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Professor Stephen King  
Chair  
Pharmacy Review (MDP 900)  
Department of Health  
GPO Box 9848  
Canberra ACT 2601

Dear Professor King

Thank you for this opportunity to comment on the Review of Pharmacy Remuneration and Regulation.

I originally trained as a pharmacist and have practiced in both hospital and community settings. I have worked as a public servant in a state health department, including a lot of experience as a regulator for several types of industry, and finally as a health policy and management consultant. During that time my view on what is required to reform pharmacy has been unwavering – you cannot reform this system when selling an item is inextricably linked to making a living, except by separating those two conflicts – nationalisation perhaps. It would provide the opportunity to integrate community with hospital pharmacy services in rural and remote Australia in a much more effective way.

Given the very low levels pharmacy services have reached, I can see no reason to continue to restrict pharmacy ownership. The privilege it conveys has been so abused it should be withdrawn. It clearly no longer achieves its intended purpose of a professional service. Its withdrawal does require the pricing reform you discuss later, and I will come to that. My experience as a regulator is that oligopolies like our supermarkets are much easier to regulate than many small businesses.

The advice I hear when I (rarely) go to a discount pharmacy is sometimes wrong, usually inadequate and invariably delivered either by or through an unqualified assistant who has been trained to sell a specific product. I have even seen this when infants' health has been involved. Frankly, it is dangerous. The pharmacists at these shops are remote from the public and I never see them interact directly with the customer.

Some of the things you canvass will be of value in giving the poor consumer a bit more help, but they do not go far enough. Despite the howls of protest you will no doubt be

experiencing, we must try to get the politicians to make the necessary change by keeping the more controversial steps included in your report.

I will comment on some, and regret that time constraints prevent me making a more extensive submission.

*...consumers also need, and expect, consistent minimum levels of service from all community pharmacies.*

*This includes community pharmacy providing consumers with professional advice on complementary medicines. To avoid potential harm, or the confusion between the efficacies of different types of medicines, pharmacists need to be easily accessible to give needed advice when consumers choose a complementary or pharmacy-only medicine.*

*Option 3.3 Access to Pharmacy Only (Schedule 2) and Pharmacist Only (Schedule 3) medicines should be clearly separated from complementary medicines within a pharmacy.*

*Option 3.4 Homeopathy and homeopathic products should not be sold in PBS-approved pharmacies.*

The difficulty with complementary medicines starts with the TGA not doing its job. Powers were put in the *Therapeutic Goods Act* to allow it to call in evidence for claims made. I do not think it has ever done so. It does not have the political support to do its job properly. All the pressures are to allow industry to make these nonsense claims about ineffective products, not to stand in industry's way.

Pharmacists' professional training should give them pause to think before selling, indeed promoting products from the evidence-free zone, but making money is prime and most of them do not recognise the tenets of evidence-based health care. The state boards were always useless in controlling behaviour that is unethical but short of dangerous, so the public is duped. And if you took a case to court the outcome would be far from certain given the present laws.

Simple separation of all listed medicines (including alternative or complementary ones) is one small step, but perhaps the area also needs a label (like tobacco products): "Effectiveness of these products has not been proven".

I fully support your proposal for homeopathic products but think it does not go far enough – it should extend to all products that are only listed not registered on the ARTG, unless also labelled as above.

The current storage arrangements for Schedule 2 and 3 items seem to me to be adequate.

*Remuneration Alternative 1:*

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

This is the best option for pricing because it would facilitate opening of ownership to non-pharmacists. It is also the most economically rational.

A loading would have to be paid in the rural and remote settings. This would have to be substantial in remote areas. The weightings proposed by the Independent Hospital Pricing Authority for hospital services, which might be a model, are way too small.

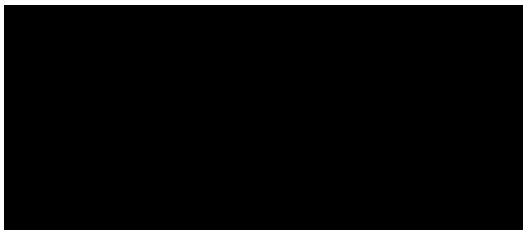
**OPTION 10-3: CHEMOTHERAPY COMPOUNDING – UNIFORM MINIMUM STANDARDS**

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

There is no longer any justification for the exemption that was provided for pharmacists in the *Therapeutic Goods Act*. It was for a time that has long passed (I was on the interstate committee that oversaw the design of the TGAct when this was discussed). All compounding premises should be regulated by the TGA in accordance with the level of risk. An industry-TGA working party could work on a lesser standard for non-sterile and sterile *immediate use* products, but all compounding should be in TGA licensed or approved premises. TGA can go over the top, and I think it did so, for example, in regulating the materials used in PET scanning but that can be worked through. The full Code of GMP may be too much in some situations, but the days of *secundum artem* preparations are long gone, especially as this part of pharmacy training has been wound back if not removed altogether. The compounding courses the industry provides are grossly inadequate.

Thank you for the opportunity to make this submission. I regret that time constraints do not allow me to make a fuller one.

Yours sincerely

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15 July 2017