … Having this data would go a long to informing pharmacists what conditions exists in their local communities and what products and services can be provided. Allowing for GP to work in pharmacies would also assist pharmacies first hand.
33. Are pharmacy services accessible for all consumers under the current community pharmacy model? If not, how could pharmacy services be made more accessible?	Generally, yes. But, it can be improved, particularly for extended hours access. The problem is for many pharmacists the provision of quality of services is not backed up by the available time to actually provide those services. However, it must be recognised that not all patients need or want a full service.
34. How should government design the provision and remuneration of new programs that are offered through community pharmacy to ensure robust provision, value for taxpayers and appropriate supply for patients in need? For instance, should all patients be entitled to an annual HMR? Should HMRs be linked to a health event, such as following hospital discharge? Should they only occur following referral from a medical practitioner?	What can be provided should be clearly defined and understood by all parties including pharmacists, doctors, patients and the community at large. This should be done via an extensive consultation process and clear lines of demarcation should exist between doctors, nurses and pharmacists and this should be understood by patients through a broad and ongoing communications program. The definition of these services should have clear terms of reference and provide for clear patient consultation and not just a tick and flick form based exercise. If a service is being provided the patient should acknowledge they have received that service.
35. Are there non-medicine-related services that pharmacists can or should provide to consumers due to their expertise as pharmacists or for other reasons (e.g. consumer ease of access to community pharmacies)? If so, why are these services best provided by community pharmacy?	Yes – see response to question 34.
36. Would any of these remuneration models be generalizable to other medicine services offered by pharmacies? Why or why not?	Yes. The whole purpose of dispensing is to ensure the advice provided at the time of dispensing is comprehensive.
37. Is cost a barrier to accessing worthwhile health services offered by pharmacy?	We have no evidence cost is a barrier for service provision. Similarly, if agreed services were bulk billed through the MBS or something similar this would also not be a cost provision. The biggest barrier to providing these services is communication to and understanding from the patient. They simply don't know what they don't know.
38. If particular health services were deemed to be of clinical value and delivered good patient outcomes, what other mechanisms could allow these programs to be disseminated around the country to relevant communities and groups on an affordable basis?	Location based mechanisms and available pharmacists are prime example of how this should happen, whether it is in a community pharmacy, supermarket pharmacy, general practice or hospital. The online provision of these services should not be ignored.
39. Should both direct consumer remuneration and government-based remuneration be applied for particular services or access arrangements?	Yes, and in this would have to be determined in detail. Paying for a service is based on the perceived value of that service to the recipient.
40. What pharmacy services should be fully or partially Government funded and what is best left to market or jurisdiction demands?	Existing PBS services should be government funded, so long as pharmacists actually have time to provide the service. Other services unless proven to be clinically critical should be defined by pharmacists in the market.
41. What does innovation look like in community pharmacy? Is there sufficient scope and reward for innovation embedded in the current remuneration model? How could this be achieved?	In a word DIGITISATION from consultation to collection. There is no scope for reward of innovation. Many of the current chains are simply not motivated or have an incentive to improve their end to end business processes.
42. Would the removal of the location rules with the retention of the current state ownership rules for pharmacies increase or decrease access and affordability for pharmaceuticals to the public? Why and for what reasons?	The removal of all location and ownership rules should occur. Removing this constriction will increase access to pharmacies and make it more affordable for consumers. Restricting anything only perpetuates inefficiency and high cost. It is somewhat ironic that the growth of discount chains is a function of how many registered pharmacists can be allocated to pharmacies in a partnership model as opposed to being truly innovative in the market.
43. Would the removal of pharmacy location rules in urban areas with their retention in other areas, particularly rural and remote areas, increase or decrease access and affordability for	We advocate the removal of location rules in urban and rural areas in partnership with allowing supermarkets to enter the market so that this penetration can at least ensure rural communities are adequately serviced.

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pharmaceuticals to the public? Why and for what reasons?	
44. Would the removal of the location rules in urban areas with their retention in other areas, particularly rural and remote areas, discriminate against rural and regional consumers or benefit those consumers relative to consumers in urban areas? Why or why not?	No, it will enhance their position by virtue of more locations being made available. If we remove the location and ownership rules market demand will drive the need for new pharmacies. It will also drive the need for further innovation.
45. If the states and territories were to amend the ownership rules so that any party could own a pharmacy, subject to requirements for dispensing only by a qualified pharmacist, how would your response to the full or partial removal of pharmacy location rules change?	No change to our response which is detailed in this report and throughout the responses. The market should be opened up.
46. Is the short distance relocation rule appropriate? Please provide examples to explain your reasoning.	As our response calls for an opening up of the market the short distance rule is a moot point.
47. It has been suggested to the Review that this creates unintended consequences in locking pharmacies into specific shopping centres and transferring effective ownership of the pharmacy approval number to the shopping centre. Is this a reasonable assessment of the effect of the location rule regarding short distance relocation from a shopping centre? Should this rule be modified, and if so, why? If not, why not?	Yes, it is a reasonable assessment. If the market opened up the problem would not exist.
48. A similar requirement exists with the same rule for relocation of pharmacies from within medical centres. Is this requirement for medical centres desirable or undesirable?	It is undesirable. Why limit the supply and location of where pharmacies can operate.
49. It has been suggested to the Review that pharmacies should be allowed to enter new locations subject to the payment of an appropriate approval fee to Government to prevent excessive entry to the pharmacy market. Any pharmacy then having been competitively impacted by a new entrant, or who would prefer to exit the market, would be able to receive compensation for surrender of its own approval number. Would such an approach be desirable or undesirable?	Given that we advocate opening up the market the payment of an approval fee to government would seem to limit the supply and access to medicines in a location. This is inconsistent with the NMP.
50. It has also been put to the Review that by limiting competition for existing pharmacies, the pharmacy location rules raise the profitability of some or all community pharmacies. Is this a reasonable expectation of the effect of pharmacy location rules? Please provide examples to explain your reasoning.	It is a reasonable expectation. As we have stated we find it somewhat perverse that the most privileged industry ownership group in the country benefits from remuneration that limits supply and access to PBS medicines for those most in need. Government should not be in the business to fund this level of inefficiency to the market and profitability for the few. It stifles innovation, access, convenience and fair price.
51. Should an approved pharmacy operating in an area for which the pharmacy location rules preclude the operation of a second pharmacy be required to provide a minimum level of services in addition to the dispensing of PBS medicines? Should such pharmacies also be required to maintain minimum opening hours in addition to those typically offered by community pharmacy?	Yes, definitely. This is why supermarkets with their scale can increase the supply and availability of medicines to the consumer.
52. The current pharmacy location rules do not preclude a pharmacist from operating more than one pharmacy within a particular area. To the extent that this may allow an approved pharmacist to restrict	Yes, they should. Current rules stifle pharmacy ownership penetration. Pharmacists should be allowed to own and operate as many pharmacies as they profitably deem appropriate. Under the current arrangements, particularly with discount chain pharmacies, pharmacists who join these chains are then encouraged to become partners

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local competition by opening a second pharmacy in the same area, should the rules be amended to support choice and value for money for consumers?	in order for the chain to expand on the ownership limitation restrictions in place. In other words, they're expanding on the back of a pharmacist's accreditation and not true innovation or market demand.
53. Recognising that restrictions on co-location of pharmacies and supermarkets exist under state and territory legislation, would the removal of this restriction from the pharmacy location rules be desirable or undesirable?	Desirable. This is a key tenet of our recommendation. Any law that constricts supply and the negotiating position of buyers in the market will only make that market inefficient in the form of higher prices and limited supply.
54. Could hospital pharmacies complement medicine dispensing and related services currently provided through community pharmacy or other public and private hospital pharmacies?	Yes.
55. If pharmacies operating out of private hospitals were required to operate 24-hours a day, would this be beneficial for consumer access? Would it be viable or economical for private hospitals to provide this service?	Yes of course it would be beneficial to the consumer. Private hospitals would have to ascertain whether it is commercially viable to do so. On the notion of 24 hour pharmacies, perhaps a law can be enacted whereby special provisions are granted to non-hospital pharmacies who can operate a 24 / 7 / 365 business and be granted a licence to do so and compensated accordingly. This would be subject to attracting pharmacists and perhaps a limitation of the licences granted in geographic areas should be in place to ensure the commercial viability of such pharmacies, noting that too many 24/7/365 businesses would be non-viable. Other pharmacies who are not granted a licence to operate 24 hours per day may still do so but would not be eligible to be compensated. The licences should be for the term of the (recommended) VABESMA agreements and automatically roll over if the geographic area granted is not subject to a competitive request for a 24-hour licence. The geographic area would need to be defined (for example 45 min travel time) and supermarkets should be excluded from the test, however if they choose to operate 24 hours they should not be compensated.
56. How might broadening the services provided by hospital pharmacies improve consumer access in rural and regional Australia?	Hospitals are in many cases first ports of call for critically ill patients so broadening services will clearly assist in consumer access to the medicines they require.
57. If hospital pharmacies were able to complement the services provided by community pharmacy, should all pharmacies be able to access similar purchasing arrangements?	Yes, they should otherwise it tips the scales unfairly in favour of hospitals whose pharmacies are only a tiny proportion of their overall fixed cost base.
58. Should hospitals be able to open dispensing pharmacies in the community? Should hospitals be able to contract with specific community pharmacies? Under these arrangements, should community pharmacies be able to access medicines through hospital supply arrangements?	We don't agree with the notion of hospitals opening dispensing pharmacies as their primary goal should be clinical care not the competitive business of pharmacy sales. The viability of a hospital is not dependent on the profitability or otherwise of its pharmacy on site. For the purpose of efficient pricing however non-supermarket community pharmacies should be allowed to be able to access medicines through hospital supply arrangements. This simple reason is that community pharmacies are not competitors to hospital pharmacies, however hospital pharmacies are competitive to supermarket pharmacies hence the need to access their pricing arrangements.
59. Should hospital pharmacies be able to establish limited dispensing arrangements, either in-pharmacy or through a delivery or mail order service, to enable post-discharge services and continuity of care to patients in the community setting?	No, for public hospitals. Yes, for private hospitals.
60. Could dispensing arrangements by hospital pharmacies to patients be extended to the broader community to complement access to medicines through community pharmacy?	Yes, as it complements both the services provided and access to medicines.
61. What other opportunities are there for public and private hospital pharmacies in securing supply options for greater access to PBS subsidised medicines?	Consistent with our response, digitisation from consultation to collection is essential.

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62. Although s100[xlii] AHSs[xliii] are able to fund the employment of a pharmacist from their primary health care budget, there are no specific funds to employ a pharmacist to conduct Quality Use of Medicines activities and manage the s100 program within the AHS. Do these arrangements impact on health outcomes?	Yes, they do. Our activity review proves that because once a pharmacy goes above 150 scripts per day there is simply no time left to provide adequate consultation to maintain this quality of service. This is why many consumers get frustrated having to wait 10-30 minutes to receive their prescriptions in many pharmacies.
63. The s100 Support Program supports increased involvement of pharmacists in the supply of PBS medicines to AHSs. Is there further scope for pharmacists to be more involved without impacting on access to medicines? Should pharmacists be able to directly claim an MBS type payment for QUM[xliv] activities conducted in AHSs? Could this be a trial program under the 6CPA?	Pharmacists should be able to claim an MBS type payment and be paid directly for it.
64. Could general improvements in remote dispensing improve the delivery of medicines in Aboriginal and Torres Strait Islander communities?	Yes of course.
65. Should the s100 RAAHS program be extended to include non-remote AHSs? Similarly, should the CTG[xlv] Co-Payment measure and QUMAX programs be extended to include AHSs in remote areas?	Yes.
66. Should AHSs in all states and territories be able to operate a pharmacy business?	Yes
67. How could appropriate QUM activities be provided in all remote areas at a comparable level of quality to those provided in non-remote services?	Continuous training. The use of technology through webinars.
68. Would it be desirable if remote s100 Aboriginal Health Services were also able to write CTG scripts?	Yes.
69. Could the arrangements for s100 and CTG co-payments be merged to allow Indigenous people who travel to access both s100 while they are at home and CTG co-payments when they travel?	Yes, it could.
70. Should access to electronic patient health records be required for all health professionals treating Indigenous patients across all locations?	Absolutely. While the government funds the responsibility to provide a health service to all of the community, the community should have a mutual obligation to ensure their health records are available.
71. Should hospitals be allowed to write CTG co-payment scripts for out-patients?	Yes.
72. Could there be more scope for tendering for the supply of medicines through AHSs?	Yes. Any activity that reduces price is a benefit to the community and taxpayer.
73. Is the current approach to CPA negotiations, as adopted in the 6CPA, an appropriate way to meet wholesalers' needs? If so, why? If not, why not?	No. The constricted supply arrangements in place via location restriction does not maximise the price and access outcomes for consumers.
74. Are there alternatives to the current CSO rules that would enable wholesalers to improve the efficiencies of their services without detracting from the consumer experience and access?	Yes absolutely. We have outlined these in the number of areas in the report. Supply chain efficiency between wholesalers and pharmacists is essential. This can be enabled a number of ways but a predictive trading hub portal might be the first way to do this and go a long way to digitising the consultation to collect process. This trading hub portal should be mandatory for all PBS prescription medicines. This could be developed by the government, run by a separate government owned entity, that initially ALL wholesalers and pharmacists hook into. *Our vision in this space is extensive and available for further review*.

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75. Pfizer supply direct and do not provide their medicines for supply through the CSO. Should all PBS medicines be available through the CSO, or is it appropriate for a manufacturer to only supply direct to the pharmacy?	Yes, it is appropriate. Why is it that Pfizer can do this profitably without government assistance and others cannot? By introducing a predictive trading hub portal between suppliers and pharmacists' manufacturers can still supply direct to pharmacists if they wish or through CSO wholesalers but it should be mandated that the portal is the information exchange between the trading entities.
76. Should s100 and RPBS items be included in normal wholesale arrangements and in the CSO? If so, why? If not, how do the current arrangements support consumer access to all PBS and RPBS items?	Yes.
77. Have recent changes to the CSO, such as the extension of the guaranteed supply period and introduction of minimum order quantities, had an impact on consumer access or choice? If so, what evidence is available to demonstrate this?	Yes. Minimum order quantities are generally aimed at reducing delivery frequency and thus supply chain costs. If consignment stock arrangements were in place further efficiencies can be gained and consumer access can be increased through 1) slightly higher onsite stock holdings and 2) less deliveries and 3) especially if it was transacted through trading hub.
78. Currently not all areas are covered by the 24-hours CSO obligations (such as Christmas Island, Derby (WA) and Mission River (QLD)). Are these exceptions leading to detrimental outcomes for patients? If so, why? If not, why not? If so, should they be included in the 24-hour rule? If so, how is this logistically possible? If not, are there other areas of Australia that could be excluded from the 24-hour rule without adverse patient impact?	We cannot comment on the specific cases you mentioned, however if the consignment stock and trading hub portal was introduced any limitations to supply in this regard would be eliminated or certainly reduced.
79. Should CSO wholesalers have such discretion, or should they as part of the CSO arrangements be required to provide minimum terms and conditions for PBS items?	CSO wholesaler should not have this discretion as it can compromise supply to consumers.
80. In the 6CPA there was a change in the CSO requirements relating to 72-hour delivery for the 1000 highest volume medicines. Was this a desirable change? What impacts has this had and is there evidence available to demonstrate this?	Anything that delays supply to consumers has a detrimental impact. The challenge is simply bigger than the 72-hour rule and requires fundamental change. Our report outlines a number of innovative options to address this.
81. CSO wholesalers can require minimum ordering amounts for specific medicines. This is likely to reduce the cost to the wholesaler while increasing inventory costs and wastage for the pharmacy. Is this desirable or undesirable? Are there other parts of the wholesaling arrangements that create or encourage cost shifting that are undesirable for community pharmacy or consumers?	If the consignment stock arrangement was in place this would not be a problem as wholesalers would have to ensure 1) enough stock exists at the pharmacy and 2) they can control the costs and frequency with which to deliver that stock. Wastage would also be reduced as 1) pharmacies would bear the cost if what was supplied does not match what was sold and 2) wholesalers through predictive forecasting techniques would be motivated to supply pharmacies what they need based on the micro to macro demand factors. This is enabled though distribution requirements planning (or DRP) as part of a broader demand management and material / manufacturing resources / requirements planning (or MRP) process.
82. Should there be requirements on wholesalers relating to minimum usage dates of stock? Would such requirements increase or decrease wastage in the system? Would this shift costs to community pharmacy and reduce the efficiency of the system?	To the effect the stock is rendered ineffective then yes there should be. Good planning goes a long way to eliminating this waste.
83. Does the current CSO arrangement lead to strategic variation in trading terms by wholesalers that is detrimental to some community pharmacies and patients. If so, how? How could the current system be modified to remove such undesirable strategic behaviors?	It is detrimental in the sense that some wholesalers will under-supply medicines based on the profile of the pharmacy (e.g. perceived high volume versus other). The trading terms covering price, stock supplied, lead time to supply and payments terms can also very. This can lead to a situation where the stock available for patients is not available when it is needed. Removing these variables and opening up the information exchange will go a long way to ensure medicine availability is consistent. Our report covers different methods of doing so.
84. Is a percentage mark-up paid by the pharmacist an appropriate way to compensate wholesalers? Would an alternative compensation arrangement be	Generally, yes. If location restrictions are removed then this should continue to be so.

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preferred? If so, please provide details of preferred arrangements.	
85. Could the Government provide either improved wholesale medicine delivery or equivalent wholesale medicine delivery at a lower cost to consumers and taxpayers by moving from a broad CSO system to an alternative system?	Yes. Our recommendations for a PBS trading portal, consignment stock, predictive forecasting analysis, information exchange and digitising the consultation to collection process go a long way to removing these inefficiencies.
86. Should the onus for the delivery of medicines to community pharmacy around Australia in a timely fashion (e.g. 24-hours) be imposed on the manufactures as part of their listing requirements on the PBS?	Yes. With the information, technology and software available today it is simply unacceptable that manufacturers have any problem with lead time to supply, safety stock levels, minimum and maximum stock management, scheduled delivery days, minimum order quantities and minimum order values.
87. Should the onus to negotiate the delivery of PBS medicines from manufacturers be placed on community pharmacies, either individually or as collectives? Would this be desirable or undesirable?	Generally, yes. But in real terms it should be collaborative. Unlike other products PBS medicine products will ALWAYS sell, so carrying slightly higher inventories will be paid back in the sales of the products.
88. Would an improved approach to wholesale medicine delivery involve the Government tendering delivery on a nation-wide basis to one or two wholesalers (with appropriate redundancies)? Should it be done on a national, state or local basis? Should tendering be limited to only Pharmacy Accessibility Remoteness Index of Australia (PhARIA) 2, 3 and 4 locations, with open competition in PhARIA 1 areas?	We believe this is short term thinking, although generally valid. There should be a perpetual tender in place via the trading portal we have previously mentioned. Why limit the supply of medicines to a limited number of local manufacturers and / or suppliers? Our trading portal recommendation could be opened up to global supply (subject to TGA certifications etc...) and would go a long way in ensuring a pricing tribunal (see our recommendation at the end of this section of the report) has visibility to the best prices locally and globally. This question may presume there is a perfect supplier for all locations and this is rarely the case.
89. The Review Panel notes that state and territory governments already tender for the supply of medicines to public hospitals, should the Commonwealth and state and territory governments work together for a single tendering model for relevant public hospitals and community pharmacy in the relevant state? If so, should it be for all medicines or specific medicines (e.g. biosimilar or generic medicines)?	As the Commonwealth fund the states for each of their health budgets we believe this should be led by the Commonwealth, collaboratively with the states, noting that some states may have different supply price arrangements. By being led by the Commonwealth also ensures there is a bigger carrot on offer to the supply market.
90. Are there any other regulatory arrangements that should be introduced to promote high standards of delivery and accountability amongst pharmacies, wholesalers, manufacturers and other entities receiving funding under the PBS?	Yes. We have outlined these in our VABESMA and VABEAMA recommendations.
91. Are there any existing regulatory arrangements that are unnecessary or overly burdensome?	Yes, location restrictions.
92. What data is already available in pharmacy and other parts of the health system that could be used to inform the monitoring and assessment of standards of delivery and health outcomes? How might a patient's existing My Health Record be used to support this?	A history, by patient, of prescribed medicines would be helpful. However, answering this question, in light of our recommendations, is worthy of a completely separate analysis and response. Our general response is that eHealth should be available to all Health Care professionals.
93. Is there a role for pharmacists to work with patients and other health professionals, possibly relating to individual medicines or specific conditions, to better create the data to analyse the health outcomes for that particular patient or group of patients, including through the use of a patient's existing My Health Record?	Yes. The components of such an initiative would need to be defined in detail.
94. If this data collection and analysis is desirable, would funding be needed from Government or from another source? If so, what would be the avenue for such funding?	Presumably yes funding would be required. However, it should be part of a broader end to end digitisation process.

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95. Are consumers aware of what programs and general pharmacy services they are entitled to? Is there enough information available regarding the services for which they are eligible?	Generally, no, they are not as aware as they could be. A regular community services announcement type program needs to be undertaken to explain this. Further to this every single pharmacy should display a consumer dispensing and services charter which outlines these services.
96. If they are not receiving the relevant service, do consumers know the avenues for feedback or complaint? Are these feedback mechanisms adequate or should they be improved? If so, are there ways of using technology to provide better feedback?	Some do, but not all. The suggested charter above can go a long way to explaining this.
97. Is the ability for the consumer to choose their pharmacist, and change pharmacists if they are dissatisfied, the appropriate or best mechanism to provide feedback?	It is a mechanism but it really is a qualitative assessment as to whether it is the most appropriate.
98. Are there appropriate standards for the dispensing of medicines and delivery of services by community pharmacy? If so, are these standards being upheld? If not, how could the current standards be improved?	Our research reveals the "standards of dispensing and associated advice" generally follows the training the pharmacists have received and are being upheld (which is not to say they always are). Standards should be reviewed periodically and in accordance with the necessary medicines to ensure they are being followed. The problem however is the provision of quality of service is hampered by time and process pressures and thus is open to "interpretation".
99. What services should a consumer expect to receive from a community pharmacist who dispenses their medicines? Why should the consumer expect these services?	Consistency of service is first and foremost essential, across the pharmacy profession, hence the adherence to standards. Consumers should always have their dosages explained, side effects of the medication, cross side effects with other medications, when the medication should be taken and at what frequency. Every possible service that a pharmacist can provide should be taught in University (including vaccinations).
100. What are the minimum services that consumers expect (and should receive) at the time of dispensing? Do these differ between initial and repeat prescriptions? Are these services being provided by all pharmacies?	We cannot comment and nor should others on what all pharmacies are doing. Our research reveals that the advice mentioned previously is being given. In the case of repeat prescriptions, the services do not differ because other factors may have come into play since the initial prescriptions. Examples could include shift work or OH&S requirements, other drugs being taken, changes in lifestyle and even changes in mental outcomes. These are all factors being considered when dispensing and advising on PBS medicines.
101. What does 'transparently cost effective' mean for consumers in the context of remunerated pharmacy services?	Being aware of what services pharmacists provide, what costs or reimbursements occurs for that service and what consumers should expect from the service and whom to contact if the service received is not to their level of satisfaction is our definition of transparently cost effective.
102. In your experience, are community pharmacies generally delivering these services? [xlvi]	In terms of services yes however in terms of transparency and understanding by consumers, then generally no.
103. Are there currently some programs that are viewed as additional to dispensing which should be included as part of the service provided by a pharmacist when a prescription medicine is dispensed (for example, a medicine checks or review)? If so, how should pharmacists be remunerated for providing these services? Should such services be included each time a prescription is filled or should 'initial' and 'repeat' prescription dispensing involves different services?	Yes, they should be and our recommendation here is that the pharmacist should be directly reimbursed (a portion of the fee) for the services provided.
104. Is there a variation in service standards between different pharmacy models?	There definitely is. Our research reveals discount chains are focused on "get em in" and "get em out". Other pharmacy business model that are not so discount focused tend to spend more time on the service front.
105. Do community pharmacies that offer discount medicines provide lower levels of service? If so, what evidence is there available to support this?	Yes. Our research reveals the experience of the pharmacists tends to be lower. The mere fact that price is a key selling differential means more volume is processed (and must be processed) and there is simply less time to both provide and experience the services (despite the pressure from some of these chains which expect pharmacists to do so).

Question	Rhodes Management Response
106. How do we measure the quality of services provided by the pharmacy?	Time and certainty of outcome for the patient. Understanding by the patient.
107. What do consumers expect from community pharmacy in relation to their medicines?	Promptness is being provided the medicine. An explanation of what the medicine does, side effect if any of the medicine and the guidance on how to take it.
108. Has the $1 discount had an impact on the access and affordability of PBS medicines? Has the introduction of the $1 discount been a successful implementation of policy?	No, it only shifted customers from those that don't discount to those that do. This was predicted given the economic demographic being served.
109. What examples can you provide of variation in prices for regular PBS prescriptions?	Some discount chains offer PBS medicines at lower prices. The lower prices are often offset by other non-PBS sales in the store so that overall profitably at the time of sale is either maintained or increased.
110. How informed are consumers of the scope of medicines and related services that can be provided by pharmacists without referral to a General Practitioner?	They are generally poorly informed hence the charter recommendation we made earlier.
111. To what degree do current advertising restrictions limit the ability of pharmacies to promote medicines and related services available to consumers?	Our charter recommendation we mentioned earlier will go a long way to addressing this.
112. In your experience, do community pharmacists provide appropriate advice for schedule 2 and 3 medicines?	Yes, mostly they do.
113. Are the current restrictions on the sale of schedule 2 and 3 medicines an appropriate balance between access and health and safety for consumers? If not, how could this balance be improved?	Yes.
114. Is the sale of schedule 2 and 3 medicines an important contributor to the income of community pharmacies?	Yes, is course. This is what differentiates a pharmacy from a supermarket in the current environment.
115. Does the availability and promotion of vitamins and complementary medicines in community pharmacies influence consumer buying habits?	Yes, and for some pharmacies this is quite important.
116. Should complementary products be available at a community pharmacy, or does this create a conflict of interest for pharmacists and undermine health care?	It can certainly create a conflict of interest but there should be a effective complimentary products available.
117. Do consumers appreciate the convenience of having the availability of vitamins and complementary medicines in one location? Do consumers benefit from the advice (if any) provided by pharmacists when selling complementary medicines?	Yes, it helps them to choose however further standardisation is required in Australia.
118. Does the 'retail environment' within which community pharmacy operates detract from health care objectives?	Not really as it is a retail business anyway.
119. Are the current consumer payments for the supply and dispensing of PBS listed medicines transparent? Are they appropriate?	No, they are not.
120. Is the PBS Safety Net adequate to address the needs of low income consumers who face high	No, it doesn't. Many customers who reach the safety net start to abuse the benefit. Some are even known to sell the drugs on eBay.

Question	Rhodes Management Response
pharmaceutical costs and other medical-related costs? If not, what other strategies can be employed to ensure access to cost-effective health care is protected and promoted?	
121. What do consumers expect for the value of the PBS co-payment, noting it is intended to contribute to the price of the medicine, supply to pharmacy, a pharmacy handling fee and a professional dispensing fee?	Consumers expect to receive and should be provided with proper counselling and a reasonable quality of service. By and large consumers seek to pay the lowest price possible.
122. What is the objective of the co-payment? Is it to ensure patients use PBS medicines appropriately, by setting a price signal? If so, is this objective enhanced or undermined by allowing co-payment discounts?	Yes, it is to ensure medicines are used appropriately. We also believe the 20-day rule and safety net need to be restructured to avoid any overuse.
123. Should pharmacists be able to discount the co-payment by more than one dollar if they choose to do so? Would such competition benefit or harm consumers? If competitive discounting is expanded for the co-payment, should any limits be placed on the potential discounts?	We believe there are strong arguments to allow this discounting as it benefits the consumer. If supermarkets enter the market this will allow all pharmacies to compete with them. However, we also acknowledge that under the current 6CPA arrangements allowing unfettered discounting would benefit existing discount chains at the expense of the smaller pharmacies. This may be a way to level the field and ensure only the strongest survive.
124. Is it reasonable for consumers to expect access to medicines outside of standard business hours? If so, why? What arrangements could be made to improve consumer access?	Yes. The NMP calls for access to medicines and this access is facilitated by the available hours to consumers. This will be further facilitated by supermarkets entering the pharmacy industry due to their extensive opening hours.
125. What services do consumers expect and value from pharmacists outside of standard business hours? Are there other settings or mechanisms that could deliver these services after hours?	Consumers deserve all of the access and service they can and that can be reasonable provided. Succumbing to illness is not time of day based, so anything that facilitates medicine availability beyond normal business hours should be encouraged. The mechanisms to provide these services out of hours can be facilitated by supermarkets entering the industry with their extended trading hours. Pharmacies in general should have not limits to extended trading.
126. Does more need to be done to encourage greater access to medicines and professional services through the expansion of existing rural and remote programs?	Yes. Relax the location rules and increase trading hours where applicable.
127. Is it reasonable for consumers to expect that all community pharmacies provide these specialist services? If so, why? If not, why not?	Yes, because all pharmacies have an accredited pharmacist in them. There should be no difference to the services provided across pharmacies. This applies to supermarkets as well.
128. Would it be desirable to align the delivery of specialist services to population need in local communities? If so, what is the best way of coordinating appropriate and relevant services for populations of need?	Yes, where applicable specialist services should be aligned to population need. Allocating such resources should be based on the information (and resources) available. These can be facilitated through hospitals, doctors and other specialist pharmacists (e.g. locums) where possible. The important thing is ensuring the community is aware of them. A web portal that outlines this is a first start.
129. How might access and service barriers identified above be resolved and consumer needs be better met? Is additional training and support within community pharmacy sites needed?	We strongly recommend that all graduating pharmacists should be trained and accredited in ALL SERVICES, not just the minimum amount. This will increase the skill pool for these services to be provided. In the interim existing pharmacists should be encourage to skill up where they can. Ideally the training for these pharmacists should also be compensated for.
130. Are there other inequities in terms of access to and quality use of medicines? If so, how should those be addressed and what population groups could be targeted?	Yes, but they're too numerous to mention in this response. Address the prime points of change first like removing location restrictions, increasing hours, increasing skills, facilitating better supply and price arrangements and digitising the consultation to collection process will address the key issue at first.
131. What can be done to increase public awareness of available pharmacy programs and services, particularly specialist services?	Community service announcements through multiple media channels (radio, television, web, advertising (print, external and digital)). Clear "in pharmacy signage" on the services provided. Website portal. In addition to the general message, each message can also be tailored to patient specific needs as well.

Question	Rhodes Management Response
132. How can we encourage and support consumers to engage more with their local pharmacy and what specific patient groups require more general awareness about available pharmacy services?	ALL patient groups require increased general awareness. The previous recommendations outline how this can be started.
133. It is the Panel's understanding that the additional $20 payable for infusions compounded by TGA licensed compounders is remuneration for the cost of gaining and holding the TGA licence. Should the PBS provide additional remuneration for compounders that meet TGA licensing requirements?	Our understanding is that it is a two-tiered fee structure. That is $60 ($40 + $20) paid to a manufacturer that holds TGA manufacturing licence. And $40 to approved suppliers through the PBS where manufacturer does not hold TGA manufacturing licence. The payment should be fixed for both TGA licenced and non TGA licenced.
134. It is unclear to the Panel that there is any therapeutic difference between chemotherapy medicines provided by TGA licenced compounders and non-TGA licensed compounders. Is there any therapeutic difference, if so, what are they? If there are no therapeutic differences, should the payment of chemotherapy compounding be the same regardless of whether the provider is TGA licensed? If there are therapeutic differences, why should the Government continue to subsidise sub-optimal medicine?	We recommend that ALL chemotherapy compounders should be TGA licenced to ensure that they provide the same quality service, otherwise there is no point to subsidise sub-optimal service.
135. Are the two compounding fees ($60 for TGA licensed, $40 for non-TGA licensed) reflecting a supply guarantee?	Our research suggests that there is no evidence that they reflect the supply guarantee.
136. If it is appropriate to have differential payments for chemotherapy compounders, what is the best way for those payments to be made? What should form the basis of the difference of the payment?	We recommend that all payments should be the same and that there is no need for differential payments. However, we would support the notion that hospital pharmacies still receive a $20 handling fee, because this money is then reinvested for the benefit of public unlike private pharmacies as the money goes to directly to the owners.
137. Are the levels of these fees sufficient to ensure long term viability of compounding services?	We have no evidence to support this as merely paying fees doesn't ensure long term viability. The Commonwealth has limited funds ($372M) and these fees are a lot less than others.
138. Should non-TGA licensed public hospitals be allowed to provide chemotherapy compounding services to other public and private hospitals?	In general, we agree with this, however we also recommend the formation of a national body to ensure the delivery of quality service. Or alternatively there should be two levels of TGA licencing, level A representing TGA licenced and level B for non TGA licenced.
139. Chemotherapy patients benefit from the ability of local chemotherapy manufacturing facilities to provide more timely medications to patients locally. These facilities generally do not hold a TGA licence. Is there a need for additional standards for non-TGA licensed compounders?	Consistency is essential so we recommend that there should be a national standard for these facilities of chemotherapy manufacturing along with TGA accreditation for more complex manufacturing or as we mentioned previously a tiered licencing system.
140. Are there other issues with the production and delivery of chemotherapy medicines which the Panel should be aware of?	We will leave this for the panel to decide.

6 Conclusion

We have offered this report, completely independently of any pharmaceutical industry body and of The King Review final report. However, for relevance was have answered all 140 questions posed by The King Review and served to offer a framework for the future.

The PGA stated in its panel discussion that *"should we take a system that is working well for consumers and taxpayers and dismantle it for the sake of an economic theory?"*

The answer is "yes we should".

The truth of the matter is it can work a whole lot better, provide much greater value for money and increase access to medicines for consumers. The CPA is a backwash of market inefficiency whose time is up. The waste is palpable and reimbursements for this waste, disturbing.

Neither the PGA nor any other body should have a monopoly in setting what is right for the pharmacy industry driven by their own respective charters and self-interest, which is to the detriment of what should be substantially better outcomes for patients and consumers.

Following our substantial research and analysis we wholly and overwhelmingly believe the pharmacy industry is ripe for change. The CPA should be scrapped and replaced with a patient centric value and efficiency charter which has at its core substantially increased access to medicines, reduced prices, greater retention of pharmacists and increased rewards for pharmacists.

The changes to the industry should be many and the sheer number of questions being asked by The King Review gives an insight into the substantial nature and potential scope of that change. Report after report has said the industry has to change, that prices are too high and location restrictions limit competition.

We say the same thing and have offered the VABESMA and VABEAMA frameworks to replace the CPA, which we encourage should be built upon.

In concluding, our points, among many we have stated in this report, are simple:

13. **Supermarkets should be permitted to enter the market**. In our first report we called out the fluffy evidence provided by the PGA in the 2014 pre 6CPA submission that asserted a level of distrust exists between consumers and supermarkets entering the pharmacy industry. However, when the survey was conducted by the pharmacists representing the Guild the question was "who is best to trust to dispense medicines pharmacies or supermarkets?" Needless to say the answer was predictable. The analogy we drew was that is like asking consumers of your local barber shop, do you trust them to do the dry-cleaning? Of course they wouldn't because there are no dry cleaners in the shop! We stated however that if the consumers surveyed were asked (and they were not) "if a registered, qualified and highly trained pharmacist who is subject to the ethical and professional standards all pharmacists are subject to, dispensed medicines from a specially configured portion of the store in a supermarket, would you trust them to do so?", we ascertain that in this scenario the answer would be predictable in the affirmative. We caution both the government and The King Review on any so-called consumer representation that might occur about any lack of support for supermarkets entering the industry because those asking the questions are simply 1) not asking the right question and 2) have a vested interest to ensure supermarkets don't enter the industry.

14. **Prices need to reduce**.

15. **Access to medicines needs to increase through the removal of location restrictions**.

16. **General practitioners should be allowed to enter the market pending the size of their operation**.

17. **Allow general practitioners to operate *within pharmacies***, without restriction as a trade-off for supermarkets entering the industry.

18. **Pharmacists need certainty**.

19. **Innovation and digitisation needs to occur across the supply chain** between suppliers and pharmacies.

20. **Innovation and digitisation needs to occur from consultation to collection**.

21. **Innovation should be encouraged, tracked and rewarded**.

22. **Managing inventory working capital must be improved across the whole supply chain** providing greater levels of certainty for pharmacies, manufacturers, wholesalers, payment terms and ultimately the Commonwealth. Importantly it provides transparency.

23. **In order to attract and retain pharmacists, their remuneration should increase** through the minor and partial direct reimbursement of the services they provide.

24. **Scrap the CPA and introduce VABESMA (VS1) and VABEAMA (VA1) in May 2020**.

We believe this will go a long way to delivering overall societal value at the personal, business, economic and industry levels we stated in our first report and be even better aligned to the NMP. It is this better and more innovative alignment that ultimately benefits consumers and patients and not the protection of a privileged pharmacy ownership industry group by an employer body seeking no change at all.

For 26 years the community pharmacy agreements have provided a pharmacy owner centric framework for the supply of medicines to Australians. However *adequately* serving the needs of the Australian community is not *efficiently* or *innovatively* serving the needs of the Australian community in the 21st century. It is certainly not doing so to increase access to medicines and provide greater value to consumers or government.

An efficient patient centric approach is now required.

7 References

[i] Pharmacy Guild of Australia

[ii] Rhodes Management and Michael Rhodes were not paid in any way for the first report or for this report. Michael and Rhodes Management are NOT members of any industry body or any pharmaceutical body and are completely independent. We have no conflicts of interest. It is this complete independence that allows us to research, analyse and comment without fear or favour on the industry, its obvious shortcomings and the participants in it. To maintain this independence this report was commenced in early May 2017 and concluded on June 26 2017. The Part 2 version authoring of this report was done independent and sight unseen of The King Review (which we look forward to reviewing after we make our report public). The Part 2a version of this report considers The King Review content in the Executive Summary.

[iii] Australia Journal of Pharmacy

[iv] A Tassone (PGA Victoria) – PSA Group Facebook Page

[v] http://www.health.gov.au/nationalmedicinespolicy

[vi] http://www.smh.com.au/federal-politics/political-news/pharmacy-explainer-what-are-the-benefits-of-deregulating-the-pharmacy-industry-20150403-1mee0k.html

[vii] The PGA is an Employer Body while the PSA is a Registered Training Organisation (RTO). The websites of both organisations outline this.

[viii] http://www.smh.com.au/national/health/damning-auditors-report-over-pharmacy-guild-agreement-results-in-little-action-20150805-giscjg.html

[ix] Sixth Community Pharmacy Agreement between the Commonwealth and Pharmacy Guild of Australia May 2015 (6CPA 201605) – section 5.

[x] Consignment stock is the process where suppliers supply the goods to the pharmacy to be stored and then eventually sold and which is only invoice once the goods have been sold as notified by the pharmacy.

[xi] It is noted however that some drugs are temperature sensitive which is easily catered for in any supply arrangement as most are supplied in Esky type ice packs or specially controlled temperature storage. Most pharmacies have allocated fridge storage for these expensive medicines and vaccines.

[xii] Cl 7.3, page 17.

[xiii] Rhodes Management.

[xiv] Exponential Smoothing, Conjoint, Price Elasticity, Bass Models, Zipf's Law, Holt Winters … just to name a few.

[xv] Page 12 – section 5

[xvi] 6CPA – section 6, cl 6.1.9 (a)

[xvii] 6CPA 201605.

[xviii] 6CPA 201605 Parts C and D, page 3.

[xix] When the 6CPA will conclude and will of course coincide with the federal budget at the time.

[xx] RPPB = Ready Prepared Pharmaceutical Benefits, EPPB = Extemporaneously Prepared Pharmaceuticals Benefits, ARPPB = Admixed Ready Prepared Pharmaceutical Benefits (6CPA)

[xxi] 6CPA 201605 Cl 8.1 – 8.7 and associated sub clauses.

[xxii] http://monash.edu/research/explore/en/persons/stephen-king(1217e073-a254-4e29-b76f-bbd12be3d075).html

[xxiii] https://ajp.com.au/features/king-review-discussing-future/

[xxiv] http://theconversation.com/how-to-slash-half-a-billion-dollars-a-year-from-australias-drugs-bill-73050

[xxv] http://www.aihw.gov.au/publication-detail/?id=60129554398

[xxvi] Via a confidential questionnaire which sought to ascertain how long it take to provide services and no service work per day. We sought the number of minutes, the types of services, the frequency of those services and compared this to the hours worked and scripts dispensed (on average). It is important to note we only asked "employee" pharmacists in order to get a response without a vested interest.

[xxvii] 8 hours X 60 minutes.

[xxviii] 3 minutes per script

[xxix] Clinical interventions (5 mins per day), 10 – 20 meds check per month (20 mins per day), Staged Supply (6 mins per day), Webster packs (DAA) Checking (20 mins per day),

[xxx] http://drugtopics.modernmedicine.com/drug-topics/news/should-boards-pharmacy-set-hourly-dispensing-quotas?page=0,1 … K Baker October 2015.

[xxxi] Registrant Data – Pharmacy Board of Australia December 2016

[xxxii] As of December 2016, there were 30,368 registered pharmacists, 1,132 of whom were non-practicing, leaving 29,236 practicing pharmacists. When accounting for provisional pharmacist numbers of 1,777 the number of general practicing and accredited pharmacists from age under 25 to age 80+ is 27,473 (pharmacists aged 70 to 80+ account for 755 practicing registrations). In what we term the prime working age group from 25 to 69 there are 25,473 practicing registered pharmacists. Those under 25 (comprising 1,224) are deemed to be interns and / or new graduate pharmacists.

[xxxiii] Prime Working Age Turnover = 4902 / 25473 = 19%

[xxxiv] Various references including http://www.payscale.com/research/uk/Job=Pharmacist, https://www.indeed.co.uk/salaries/pharmacists-salaries, http://pharmacistsfirst.com/pharmacist-salary/, http://www.payscale.com/resaearch/CA/Job=Pharmacist, http://www.pharmacytimes.com/contributor/alex-barker-pharmd/2016/04/2016-pharmacist-salary-guide, http://www.payscale.com/research/uk/Job=Pharmacist . All amounts in the graph are reflected in Australian dollars (AUD).

[xxxv] Notwithstanding this we acknowledge that many questions deserve a greater length of response and referencing however as we are about outcomes our answers are succinct enough to provide the appropriate context and content.

[xxxvi] TGA = Therapeutic Goods Administration

[xxxvii] By the doctor who write or prescribes the script.

[xxxviii] By the patient whom collect from the pharmacist their prescription medicines.

[xxxix] http://www.erx.com.au/

[xl] Pharmacy Board of Australia Guidelines for dispensing of medicines – point number 4.

[xli] United Arab Emirates

[xlii] s100 http://6cpa.com.au/aboriginal-and-torres-strait-islander-specific-programmes/s100-pharmacy-support-allowance/

[xliii] AHS = Aboriginal Health Service

[xliv] QUM = Quality Use of Medicines

[xlv] CTG = Close the Gap

[xlvi] For context refer to Figure 12 in the document Review of Pharmacy Remuneration and Regulation – Discussion Paper – July 2016. Health.gov.au.