Submission[1]
Draft report of Productivity Commission Discussion Paper titled Review of National Competition Policy Arrangements

Retail (community) pharmacy practice and NCP reforms

1. BACKGROUND[2]

The objective of National Competition Policy

The objective of the legislation review program is to remove restrictions on competition that are found not to be in the interests of the community, for example, legislation that restricts entry into markets or constrains competitive behaviour with markets.

Health: Pharmacy

Pharmacies are an integral part of Australia's health care system.
Communities depend on pharmacies to

- Dispense restricted medicines and pharmaceuticals
- To provide advice on their safe and proper use.

State and Territory legislation aims to
Protect the community from harm by ensuring pharmacists dispense over-the-counter and prescription medicines safely and competently.

Commonwealth Government through the Pharmaceutical Benefits Scheme (PBS) seeks to ensure communities have timely, reliable and affordable access to necessary and cost-effective medicines.

Removing unwarranted or out-of-date restrictions on competition can help governments deliver these objectives more effectively.

2. OBJECTIVE OF THIS SUBMISSION

- To highlight the need for reform in the delivery of PBS to disadvantaged groups and people at risk.
- To advocate a change in the way pharmacy services are viewed by primary health care policy makers
- To promote a model of pharmacy practice that is driven by a desire to improve health outcomes and play a part in the continuing evaluation of the PBS.

3. NEED FOR REFORM

You say that (Not all reforms have been delivered)
The failure to act on recommendations by a national independent review of pharmacy to relax ownership and other anti-competitive restrictions is a case in point.
The problem has been the reluctance of the government to stand up to the lobby of the retail pharmacy sector which itself fails to recognise the consumer as the point of focus.
As long as a welfare program, the delivery of PBS, is driven by a private sector intent on maximising profits, there will not be equity of access to people in need, especially disadvantaged groups.
This is evidenced in

- The access of Aboriginal people, especially those living in remote communities

---

[1] © RWM Consultancy PO Box 527 Parap NT 0804 December 2004
[2] National Competition Council website

- The frail aged living in facilities acquiring their pharmacy services in dose administration aids and being forced to obtain these from a retail pharmacy.
- The patients of medical centres where a full range of primary health care services are available but not a pharmacy
- The patients of multi purpose health services that are denied a pharmacy due to the location rules associated with dispensing of PBS prescriptions.

The Wilkinson review advocated that these health services should be able to have a "dispensary" for the supply of PBS[3].

TO EXPLAIN

Aboriginal people – even though arrangements have been made to supply remote Aboriginal health clinics with PBS items at no cost through a retail pharmacy – it is a "second class" PBS for Aboriginal people and as such is distinctly racist in nature. A fee of $1.14 is paid to the retail pharmacy for every supply and there is no "value added" component of the transaction. The "mainstream" PBS provides the retail pharmacy with $4.70 for dispensing the medicine to the individual patient.
There is only one reason why this is allowed to continue unchallenged and that is because the Pharmacy Guild has hailed the process of supply under Section 100 of the National Health Act as a success. It may be a success in getting the goods to the clinic but after that the same unsafe practices exist in the supply on to the patient.
The only resolution to this is to allow Aboriginal health services to be able to obtain an Approval Number to supply PBS in the same manner as is done in mainstream society.

Aged care facilities – the supply of medicines for residents of aged care facilities and nursing homes is made from a retail pharmacy which specialises in the supply of medicines in a dose administration aid that allows the staff to hand out medicine accurately and in a timely manner. In this way it is meeting the standards for quality use of medicine. The problem comes when the supplying pharmacy is to claim for the cost of the medicine against the protocols for the PBS through the Section 85 arrangements for the mainstream population. The inability of the retail pharmacy to put in place a more efficient supply route with the PBS is indicative of the failure of the system to adapt to innovative practices for the special needs of the residents.
The result of this is retail pharmacies competing with each other for the business and offering the packing service at no cost. The outcome of this is a factory type scenario from a distant pharmacy and a reluctance to explore options for efficiency.
The resolution is to allow the facilities to have their own Approval Number to be able to supply the medicine and benefit to whatever profit is made to employ their own pharmacist. In this way all services would be provided from an in-house pharmacy service more responsive to the residents' needs and collaboration with the doctors.

Medical centres / Multi purpose health services- the location rules that prohibit an Approval Number being located within 1.5Km of another pharmacy is preventing patients who elect to visit a medical centre from having as ready access to a pharmacist as to any other health professional. The fact that doctors are denied the ready access to a pharmacist to liaise with and seek advice from when treating a patient is not in the best interest of the patient. The example of the Woodbridge Medical Centre[4] in Western Australia was the classic case at the time of the Wilkinson Review where because the nearest pharmacy was 825 metres from the centre, albeit over a busy highway – there could not be an Approval Number given for the Woodbridge Medical Centre Pharmacy. This is an example of regulation not moving with current trends in patient needs. The Centre has 14 doctors, nutritionist, pathology, radiology and other associated services. But it could not have a pharmacy.

[3] NCP review of pharmacy regulation. February 2000 Page 76
[4] Rockingham Kwinana Division of General Practice.

You say

Some of the questionable restrictions in the pharmacy sector form part of the Australian Community Pharmacy Agreement governing the provision of prescription pharmaceuticals under the Pharmaceutical Benefits Scheme. This agreement is due to be renegotiated next year.

It is hoped that the location rules pertaining to the issuing of Approval Numbers to the above examples can be considered in the context of the Fourth Community Pharmacy Agreement and the author hopes the Productivity Commission can make this point strongly in its final report to Government in February 2005.

The fact that nothing has happened is because of the strength of the lobby to maintain the status quo. This has not been in the best interest of the Australian consumer, especially those from disadvantaged groups or at risk groups in the community.

4. THE WAY PHARMACY SERVICES ARE VIEWED BY PRIMARY HEALTH CARE POLICY MAKERS

The lobby for retail pharmacy has set back the progress of the pharmacy profession in terms of its acceptance by other primary health care professionals. So long as the provision of services with respect to the supply of PBS to the Australian community is being restricted (by regulation) to a retail setting it (the pharmacy profession) will never be able to take its place alongside the doctors, nurses, radiologists and pathologists in the health clinic setting. A large sum of money is being spent on educating young people to graduate as pharmacists after a four year full time university course only to see many of them enter the retail trade as business people. The cost benefit of this needs to be examined as a by product of the push to maintain PBS supply in a retail shop.

You say

…in the pharmacy sector such ownership restrictions have the potential to increase the costs of service provision and reduce access to services.

It is the contention of this author that the profession of pharmacy can move ahead and be a significant contributor to health gains if able to practice in a setting that is more conducive to providing a close working relationship with clinicians in a multi-purpose clinic setting.

The location rules as described above together with the ownership restrictions are preventing PBS to move into areas where the knowledge gained by a pharmacy graduate can be used to compliment the decision making of prescribing doctors.

Innovation in the pharmacy profession could allow this to happen without the strong push for the maintenance of the status quo in terms of ownership and PBS location.

With respect to the recent attempts (2004) of both New South Wales and Victoria to change the laws with respect to the number of pharmacies a pharmacist may own

You say

Both New South Wales and Victoria prepared legislation to increase the number of pharmacies each pharmacist can own, but following discussions between the Prime Minister and the respective state Premiers, these changes were withdrawn.

Not surprisingly, these developments have meant that ownership restrictions remain the subject of much debate. Woolworths (sub. 115), for example, suggested that the restrictions protect the livelihood of pharmacists at the expense of consumers.

The strategy of the retail pharmacy lobby in opposing these reforms was to “con” the public into believing that the proposed amendments would allow supermarkets to own pharmacies and have these located within their premises. This was untrue. It did however strike a chord with the electorate and resulted in petitions being signed with numbers in the 500,000 range. This evidence of the power of the lobby and the support it could muster

was more the reason for the Prime Minister's intervention rather than the legitimacy of the arguments.
This is a sad state for reflection when the better health of consumers should be the focus rather than the wealth of retail pharmacy owners and the protection of their retail industry. Whether or not Woolworths or Coles should own a pharmacy is another argument that can only be approached on a basis of honesty. Unfortunately 2004 has not been a year for honesty in the political arena.
Actions such as those just mentioned, coupled with the hysteria that is being generated among the pharmacy student population, does nothing to enhance a climate of academic debate on where pharmacy should sit on the priorities of need in improving health services. Unfortunately the retail pharmacy industry has pigeon-holed its profession in a location removed from the real action in health care. This at a time when the use of drugs in the community and the problems associated with the spiraling cost of the PBS is in the news and a rational approach to drug use is being called for by the health professional industry. Evidence of this is in the statement of the AMA President in calling for a Senate Inquiry into the PBS and its supply to the Australian community[5].
Dr Glasson said *"We need a Senate Inquiry to ensure the next Pharmacy Agreement properly serves the needs of patients and communities."*
The location in a retail setting would also have contributed to the following words of the AMA President in a speech given on 17 September 2004[6]:
"*In particular, the AMA is concerned that most pharmacies in Australia do not currently have appropriate locations where private consultations relating to sensitive health issues - such as incontinence or sexual health, or traumatic events such as childhood immunisations – can occur. The lack of privacy is a major disincentive to people seeking professional advice or treatment on these important health issues."*
If pharmacists are to be recognised for the knowledge they have they need to move to a location that is more conducive to collaboration with other health professionals. The failure of the industry to embrace reforms such as those alluded to in the Wilkinson Review and your own Discussion Paper is holding back the professional satisfaction for pharmacists in the future and must bring in to question the money being spent on pharmacist education at the university level.

5. ALTERNATIVE MODEL FOR PHARMACY PRACTICE

The PBS is currently helping to pay the rent of Approved Pharmacies located in high cost rental real estate across the country. The Pharmacy Guild claims that 63% of the turnover of the average pharmacy comes from the PBS side of the business[7].
Given this, the present location in high rental accommodation has to be questioned if the purpose of the business is to dispense PBS medicines and supply the public with their medicines that cannot be sold any where else due to safety reasons. This is controlled by the decisions of the National Drugs and Poisons Scheduling Committee.
Removal of the ownership provisions will allow innovative options to be considered for the most cost efficient location of "dispensaries" to conduct a community service in the provision of prescription needs and scheduled medicines. The owners of the businesses could be existing medical centre operators, health insurance sector members or the friendly society movement.
In its oral submission to this review the Australian Friendly Society Pharmacies Association has made it clear that its motives are for the membership of its organisations and is not dollar driven[8]. The opposition of the pharmacy lobby to the Friendly Society movement stems from the tax advantages the latter is able to receive thus giving them an advantage in an economic sense. It would be hard for anyone to criticise the professionalism of the operations from the Friendly Society pharmacies across Australia. This in itself is ample

[5] AMA Media Release 26 October 2004
[6] Speech – The Pharmaceutical Benefits Scheme: Separating Fact from Fiction. 17 September 2004
[7] Pharmacy Guild submission to Productivity Commission June 2004
[8] **Public Hearing Transcript - Canberra 14 December 2004**

evidence that it does not have to be a pharmacist that owns a business to provide a good high quality service. Indeed in the opinion of this author the FS movement runs the most professional practices in Australia.

This author contends that so long as the proprietor of the business is relying on the sale of more drugs for their own return on investment there will not be the opportunity for a proper evaluation of the PBS and its usefulness in improving health outcomes to be undertaken in an ongoing manner. The retail pharmacy industry now is motivated to sell more drugs and this is evidenced at times when there is a campaign to collect unwanted medicines from people's homes – tonnes of unused medicine is collected that amounts to millions of dollars of wasted PBS dollars of taxpayers money. The Quality Use of Medicines program reports that:

Data supplied by the Pharmacy Guild and the Commonwealth Health Department suggested that between 150 and 200 million dollars worth of unwanted or unexpired pharmaceuticals are destroyed annually in Australia.[9]

The total collected in 1998-99 was 2581.42 tonnes of unwanted medicines[10].

A model that embraces the following principles should be examined as an alternative to the existing retail pharmacy structure:

1. Low rental accommodation
2. Located near to or adjoining existing medical/community health centre facilities
3. Concentrating effort on dispensing PBS and non-PBS medicines
4. Sale of restricted products requiring pharmacist advice in use
5. Providing timely consumer medicine information
6. Acting as a consultancy to all health professionals and community groups
7. Monitoring the compliance of clients to doctors recommendations re taking of medicines
8. Providing dose administration aids to all persons with chronic diseases and needing compliance for symptom control
9. Employing pharmacists with a desire for a professionally fulfilling role in primary health care
10. Assisting in implementing the National Medicines Policy principles
11. Conducting activities towards improved quality use of medicines.

Such a model of pharmacy practice would provide consumers with a choice. This would enable them (consumers) to decide whether they wanted the fully blown professional service or the retail pharmacy model that would still exist.

The opening of the ownership provisions of pharmacy businesses and the location of PBS Approval Numbers would allow such an innovative model to be tested with the opportunity to give the Australian consumer a real choice in pharmacy service delivery.

You say

"It is now generally accepted that Australia's health system is beset by structural problems that require nationally coordinated action. But there is less agreement on the best way forward. An independent review of the whole system is needed to provide a roadmap for reform."[8]

This submission urges you to recommend that, as **you say**-

The 2005 review of the Australian Community Pharmacy Agreement, governing remuneration for the provision of pharmaceuticals subsidised under the PBS, would be yet another vehicle for re-examining restrictions on competition in this sector.

...and that government ensures that this happens.

ROLLO MANNING
DARWIN
December 2004

---

[9] Overseas Pharmaceutical Aid for Life (Opal)/Return Unwanted Medicines Pty Ltd [ID : 473]
[10] Ibid