Pharmacy Remuneration and Review

Submission by Timothy Logan, s90-approved pharmacist

Tim Logan’s Nambour Pharmacy

Reviewers: To give background to my submission, I have been a proprietor of s90-approved pharmacies, dispensing and supplying medicines to various communities, subsidised by the Pharmaceutical Benefits Scheme, since 1984. I have practiced in rural and regional areas of Queensland, chiefly in neighbourhood and regional shopping centres. I have also, as an elected official of the Pharmacy Guild of Australia, been a part of the Pharmacy Guild team involved in the negotiation of the 4th and 5th Community Pharmacy Agreements. All views expressed are my own, and should not be taken to represent the entirety of Pharmacy Guild policies. I will respond to selected individual and groups of questions as posed by the panel discussion paper for this review.

1. In your opinion, is the ratio of community pharmacies to population optimal? What data would you use to support this opinion?

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?

I believe the figures presented in the discussion paper demonstrate that, in the major Anglophonic developed countries of the world, a ratio of around 4000 people per pharmacy seems to be a level the market can bear. I submit that, as will be demonstrated by the Pharmacy Guild’s geospatial data applicable to community pharmacies in Australia, the current situation where pharmacies are well-distributed, particularly in comparison to other essential services, means that maintaining or increasing the numbers of people per pharmacy can be achieved without impacting ease of access, and that, in the current environment of reducing gross margins in PBS dispensing, decreasing the numbers of people per pharmacy would have a severe impact on viability of many pharmacies, including my own, and the quality of the network in terms of community access.

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?

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?

I submit that the postulation in these queries is impractical and inappropriately interventionist. An s90-approved pharmacy will succeed if it fulfils the needs of its community, and this should not be curtailed if all professional requirements of dispensing are met. The issue of the ability of an agency monitoring and enforcing policies in regards to the ‘classification’ of a pharmacy in such a scheme is germane to this concept, and a have little confidence that it could be achieved.
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

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?

I believe that a scenario in which the Commonwealth negotiates the nature of the health outcomes of Community Pharmacy Agreements with community stakeholders, including prescribers and consumers, then negotiates the way it will remunerate the s90-approved pharmacies to achieve those outcomes is the only practical option. Introducing parties with no financial exposure (other than as taxpayers) into a negotiation between payer and payee is not a rational business practice, in my view. While the Pharmacy Guild of Australia represents an absolute majority of s90-approved pharmacy proprietors, it is reasonable that it should continue to be the prime negotiator on behalf of the payees in the negotiation of Community Pharmacy Agreements

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?

While ever s90-approved pharmacies are constrained in the way they operate their business in terms of price, range, conditions of supply and professional accountability, it is a nonsense, in my view, to imply that regulation that does not permit untrammelled commercial opportunism to occur is ‘protection’.

15. Is the ‘swings and roundabouts’ approach to remunerating pharmacists for dispensing appropriate? Does it lead to undesirable incentives?

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?

In my view, the administrative complexity, and practicality of ensuring compliance to business rules, of any more than one or 2 strata of dispensing fees would render such a concept unworkable, and labour-intensive

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?
For medicines costing less than $2089.71, the current remuneration scheme is viable. The advent of high-priced medicines such as the Hepatitis C treatments recently listed (DPMQ for Sofosbuvir is over $19000) on the PBS is NOT appropriate or viable, and should be changed to permit approved pharmacists to fulfil their professional obligations viable. Gross remuneration of $77 or so to handle clinically complex medicines, and an enormous investment in healthcare by the taxpayer is unfair and unsustainable.

22. Should the timeframes for payment settlements for very high cost medicines be lengthened throughout the supply chain and mandated by Government?

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?

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?

See above; a more rational remuneration system is the primary solution, in my view, but longer timeframes could also assist. Sourcing the medicines from a government agency at no charge to the pharmacy and dispensing them for a fee may also be an option to de-risk this aspect of pharmacy fulfillment of PBS prescriptions for these medicines.

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?

The current regulatory banning of cigarette sales in community pharmacies is appropriate, and the fact that Australian pharmacies have not chosen to seek alcohol retailing licences (to my knowledge) is appropriate. In terms of complementary medicines without a robust evidence base, if a government agency chose to implement a compulsory labelling scheme for these products that clearly indicated an evidence base, or a no-evidence-found symbol, it would make the efforts of most pharmacists to point out the gap between marketing claims and evidence to consumers seeking them out. If supplies to consumers do not interfere with current medical treatment, the sourcing of medical advice, or exploit people in a financial sense in a material way, I see no way this can be implemented fairly, or any prohibition of these products in s90-approved pharmacies to be adequately monitored and enforced.

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?

Such a pharmacy could conceivably be viable, but forcing all pharmacy businesses to operate in this manner ignores the evidence-based, non-prescription products that can be important adjuncts to patient therapy that are sold in most pharmacies, and so is a pointless restriction, in my view.
29. Is it appropriate that the PBS links the remuneration for the provisions of professional advice to the sale of medicines?

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?

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?

The provision of information about medicines should always be available at the point of dispensing. A schedule of complex medicines such as HIV treatments, Oncology treatments and Hepatitis C treatments could have a complex dispensing fee payable to address the expertis and effort necessary to deal with their use. I am unsure what policy imperative would necessitate this to be via an MBS payment as opposed to a PBS payment.

37. Is cost a barrier to accessing worthwhile health services offered by pharmacy?

The remuneration of a service that does not permit a Return on Investment of funds and resources utilised dooms such programs to failure. Cost recovery is insufficient incentive to participate.

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?

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 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?

With rare exceptions, the current location rules, from my observation, have permitted the professional sub-group of s90-approved pharmacies to absorb the cuts in pharmacy remuneration that have resulted from the Commonwealth’s Price Disclosure scheme for PBS medicines. Untrammelled issuing of licences will make viability of these pharmacies more challenging, and could result in corner-cutting by financially-distressed professionals attempting to keep their businesses ‘alive’. The issue of ‘rent hostages’ in facilities where the approved pharmacy cannot move their approval out of the facility because of the 500m exclusion provision of certain rules is an issue that warrants attention. It could be argued that short location rules in CBDs of major cities (over 50000 population, say) could be slightly relaxed.

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?

As this is a state issue, I cannot see why this review is considering this issue under its terms of reference.
46. Is the short distance relocation rule appropriate? Please provide examples to explain your reasoning.

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?

See answer to Qs 42-44

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?

This, in my view, in not a totally unpalatable option, depending on the quantum of the compensation

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.

As mentioned above, it has insulated some pharmacies from the significant reductions in revenue that have arisen from the PBS price reductions seen over the last 36 months due to Price Disclosure, and allowed them to (just) survive

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?

Depending on the nature of the requirements, I don’t find this option completely unpalatable

54. Could hospital pharmacies complement medicine dispensing and related services currently provided through community pharmacy or other public and private hospital pharmacies?

If they were operating under the same remuneration and co-payment scheme, this may be worth considering

56. How might broadening the services provided by hospital pharmacies improve consumer access in rural and regional Australia?

I can’t see that it would make any significant difference that would benefit the community; it may in fact cause nett harm to the community by reducing the viability and service offering of the community pharmacy or pharmacies already operating
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?

The fulfillment of the Community Service Obligation of pharmaceutical wholesalers provides significant benefits and efficiencies to consumers and pharmacies alike with the quality and ease of access to PBS afforded in the vast majority of cases. Having extra accounts with different rules for essential medicines adds an unwelcome level of complexity to stock procurement.

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?

As a Guild official, I have had many complaints from s-90 approval holder members in which PBS-listed s100 medicines or products are not available from CSO wholesalers, and cost more that the PBS DPMQ, or are not available from the wholesaler for less than the DPMQ. If a price is fixed by the Commonwealth for the supply of a listed product, surely the conditions of listing should include a requirement to provide that product to a pharmacy, under normal commercial terms, at a price that permits the DPMQ to clear the procurement costs.

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?

My experience is that the wholesalers have not implemented these minima yet. I believe, if they do get implemented, they are a retrograde step that will impact consumer access to medicines, as stock outages will take longer to fulfil under the 72-hour rule.

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?

See answer above.

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?

This is another element, not yet implemented (in my experience), that would impede efficient procurement of PBS medicines.

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?

Both wholesalers and manufacturers should be constrained from supplying medicines with less than 4 month’s dating (for one-month supply).
84. Is a percentage mark-up paid by the pharmacist an appropriate way to compensate wholesalers? Would an alternative compensation arrangement be preferred? If so, please provide details of preferred arrangements.

The plummeting price of many PBS medicines as a result of PBS price reductions subsequent to Price Disclosure has severely impacted wholesaler revenue. The CSO is not adequate to cover the lost revenue here. A payment of an AHI, such as is made to pharmacists, may be more appropriate that the current mark-up scheme

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?

I believe so.

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?

I believe that standards do exist and are appropriate. I believe that, in certain areas, the Commonwealth is failing to prosecute breaches of these standards. An example of this is the failure of the Commonwealth to take discernible steps to address certain pharmacists from operating unapproved pharmacies, but providing PBS benefits at these unapproved locations by processing them through an approved pharmacy via a VPN. The public nature of this submission precludes more specific details being provided here, but I can provide information to the panel, without prejudice, if desired, in a private interview

104. Is there a variation in service standards between different pharmacy models?

105. Do community pharmacies that offer discount medicines provide lower levels of service? If so, what evidence is there available to support this?

I have had anecdotes from customers complaining of the failure of certain large-format pharmacies to give them adequate advice concerning PBS medicines, as the reason for their continued patronage of my pharmacy, which is not a large-format discount operation

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?

It has caused confusion amongst consumers and has severely impacted the viability of my pharmacy. My view is that it was a venal, self-aggrandising policy brought in by politicians who had others to bear the cost of delivering the benefit, and that the policy benefitted one group of society more so than the most frequent users of medicines

109. What examples can you provide of variation in prices for regular PBS prescriptions?

An examination of the PBS schedule of under co-payment medicines (DPMQ less than $38.30) will demonstrate a plethora of prices for medicines. The existence of generic brands offering commercial terms has enabled some pharmacies to offer reduced prices compared to the listed prices, but as Price Disclosure reductions continue, this gap is shrinking
111. To what degree do current advertising restrictions limit the ability of pharmacies to promote medicines and related services available to consumers?

I don’t believe they do

112. In your experience, do community pharmacists provide appropriate advice for schedule 2 and 3 medicines?

Almost all the time

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?

I believe so

114. Is the sale of schedule 2 and 3 medicines an important contributor to the income of community pharmacies?

I believe so

115. Does the availability and promotion of vitamins and complementary medicines in community pharmacies influence consumer buying habits?

116. Should complementary products be available at a community pharmacy, or does this create a conflict of interest for pharmacists and undermine health care?

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?

118. Does the ‘retail environment’ within which community pharmacy operates detract from health care objectives?

My answers to qs 26 & 27 apply here as well

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?

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?

My answer to q 108 applies. Obviously, the co-payment is designed to offset the cost of the PBS to conform to governmental budgetary objectives; anecdotal evidence also abounds of the hoarding or wasting behaviour of people who receive medicines at no cost, with no time intervals applicable.
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?

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?

Day and night pharmacies have been a feature of the landscape for many years to address this need. In major centres, the opening closing times of some of these have drifted out to 7am opening and 11pm closing. The availability of medicines outside these hours at the same prices as business hours is naïve, and ignores the security and statutory wage loading needed to operate safely. Severe illness with an onset between 11pm and 7 am is more appropriately dealt with in a hospital environment, in my view. The availability of Prescribers Bag medicines is there to deal with less urgent, but acute illnesses in these hours. 24-hour pharmacies are a luxury that can only be supported by the population of the mainland state capitals, in my view.