Review of Pharmacy Remuneration and Regulation
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Consumers Health Forum OF Australia

SUBMISSION

INTERIM REPORT:

REVIEW OF PHARMACY REMUNERATION AND REGULATION

July 2017

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Introduction

The Consumers Health Forum of Australia (CHF) welcomed the inclusion of the Independent Review of Pharmacy Remuneration and Regulation in the Sixth Community Pharmacy Agreement. There has been increasing scrutiny on many parts of our health system, looking for ways to make it more effective efficient, accountable and to make it more consumer centred. We see this review as part of that broader reform agenda, looking to get the best value from the funding that goes into this sector and ensuring it is a sustainable sector that continues to meet the ever changing health landscape.

CHF has participated in all of the review's processes to date; attending public consultations, putting in a submission in response to the discussion paper and having briefing sessions with the review panel to discuss some of our ideas. In 2015 we undertook a survey of consumers to get their views on community pharmacy which informed our original submission. We held a webinar for our members and others on 13 July 2017 to discuss some of the options in the Interim report and invited feedback which has helped refine our responses to the options in the Interim report

The Interim Report correctly identifies the challenges of the current approach and makes a strong case for the need to change. This is not to say that the current system fails consumers or that it is a system in disarray, Indeed we know from the many surveys done by the Pharmacy Guild and others including our own 2015 survey, people value community pharmacy and see it as a vital element of our national health infrastructure. Consumers also have a high regard for pharmacists.

Overall CHF believes most of the options in the Interim Report, if put into place, would lead to a more consumer centred community pharmacy sector that is sustainable in the long run. If most of the options were implemented the community pharmacy sector would be better placed to deal with population shifts, ever increasing rates of technological change and workforce changes in pharmacy as well as the changing health system landscape with its greater emphasis on collaboration and integrated care. It would also help clarify and more centrally position pharmacy's place as an integral part of the primary health team. We have identified a couple of areas where we think the report could have said more, particularly in the use of technology and addressing after hours services

In this submission we have concentrated on those areas where we know consumers have concerns and those which we think are critical to move to a modern health system. We do not address all the options in detail in the body of the submission but Appendix 1 shows our positions on all of the options with some comments.

Issues

Pricing (Options 2-1 and 2-2)

Access to affordable medicines is a key component of the National Medicines Policy and is the reason why we have subsidised medicines through the Pharmaceutical Benefits Scheme. Consumers value that access and the PBS. The co-payments are set as a maximum that people pay for prescription medicines that are covered by the PBS and people understand that and have grown to accept the need for a consumer contribution to keep the system sustainable.

As the report highlights, the pricing arrangements for prescription medicines are very confusing for consumers. The relationship between the co-payment, the dispensed price and the actual price a consumer might be asked to pay is not well understood. The advent of discounters into the market has further confused the market. We get many queries from consumers about why the price of their medication varies so much depending on where they get it from and many are surprised to hear that pharmacies are effectively allowed to set their own price up to the co-payment for that individual. This has a greater impact on general rather than concessional patients.

This confusion is exacerbated by incorrect information on the PBS website which says the dispensed price plus allowable additional fees is the maximum price pharmacists are legally allowed to charge even though as the report points out, that is not the case. The quote from a consumer below highlights the confusion and discrepancies

> *I was in Carnarvon and went to buy a tablet which usually cost under $6.00 and they said it was $20.95. I queried and was told that was the right price. I googled PBS pricing and found out that the maximum price they were legally allowed to charge was $19.64 for the brand I had. I rang the Chemist and explained and was told that that was the price that was on the AMCAL web page.*
>
> *Anyway travelling I left it, but I had to buy some more of the same tablets in Broome. I had already bought other medication in Broome but had not checked the prices thinking it was a one off the overcharging. I rang the 4 chemists in Broome re the prednisolone and 3 quoted above the price by over $2.00 the maximum allowable price.*

CHF strongly supports the first half of Option 2-1 which seeks to set an enforceable maximum price of either the co-payment or the dispensed price. It would reduce confusion for consumers as they would know the maximum price they can be asked to pay regardless of where they are or which pharmacy they go to. It is clear that where there is less competition amongst pharmacies that the price is often higher and this seems inequitable. It gives pharmacies, which have localised monopolies through the location and ownership rules the opportunity to take windfall profits through open ended pricing to the co-payment.

The dispensed price includes a dispensing fee for the pharmacy and there seems no logical rationale for why they can add an open ended fee 'additional allowable fee'. This looks like double dipping and should not be allowed to continue.

The second half of the Option to prohibit discounting is more problematic and opinions given to us by consumers show the diversity of views. For those who can access discounting pharmacies there are real concerns that this will push up the costs of medicines for many patients. As one consumer put it

> *As a person who has multiple health conditions and doesn't have a healthcare card, I feel it is essential to be able to have competitive pricing available. If the stopping of discounting were to come in that would cost me several hundred dollars per year.*

CHF has consistently opposed measures that push up out of pocket expenses and so would be opposed to this proposition on that basis. We know from published ABS data that around 1 in 10 people who are general patients are not filling scripts because of costs and this may make that worse as some people do shop around for the cheapest place. Changes to pricing in this way will not have so much of an impact on concessional patients who make up vast majority of PBS scripts

We also see the move to disallow discounting as anti-competitive and a move against Chemist warehouse and other discounters which is not beneficial to consumers. Given the location rules inhibits direct competition by setting up in a similar location the capacity to offer discounted medicines is one of the few forms of competition available.

We appreciate that discounting advantages people in major population centres where there are more pharmacies, particularly in shopping centres and it is easier for people to shop around. This is a contributor to inequity between urban and rural people and we can appreciate that removing discounting could be seen as reducing that inequity.

We think however the costs in terms of pushing up prices for many people would outweigh the benefits and that this is not the best policy lever available to deal with the urban/rural divide on this issue.

The introduction of a maximum price would help reduce the inequity as information from consumers suggests it is pharmacies in rural and regional areas that charge the higher prices. Any measures to help reduce inequities for rural consumers needs to be delivered in the context of broader national rural health strategy that looks at system wide approaches.

Option 2-2 is to abolish the $1 discount on co-payments. CHF does not support this option. Whilst we appreciate it is voluntary for pharmacies and only around one third of people are able to access the discount, for those people it is a substantial saving. We believe it would significantly disadvantage people who are concessional patients who do not reach the PBS safety net. For those who do reach the safety net it will also mean a higher payment for medicines until they reach the safety net.

Many have run the argument that it takes longer to get to the safety net if the discount is applied which is true. However for concessional patients, who by definition are on low incomes the present time saving of $1 may be of great value as they often budget on a weekly or fortnightly basis, particularly when they have multiple scripts. The potential adverse impact on them has been ignored.

Digital Impact on Community Pharmacy (Options 2-7 to 2-9 and 10-6)

CHF is disappointed that the options around new technologies and the digital impact on community pharmacy were limited to electronic prescribing and medication records

One area we think could be explored more fully is the access to online pharmacy and which could help people living in rural area access discounting pharmacies. We were disappointed that the report did not look more closely at this type of service and put forward any options for how more pharmacies could use new technologies to enhance the offerings from such services. We know people have changed their shopping habits for many other goods and services to using online and delivery services and think there is scope to harness new and emerging technologies be encouraged to offer such services.

The option (10-6) to introduce machine dispensing is a useful first step in this direction and we support the idea of trialling this in a small number of locations. There will need to be significant work around security, remote access to a pharmacist and other logistics which can be sorted out in eth development phase. Clearly machine dispensing would need to include providing the consumer medicine information at the point of dispensing as a routine part of the process.

The access to a pharmacist could be tied into the development of a 24 hour medicines line as suggested in Option 5-7. This would ensure that the community pharmacy who would have responsibility for the machine, assuming it would be linked to one, would not need to be on call for all the hours that the machine operated.

Any trial of machine dispensing would need to include consumers in the design and development and have consumer experience as part of the evaluation mechanism.

CHF supports Options 2-7 and 2-9 as the minimum that should be in place with regard to electronic prescriptions. We would make the point that whilst promoting electronic prescribing we need to ensure that the more traditional paper based system continues and is supported for consumers who prefer it. This is particularly important for people who move around and need to be able to get their prescriptions.

The reinforcement , in Option 2-9, of the consumer having choice of pharmacy for electronic prescriptions is very welcome as it puts the consumer at the centre and acknowledges that the prescription is for the individual. We know people use different pharmacies for different medicines and they need to be able to continue to do that.

We support Option 2-8 on electronic medication records but think it needs to explicitly link to the My Health Record as we want one integrated electronic health record.

Consumer Medicines Information (Option 2-6)

The provision of the formal consumer medicines information document and the broader issue of what information consumers need to help promote adherence and safe use of medicines needs more attention across the board. This report looks at the pharmacist's role and makes some suggestions about how this could be improved. This needs to be seen in the context of the whole system and there need to be realistic expectations on how much pharmacists could and should be expected to carry the responsibility for consumer understanding of their medicines. We are particularly interested in ensuring prescribers take a more active role in explaining why people are prescribed a particular medicine and what benefits they would get from this.

This needs to be part of a broader push to improve health literacy and how all health professionals play a role in this but pharmacist, a soften the first point of contact for people have a particularly important role.

After a stakeholder workshop in August 2016 on the issue Medicines Australia agreed to auspice a working group of manufactures, pharmacists, academics and most importantly consumers to look at CMI; looking at their format and what information needs to be included and how they are best made available to consumers. We would like Option 2-6 revised to ensure it is a co-design process with consumers, who are the target for CMIs involved in any work going into the future.

In previous CPA's the dispensing fee had an identified component for making the CMI available. This was rolled into the broader dispensing fee but its needs to be made clearer that this is an integral part of dispensing. We know that the provision of CMIs is patchy and there needs to be a renewed push on this to ensure people are offered them when appropriate.

Medicines on discharge from hospital (Option 2-10)

The evidence is clear that if we can get people who are discharged from hospital with medications into a good pattern of taking them then their long term adherence is improved and the possibility of readmission within a short period of time is reduced. A key component of this is that they have the medications to take and the proposal here to have a standardised approach to medicines on discharge is very welcome.

One of the issues which needs to be addressed is how much is adequate. People returning to rural and remote areas are likely to need a larger initial supply as it may take them some time to return home. ACT and NSW do

not give discharge packs of medications whilst other jurisdictions do but the adequacy in terms of quantity of the packs varies.

We also hear from consumers that the information they get on their medicines when discharged is very variable and there is certainly room for improvement on this front.

The Pharmacy Trial Programme is looking at a trial of for improving adherence to medicines after discharge by enhanced follow up of consumers by community pharmacy. This trial could provide valuable information on both the access to medicines on discharge and information which could then feed back into the development of a standardised discharge pack.

Complementary Medicines (Option 3-2)

The sale of complementary medicines in community pharmacies is contentious with many consumers expressing the view that it should not happen and others saying that they prefer to buy these products in a pharmacy because they can get advice on them. CHF believes that if community pharmacy is going to sell these products then they need to do so responsibly and acknowledge that they have a key role in helping people understand the products. Again it is part of their role in improving health literacy.

We support Option 3-2 which requires pharmacies to have these products in a clearly separated area of their store as this would help minimise confusion with over the counter medicines.

We also support the proposal to have clearer signage and better information for consumers on the limitations of the evidence for effectiveness of such products. The current Medicine and Medical Device Regulation reforms is looking at complementary medicines and its proposals will make it easier for consumers to see what the evidence is on how the product will assist them.

We also support Option 3-3 which precludes complementary medicines being behind the counter with the proviso that if they are a TGA registered product they can be behind the counter. Their placement behind the counter is misleading as it makes consumers think they are the same as S2 and S3 medicines which have had to satisfy a higher level of evidence on efficacy.

Sale of Homeopathic Products (Option 3-4)

CHF supports the view that it would be better if pharmacies did not sell homeopathic products given the NHMRC's review showed no benefits of such products. Having them for sale in pharmacy gives them a legitimacy in the eyes of consumers which is misleading.

However these products are legal so it is hard to see how it is enforceable to disallow their sales. Pharmacies can sell almost anything they want. Many are in fact mini- supermarkets selling wide range of products so even without TGA listing it is hard to see how they could be banned. We think there needs to be stronger disclaimers about potential efficacy and more about potential harm at point of sale and that pharmacy staff should have a clearer understanding of the limitations of these medicines and be cautious in recommending.

As with other complementary medicines the risk is that a consumer will use these instead of seeking the advice of a health professional. There needs to be enhanced protocols in place for Pharmacy staff to encourage conversations with the pharmacists if the consumer is talking about specific symptoms.

Remuneration for Other Services (Option 4-6)

Pharmacists are delivering a wider range of primary health services. Currently these are block funded through the CPA. We support the report's call for all primary health services to be funded through the same mechanism.

It is important that similar services are funded in the same way to ensure a level playing field across primary health.

Given the current arrangements for GPs etc, this means moving pharmacy delivered primary health onto a fee for service arrangement, with or without a cap on the volume of services. It would be most efficient to do this by giving pharmacists access to the relevant MBS items and rebates or creating some pharmacist only items on the MBS. Any item number created would need to go through the MSAC process to ensure there is a robust health technology assessment and that there is evidence of efficacy and cost considerations have been taken into account.

We do have a concern to make sure there is not duplication of services as this would be wasteful in terms of total health resources. We are looking for collaboration between primary health professionals, particularly GPs and pharmacists with each providing the services where they have the greatest competitive advantage in terms of skill and both working with the consumer's wellbeing as the central purpose of their practice.

This option should be considered alongside Option 7-3 which seeks to move all the professional services out of future Community Pharmacy Agreements and find another way of funding and administering them. CHF welcomed the move in 6 CPA to use MSAC to evaluate potential new professional services and for a robust evaluation of existing professional services before they were continued.

Location Rules (Options 5-4 and 5-5)

CHF has consistently opposed the continuation of then location rules as anti-competitive and not working in the consumer's interest. We are disappointed that the Government has effectively ruled out any reform of the rules to provide better more affordable access to medicines.

Given there is not to be major reform we strongly support the call for a statement of the policy objective of the rules and a process for monitoring the way in which they achieve that objective. There have been modification to the rules in the past as circumstances change and we think there should be the capacity to revisit the achievement against the objective and propose possible modifications as and when required.

We support Option 5-5 as it seeks to ensure there is real competition between pharmacies. This is particularly important for smaller towns where the two existing pharmacies are often owned by the same person but a competitor is excluded because of the location rules. Consumers have raised with us their concerns about the impact this has on prices and services offered. We do not believe this works in the consumers' interest.

Pharmacy Opening Hours (Option 5-7)

CHF was disappointed with the Report's coverage and very limited response on extended and after- hours pharmacy services. We highlighted this as an area of need in our original submission and continue to hear form consumer s on this issue. In many ways, it is an extension of the community's concern about variation in access to after-hours GP services. The discussion becomes more pertinent as we see a move for community pharmacists to be a more important part of the primary health team and provide more professional services.

Extended hours for pharmacy is more common in urban and some regional areas but less so in rural one. This means access to medicines and other pharmacy services, is compromised. The option to have a 24 hour advice line is not sufficient response; it does not give access to medicines.

The Victorian Government has acknowledged this need with its introduction of Supercare pharmacies to provide services 24/7 with some of these services in rural areas. Clearly the Victorian Government has identified that there is a gap in health services and is using Supercare pharmacies to fill that gap. CHF would have liked to see

an Option which was to work with State and Territory government to look at integrated approaches such a Supercare pharmacies to help meet demand for after hours services.

CHF supports the introduction of a 24 hour medicine line and believes it should be developed through expanding the existing medicines line. The expansion of this role should include consumer involvement in identifying the types of information people want and where they might go to find it. As identified in our discussion on the Pharmacy Atlas the choice of host can be critical to take up rates.

In the access to pharmacy area CHF would have liked to see something more on outreach services from community pharmacy. In particular we would like to see some measures that encourage community pharmacy to think outside the walls of their retail outlet. As part of the call for ideas for the Pharmacy Trial Programme we suggested that community pharmacy could play a greater role in providing the first line of primary health care to homeless people and those they needed to develop an outreach service that addressed the needs of that particular group.

Transparency and Evaluation/Monitoring (Options 5-10 and 5-11)

CHF has argued over many years for greater transparency in how the funds under the Community Pharmacy Agreements are allocated and what they are spent on. This was a central part of our submission to the ANAO audit of the 5 CPA.

Option 5-1 is very vague; it does not spell out what additional information would be needed to provide greater transparency, who would collect it and how it would be published. We support the option in principle but need there to be more detail on how this would be put into effect.

We believe there should be an annual report for the funding allocation and distributions across the component parts of the CPA, including any administrative costs, which should be published on the Department of Health's website. This is tax payer funding and consumers and tax payers expect information on the program to be on a government website rather than on the website of the key beneficiary, in this case the Pharmacy Guild.

We believe monitoring for compliance and evaluation of the agreements needs to be treated separately. There needs to be a more robust monitoring process, especially if future CPAs continent to include professional services programs. The annual report outlined above could include some monitoring information and would provide a useful mechanism for reporting. There also needs to be a process for dealing with non-compliance, including sanction/penalties which seems to be missing entirely from the current arrangements.

In our submission to the ANAO audit of 5 CPA we highlighted the absence of a robust independent evaluation as a cause of concern. We called for this to be included into 6 CPA but this did not happen. Any such evaluation should look at how 6CPA meets its stated objective, what are the outcomes from the various components of the agreement. A more robust evaluation would have helped inform this review and would certainly help to inform the development of future arrangements.

Future Community Pharmacy Agreements (Options 7-1 to7-3)

The report addresses the questions of what future agreements should cover and who should participate in them. It is not possible to separate out what the scope of the agreement should be with who should be party to it. However regardless of the scope of the agreement we do not believe there should be a bilateral agreement with Pharmacy Guild and the Government.

If future agreements were to continue to have the same scope as now then they need to move from being bilateral agreements between the Pharmacy Guild and the Government to being multilateral agreement. It seems unreasonable to have an agreement which impacts on many stakeholders but not allow them to be party to the negotiations or be signatories to the agreements. The stakeholders who would need to be involved include:

- The Pharmacy Guild of Australia representing some community pharmacies
- Other community pharmacies who are not members of the Guild. Thought would have to be given on how to involve them given they do not as yet have an umbrella organisation
- Pharmaceutical Society of Australia (PSA) as the professional body
- Consultant pharmacists who undertake some of the professional services
- Consumers Health Forum of Australia (CHF) as the national health care consumer organisation funded under the Health Peak and Advisory Body Programme
- Wholesalers
- Royal Australian College of General Practitioners because of the primary health service component of the professional services

We support Option 7-1 which would limit the scope of future CPAs to issues around dispensing medicines under PBS subsidy and related services. Wholesaling considerations are better dealt with by separate arrangements with safeguards in place to ensure supply in reasonable timeframes and adjustments available for differential costs.

Professional services we have discussed above in Option 4-6 and we would like them all to be evidence based interventions with their own guidelines and administration and some possibly funded through the MBS. There have been problems with block funding them through CPAs; the experience of HMRs under 5CPA is an excellent example of this.

The more the scope of the CPA is narrowed the fewer stakeholders need to be involved. For option 7-1, our preferred option, we believe the agreement need to include

- All community pharmacists -Pharmacy Guild and non-Guild pharmacists
- PSA
- CHF

It has been suggested that the Government represents consumers and so there is no need for CHF to be involved. We would argue Government as the funder represent tax payers and is balancing a number of competing demands. It does not necessarily have a good understanding of what consumers want or need from community pharmacy. As we move to a more consumer centred health care system then consumers need to be actively involved in all parts of the system not just as passive recipients of services. This includes being involved in service design and planning and being part of governance structure for the system such as the Community Pharmacy Agreement.

Health Programs (Option 8-2)

CHF supports the key principles for the Community Pharmacy Program as outlined in Option 8-2. We believe there needs to be greater clarity for consumers about what to expect and these principle lay a solid foundation for deciding what should or shouldn't be delivered through community pharmacy now and into the future

The discussion about who pays for the services is well overdue. Some pharmacies are already implementing user pays for some services such as sick certificates, immunisation etc and more may want to do that, particularly if Option 4-6 is adopted and they move to funding similar to other primary health services. That then brings into question discussions around bulk billing, what gap payments to charge and any safety net provisions such as are in place for MBS and PBS.

It would be good to have an agreed set of principles which could inform discussions of issues around who pays and how much they pay for all the services.

Access for Aboriginal and Torres Strait Islander People (Options 9-1 and 9-2)

CHF supports both the options as important steps towards closing the gap in health outcomes for Aboriginal and Torres Strait Islander people.

It is an absurdity that the access to medicines program determines access based on where the prescription is written or dispensed rather than being assigned to the person who needs the assistance. This proposal puts the person first and assigns the benefit to the individual which is totally in line with consumer centred care. It also ensures that changes to people's lives, which can determine where they live are not a barrier to access to affordable medicines.

We think it is important that community pharmacy is able to offer culturally appropriate services. Whilst this does not necessarily require the service to be operated by an Aboriginal health service we think that they are well placed to take on that role, particularly in rural and remote communities where they may be the only health service. We support the idea of a trial of such a service.

Summary Response to Options

We have grouped the options presented in the report into three categories:

- Options we support and believe should go into the final report as recommendations
- Options we partially support but need some refinement or more work before going into the final report
- Options we do not support

The rationale for our position is explained in the body of the submission for all those we do not support and for some that we support. Where we think the options need some refinement/more work we have indicated the direction for that work and suggested some alternative approaches.

CHF supports

OPTION 2-3: PBS SAFETY NET

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

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

OPTION 2-4: LABELLING

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

OPTION 2-5: PHARMACY ATLAS

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

OPTION 2-6: CONSUMER MEDICINES INFORMATION

A Consumer Medicines Information (CMI) leaflet should be offered and made available to consumers with all prescriptions dispensed in accordance with Pharmaceutical Society of Australia (PSA) guidelines. The PSA guidelines and the distribution of CMIs to consumers need to be audited and enforced to ensure compliance.

Pharmacists and the pharmacy industry should continue to work on the improvement of CMIs and the use of technology to make medicines information more available to consumers.

OPTION 2-7: ELECTRONIC PRESCRIPTIONS

The government should initiate an appropriate system for integrated electronic prescriptions and medicine records as a matter of urgency.

OPTION 2-8: ELECTRONIC MEDICATIONS RECORD

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

OPTION 2-9: ELECTRONIC PRESCRIPTIONS – CONSUMER CHOICE

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

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

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

OPTION 3-1: COMMUNITY PHARMACIES – MINIMUM SERVICES

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

OPTION 3-2: COMPLEMENTARY MEDICINES - SUPPLY FROM PHARMACIES

Community pharmacists are encouraged to:

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

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

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

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

OPTION 4-1: ACCOUNTING INFORMATION

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

a) a. determine a set of accounting principles that will apply for community pharmacies in order to provide the relevant information needed to determine the best-practice benchmark cost of a dispense (as these terms are defined in this report)

b) require community pharmacy (as a condition of being approved to dispense PBS medicines) to provide the necessary accounting information to inform consideration in the development of each Community Pharmacy Agreement (including as a basis for the determination of a best-practice pharmacy). The relevant accounting information should be provided for each financial year and no later than 31 December of the following financial year (beginning with 31 December 2018)
c) designate a body within the government (although potentially an existing independent statutory authority with the relevant expertise such as the Pharmaceutical Benefits Remuneration Tribunal or, more broadly, the Australian Competition and Consumer Commission) to provide a recommendation to the government on the best-practice benchmark cost of a dispense as required over time by the government. The first such advice is to be provided as soon as practical and certainly before the end of 2019. The timing of later determinations will depend on the process used in the future by the government to set the remuneration for dispensing PBS medicines
d) the information and advice submitted to the government should form the basis for the average remuneration for a 'dispense' to community pharmacy in the future and certainly from the expiration of the Sixth Community Pharmacy Agreement. The provision of appropriate accounting information should be an ongoing requirement to support the development of each Community Pharmacy Agreement.

OPTION 4-6: REMUNERATION FOR OTHER SERVICES

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

OPTION 5-4: LOCATION RULES – POLICY OBJECTIVE

If the government retains the pharmacy location rules (or some version of these rules) following the end of the Sixth Community Pharmacy Agreement then the policy objective of these rules should be clearly stated and the rules modified to ensure that the desired outcomes are achieved over the medium term. The objective of the pharmacy location rules should be to assist the Australian consumer to ensure equitable and affordable access to medicines for all Australians, consistent with the National Medicines Policy, with evidence to demonstrate the achievement of this objective.

OPTION 5-5: LOCATION RULES – OWNERSHIP AND LOCATION

In areas where pharmacy location rules are maintained, any group of two or more pharmacies, each of which are located within 1.5 kilometres of another pharmacy in the group that have an overlapping ownership should be considered to be a single pharmacy for the application of the location rules. The nominal 'location' of this single pharmacy would be the location of the pharmacy within the group that had the smallest turnover (in terms of the number of Pharmaceutical Benefits Scheme scripts dispensed) in 2016. For avoidance of doubt, a group of pharmacies would be considered to have an overlapping ownership if any individual or set of individuals have ownership of at least 20 per cent of the equity in each of the community pharmacies in that group.

It is also considered that this option should be implemented five years after this Review to allow an appropriate time frame for transition. The oversight of this option should be undertaken by the Australian Competition and Consumer Commission.

OPTION 5-6: INFORMATION ON PHARMACY OPENING HOURS

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

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

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

OPTION 5-8: RURAL PHARMACY MAINTENANCE ALLOWANCE

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

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

OPTION 5-9: HARMONISING PHARMACY LEGISLATION

As early as practicable, the Australian Government, through the Australian Health Minister's Advisory Council, should seek to harmonise all state, territory and federal pharmacy regulations to simplify the monitoring of pharmacy regulation in Australia for the safety of the public. In the long term, a single pharmacy regulator could be considered. As an interim measure, state and territory registering bodies need to coordinate with the Australian Health Practitioner Regulation Agency to ensure that pharmacy regulations are being adequately monitored for best practice of pharmacy and the safety of the public.

OPTION 5-10: TRANSPARENCY

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

OPTION 5-11 EVALUATION MECHANISMS

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

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

6-1. ALTERNATIVE 2: The government should retain the current CSO arrangements but ensure that all service standards, such as the 24-hour rule, are uniformly implemented.

6-1. ALTERNATIVE 3: The government should conduct a separate review of the CSO to ensure current arrangements demonstrate value for money. A review would also present an opportunity to potentially streamline existing or remove unnecessary regulation. Such a review would require the full cooperation of the CSO Distributors, which would provide financial data and other relevant information to government.

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

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

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

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

OPTION 7-3: SCOPE OF COMMUNITY PHARMACY AGREEMENTS – PROGRAMS AND SERVICES

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

OPTION 7-4: COMMUNITY PHARMACY AGREEMENT PARTICIPANTS

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

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

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

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

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

OPTION 10-1: SECTION 100 HIGHLY SPECIALISED DRUGS

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

OPTION 10-6: MACHINE DISPENSING

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

OPTION 10-2: CHEMOTHERAPY COMPOUNDING – PAYMENTS

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

OPTION 10-3: CHEMOTHERAPY COMPOUNDING – UNIFORM MINIMUM STANDARDS

There should be a clear, uniform set of minimum quality standards for all approved chemotherapy compounding facilities based in a hospital, a community pharmacy or elsewhere. These minimum standards should:
a. not require that a compounding facility be Therapeutic Goods Administration (TGA) licensed to meet the minimum requirements
b. mean that a TGA-licensed facility clearly satisfies the minimum standards
c. reflect the variety of settings that are appropriate for the preparation of chemotherapy medicines, including 'urgent' preparation in a hospital setting or a community pharmacy setting

OPTION 10-4: CHEMOTHERAPY COMPOUNDING – PRACTICE MODELS

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

CHF supports in principle but need some refinement

OPTION 2-1: PRICING VARIATIONS

The payment made by any particular consumer for a PBS-listed medicine should be the co-payment set by the government for that consumer or the dispensed price for that medicine, whichever is the lower. A community pharmacy should have no discretion to either raise or lower this price.

We do not support the second part of this Option to prohibit discounting of prescription medicines

OPTION 3-4: SALE OF HOMEOPATHIC PRODUCTS

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

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

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

OPTION 6-2: SUPPLY OF HIGH-COST MEDICINES

In line with Option 6-1, patients should be able to receive high-cost medicines from the community pharmacy of their choice. A cap should be placed on the amount that a community pharmacy contributes to the cost of a medicine. This cap should be in the range of $700 to $1000 so that all PBS-approved community pharmacies can supply all PBS medicines required by the public.

CHF does not support

OPTION 2-2: REMOVING $1 DISCOUNT

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

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

6-1. ALTERNATIVE 1: The government should remove the Community Service Obligation (CSO), and suppliers of PBS-listed medicines should be placed under an obligation to ensure delivery to any community pharmacy in Australia within a specified period of time (generally 24 hours), with standard terms of trade offered to the pharmacy (such as four weeks for payment) using one or more of a specified panel of wholesalers as follows:

a) an initial Panel of around five wholesalers would be approved. It is expected that these will include the existing CSO Distributors
b) the relevant terms of trade and other supply conditions may vary between medicines. For example, for high-cost medicines or medicines that have cold-chain supply requirements, the supply conditions may differ from those for low-cost medicines to ensure that there is not an unreasonable risk or cost placed on either community pharmacy or consumers
c) a cap should be placed on the amount that a community pharmacy contributes to the cost of a medicine. This cap should be in the range of $700 to $1000.

Comments

We believe the current COS ensures access for everyone to medicines they need. Any changes would need to be carefully monitored to see the impact on access.
This alternative seems to add a layer of complexity without giving any guarantee of better access. Our preference is for Alternative 2.

OPTION 10-5: GENERAL MEDICINE – LISTING ARRANGEMENTS

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