

Transcript: Review of Pharmacy Remuneration and Regulation

Interim Report

PRESENTED BY: PROFESSOR STEPHEN KING

Chair, Review of Pharmacy Remuneration and Regulation

^Stephen King: ^

Welcome. My name is Stephen King, and I am the Chair of the Review of Pharmacy Remuneration and Regulation.

On behalf of my review panel colleagues, Mr Bill Scott and Ms Jo Watson, I'm pleased to release the review's interim report.

The interim report presents the review's key findings and a series of options or possible reform paths for stakeholders to consider. Many of these options for reform were raised by stakeholders in our discussions with them or in their written submissions and responses to the online review survey.

The options were also informed by evidence gathered and analysis provided by various consultancies. The possible reform paths reflect both evolutionary and more transformative options to strengthen community pharmacy. We encourage you to consider the options, to think about their potential impact and provide any new evidence or insights in relation to them, and what pharmacy should look like in the future.

As you will see, in a number of areas we provide alternative options. The panel would like to give all interested stakeholders the opportunity to carefully consider the impact of each of the options outlined in the interim report before any final recommendations are made and presented to the government.

In July 2016 the review panel released a discussion paper posing a series of questions based on the terms of reference. Written submissions on all aspects of the review were invited and closed on the 23rd of September last year. We received over 500 submissions and would like to thank the individuals and organisations who have helped us through their submissions and their input to the forums.

The sustainability and viability of an effective community pharmacy sector is a key consideration for the review. However this is primarily a consumer focused review. The review aims to identify the services and programs that consumers value from community pharmacy. Further, in line with

Australia's national medicines policy, future arrangements should be able to support reliable and affordable access to medicines, and to promote the quality use of medicines.

The panel has considered options for future arrangements in the context of a long term sustainability and equitable distribution of the PBS. Our strategic vision is for an integrated and sustainable community pharmacy sector which is adaptive to changes in healthcare that are inevitable given Australia's ageing population, the rapid advances in technology and ongoing PBS reform. Our intent is to develop a flexible framework for community pharmacy remuneration and regulation going forward.

Feedback provided to the panel clearly shows that consumers recognise and value the different pharmacy models operating in Australia. The panel therefore does not consider that there is or should be a one size fits all business model for community pharmacy. Rather maximising the ability of consumers to self-select the retail model that best suits them is a key factor underpinning a viable and vibrant pharmacy sector.

At the same time, consumers should expect and receive certain minimum levels of service from all community pharmacies. For example PBS medicine prices currently vary significantly between community pharmacies. This creates consumer confusion. The panel believes there should be no pricing variation for PBS medicines. The payment made by any particular customer for a PBS listed medicine should be the co-payment set by the government for that customer or the dispensed price for that medicine, whichever is the lower. Community pharmacies should not have discretion to either raise or lower that price.

Now in line with this, the one dollar discount has led to inequitable outcomes and consumer confusion. It should be removed. It might be argued that the one dollar discount policy has saved some consumers up to a dollar in their co-payment for medicines. This is clearly the case. However the policy is not uniformly applied and is often not available for consumers outside urban areas. It also undermines the principle of a medicine co-payment that is set by the government to balance the level of government funding with consumer incentives and equity of medicine access.

The review panel has also found the consumer experience could be improved by automating the safety net and designing it so that consumers can more evenly spread their pharmaceutical costs over a 12 month period, secondly making sure that consumers can easily access information about community pharmacy, the services and programs offered by a pharmacy, the opening hours of that pharmacy, and any specific accessibility services of the pharmacy such as multilingual staff.

Thirdly, we should improve processes to ensure consumers get the medicine information that they should be receiving and that they need to safely use their medicines. Fourthly, we feel there should be more use of electronic prescribing, prescriptions and record keeping, and finally where appropriate hospital pharmacies should provide a discharge pack with sufficient level of patient medication to allow the patient to safely access a community pharmacy and their community health practitioner without running short of medication. This will be particularly helpful for consumers from rural and regional areas.

More diversity in pharmacy business models is valued by consumers. Consumers also expect certain minimum services from all community pharmacies. The panel notes that it is important for pharmacies to be able to stock products and provide services that best meet local needs. But we also consider that a minimum level of products and services should be provided by all pharmacies that dispense PBS medicines.

Community pharmacies are agents of government who are funded to deliver PBS medicines to consumers. So a minimal expectation is that each pharmacy will supply any prescribed medicine and also be able to provide any products that are needed so that consumers can safely use that medicine.

The panel considers that an appropriate minimum schedule of services can be included in professional standards and guidelines for dispensing. This schedule would not only set out the minimum service standards that all community pharmacies should provide, but it will also feed in to the calculation of appropriate remuneration for dispensing services, and I'm going to talk about that on the next slide.

The panel is also of the view that complementary medicines for sale should be displayed in a separate area where customers can easily access a pharmacist for appropriate advice about their selection and use. However homeopathy and homeopathic products should not be sold and stocked in pharmacies. While most stakeholders supported the continued sale of complementary medicines in community pharmacy, the practice of homeopathy and the sale of homeopathic products did not receive such support.

When you consider pharmacy remuneration, you need to remember that a pharmacy is a complex business, and the review panel has seen a wide range of different business models for community pharmacy in its Australia wide investigations. Appropriate remuneration for community pharmacy does not mean that any community pharmacy regardless of its efficiency of operations should make a profit. Rather the focus must be on the remuneration that ensures an efficient pharmacy is appropriately compensated when consumers access that pharmacy to gain medicines in a way consistent with the national medicines policy.

Now for this reason remuneration for dispensing should be business model neutral. The remuneration for dispensing paid by government and consumer co-payments to community pharmacy should be based on the costs of dispensing for a best practice pharmacy. However this approach has not been used to date.

Indeed the information needed to allow the government to work out the cost of best practice in dispensing is not currently available. In order to ensure that community pharmacies receive appropriate compensation for dispensing, community pharmacies first need to provide the relevant information to the government. This information can then be used to ensure that pharmacies are remunerated fairly and on the basis of best practice.

On the basis of the limited information that has been made available to the panel, and taking a very conservative approach given the data restrictions, the panel believes that the current benchmark for a best practice efficient dispense is somewhere between \$9 and \$11.50. Now this presentation is too brief to go into the technical details relating to the determination of a best practice dispense, however the remuneration for dispensing should be a simple dispense fee based on, in technical terms, the efficient, average, long run incremental cost of a dispense in a community pharmacy.

The panel also notes that there exists significant variation in regulatory requirements applying to pharmacy across state and territory jurisdictions. These differences can lead to confusion and potential risks to consumers and health practitioners. More broadly, variations in legislation between jurisdictions may create hurdles and undue administrative burden, particularly for online pharmacies which should have the ability to operate across state and territory borders.

The opportunity to move towards uniformity in these regulations and the positive outcomes that this might create for community pharmacy and consumers needs further government investigation. During the Sixth Community Pharmacy Agreement negotiations, the then Minister for Health and the Department conducted a series of bilateral and multilateral consultations with a broad range of stakeholders. However neither consumers nor the broad community pharmacy profession were represented as signatories to the Sixth CPA. But the community pharmacy agreements affect consumers and all community pharmacists, not simply pharmacy owners.

The panel considers that the Pharmacy Guild representing pharmacy owners, the Consumer Health Forum representing consumers, and the Pharmaceutical Society of Australia as the peak representative body for pharmacists in Australia should all participate as signatories in any future community pharmacy agreements. Further, future community pharmacy agreements should focus on the dispensing of PBS medicines. They should not include issues relating to medicine wholesaling such as the CSO, and they shouldn't include the regulation or remuneration of professional programs offered by community pharmacies.

The CPA is not the right mechanism to attempt to capture more broadly based programs and services or supply chain activities, as these involve multiple key stakeholder groups and extend well beyond the funding of just the PBS related services.

Advances in medicine mean that more high cost medicines have been listed under the PBS in recent years. The supply of complex and high cost medicines has put pressure on the existing supply chain and pharmacy remuneration arrangements. It has become clear to the panel during our consultations that the financial risks and cash flow issues associated with the dispensing and stocking of high cost medicines is a significant area of concern for pharmacies.

Many pharmacy owners expressed concern over the risk of patients failing to return to pick up their high cost medicine after the pharmacy has ordered them. They advised that the cost of the medicine then became a loss to the pharmacy, as these items were not able to be returned to the wholesaler or manufacturer. Pharmacies also advised that they incur risks of stock being damaged or a script being lost.

The review panel also believes however that patients should be able to receive these high cost medicines from the community pharmacy of their choice. So the panel agrees with pharmacy stakeholders that alternative payment options for high cost medicines need to be investigated to avoid excessive cost to community pharmacy. For example community pharmacy could pay up to say \$1,000 to wholesalers for any PBS listed medicine that costs at least \$1,000. With the government paying the rest directly to the wholesaler, that would limit the risks to the community pharmacy.

For wholesaling, the panel supports the introduction of standard terms of trade for all wholesale medicine supply. Further, the current CSO payments appear unconnected with the relevant wholesaler distribution costs, and may be leading to wholesale margins that are higher than necessary for an effective and efficient supply chain. For this reason the report also outlines various options that would reform the current CSO arrangements.

While time prevents me going into any further detail in this presentation, I really encourage you, look at each of the options and provide any feedback in the written submission process.

Submissions to the review noted that many services and health programs delivered by community pharmacy are underfunded or not funded at all. Common examples are home delivery services, minor ailments, wound care, triage services, unwanted medicine return services, and liaising with hospital staff upon admission and discharge or more generally with other health professionals.

Pharmacy owners and employees often described how valuable these services are to the local community, and they expressed concern about the ability for community pharmacy to continue to

provide these services without appropriate funding. Significant opportunities exist for the better use of community pharmacy and pharmacy programs, and for the services to improve the health of Australians.

The government should investigate how best to support these pharmacy programs that meet local needs, are able to demonstrate improved health outcome for consumers, and that provide value for money. For example primary health networks may be able to play a role in this area.

The Australian government has made a number of commitments to closing the gap in disadvantage between indigenous and non-indigenous Australians across health, education and employment. Now central is the government's commitment to have timely and affordable access to PBS medicines, as well as quality use of medicines and medication management support services. There are a number of programs that have been implemented in urban, regional, rural and remote locations to improve access to and the affordability of medicines.

Now the panel notes that although related these programs operate independently with differing eligibility criteria applied to each one. This raises difficulties for both consumers in terms of access, and for pharmacists and other health professionals with respect to administration. This can be improved. For example the panel has found that the current closing the gap arrangements put unnecessary limitations on remote clients requiring ongoing medications when travelling into urban and rural areas. We note that Aboriginal health services in rural and remote locations cannot write closing the gap prescriptions. And there are a range of other areas where the arrangements could be simplified and improved to focus on the consumer.

One option would be to ensure that the benefits of these programs to the individual followed that individual regardless of where the prescription is written or dispensed. The review panel has considered other options that would allow eligible patients to pay the same closing the gap co-payment for their PBS medicines regardless of location and assist their continuity of care. The panel was also of the opinion that all levels of government should ensure that any existing rules that prevent an Aboriginal health service from owning and operating a community pharmacy located at the AHS are removed.

The review panel has found that the distinction between highly specialised and other PBS medicines is causing administrative inefficiencies and unnecessary risk to patient health. While expanded access has brought with it the opportunity to support an increased role for community pharmacy in primary care through supported community access, it remains the complexity of dispensing across hospitals and community pharmacy makes the system unduly difficult for the consumer to navigate.

As the use of medicines such as HIV, anti-retroviral and Hepatitis C medicines becomes more commonplace in the contemporary community setting, there is a need to address issues of complexity as potential barriers to access. One option to remove consumer confusion might be to reform the highly specialised medicines program under section 100 of the National Health Act to remove the distinction between section 100 and other medicines. This could include for example harmonising access and fees regardless of where the medicines is dispensed.

With regards to compounding, the review panel found that the rationale for differential payments for compounding of chemotherapy preparations is not substantiated on the basis of patient risks or health outcomes for medicines. 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 and may for example be TGA licenced.

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

Thank you for listening to this overview of the interim report, findings and options. We the panel encourage you to read the interim report and provide feedback on the options put forward. You can have your say through a written submission to the review, responding to the online questionnaire, or engaging with the panel during our consultation activities. Details of the submission process and consultation activities can be found on the Pharmacy Review webpage at health.gov.au/pharmacyreview.

The review panel has been honoured to receive such comprehensive and strong participation from stakeholders in the review process to date. We seek your ongoing support as we progress towards the final phase, the release of a final report later this year.

Thank you, and we look forward to receiving your submissions.

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