The Pharmacy Guild of Australia

13 December 2017

Mr Gerry McInally
Committee Secretary
Senate Select Committee on Red Tape
PO Box 6100
Parliament House
CANBERRA ACT 2600

Dear Mr McInally

Thank you for the opportunity to appear before the Senate Select Committee on Red Tape's public hearing into the Effect of Red Tape on Pharmacy Rules on 27 February 2017.

As part of the Committee's deliberations, I would like to submit further information relating to the correction of factual errors in the oral evidence by Mr Michael Rhodes of Rhodes Management.

Yours sincerely

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There are a number of factual inaccuracies in the evidence by Mr Michael Rhodes of Rhodes Management at the Senate Select Committee on Red Tape hearing on Monday 27 November, 2017

P 12 Paragraph 3

Mr Rhodes*: I would like to state from the outset that both government and patients deserve better from the pharmacy industry. Right now, it's heading towards a $20 billion per annum industry funded through the PBS medicine scheme and reimbursement of pharmaceutical services provided, mostly, by employee pharmacists. Let me draw a distinction between the types of pharmacists. There are owner pharmacists, who constitute around 3,000 in Australia—mainly across the big chain stores and who, overwhelmingly, do not work in the pharmacies they own—and there are employee-in-hospital pharmacists, who constitute over six times that amount and are made up of a 60-40 split between female and male, predominantly between the ages of 25 and 39. These constitute 60 per cent of active pharmacists.*

Fact: These figures would equate to 18,000 hospital pharmacists. The Society of Hospital Pharmacists of Australia website says it represents 4,000 hospital pharmacists. There are over 4,000 owner pharmacists and Health Workforce Australia figures indicate that there are approximately 20,000 employee pharmacists in community pharmacy.

P 12 Paragraph 5

Mr Rhodes: *Back in 2015, the Auditor-General criticised the opacity and lack of accountability of how CPA arrangements come about and the lack of transparency in delivering value in those arrangements. Other studies such as the King and Harper reviews have also been conducted and have called for the CPAs and the CSOs, or community service obligations, to be abandoned. The five-year moribund and static CPA terms are only negotiated between the PGA and the government at the exclusion of patients; suppliers; employee pharmacists and hospital pharmacists; and educators and accreditors. My question is: how on earth is that representative of the industry?*

Fact: This is incorrect. That Harper Review final report did not call for either the CPAs or the CSO to be abandoned. The Interim King Review Report didn't call for the removal of the CPAs and in terms of the CSO, it listed three alternatives, including one to remove and one to retain the CSO.

Far from excluding these groups, the CPA consultation process includes multilateral and bilateral consultations between Government and consumers, wholesalers, employee pharmacists and hospital pharmacists.

P14 – Paragraph 1

Mr Rhodes: *There are mechanisms in place—I think it's called the RPBA, the remote support for those pharmacies—and, if anything, they should be maintained or increased.*

Fact: It is the RPMA or Rural Pharmacy Maintenance Allowance

P14 – Paragraph 3

Mr Rhodes: *As we understand it, the location restrictions—I can't remember the exact algorithm because the guidelines by the PGA is about 80 pages long—in summary, there are limitations on the distances between pharmacies. That's often abused if you have a pre-accredited pharmacy number, which is when you see pharmacies open up next-door to each other. But there are rules of one kilometre, 1.5 kilometres, two kilometres, five kilometres that restrict pharmacies being opened in certain locations. We're calling for no restrictions. You or the Chair mentioned earlier that Chemist Warehouse doesn't support the CPA arrangements because it wants to grow its business. Right now, what we see is that the market is being funded inefficiently because there are businesses out there losing money that just shouldn't be providing a service—they can't provide a quality of service to patients.*

Fact: They are not the Guild's guidelines and they are not 80 pages long. They are administered by the Australian Community Pharmacy Authority (ACPA) which sits in the Department of Health. The ACPA Applicant's Handbook cover to cover (including the glossary) is 49 pages. The specific requirements for each rule are outlined in no more than 4 pages.

What is a 'pre-accredited pharmacy number"?

There are no 2km or 5km location rules – they don't exist.

P 15 - Paragraph 3

Mr Rhodes: *One of the things that is frustrating for pharmacies is that when they're dispensing medicines and giving customers a tax invoice, you don't actually see the PBS price. And we're saying you should see the PBS price, so you do not get overcharged for that medicine. But we're also saying that, with that supply chain portal solution, sometimes manufacturers and wholesalers have an abundance of stock, so why not put out there an option to buy stock at a lower price? It's pure supply and demand.*

Fact: The pharmacist has to print the full cost on the dispensing label under Section 64 Labelling of pharmaceutical benefits – full cost, of the National Health (Pharmaceutical Benefits) Regulations 2017:"A pharmaceutical benefit supplied by an approved supplier must be labelled with the words "full cost" followed by the full cost of the pharmaceutical benefit.' This "full cost" is not the Patient Co-Payment but is often greater than what the patient will pay.

If a pharmacy can purchase a medicine for less than the Agreed Ex-Manufacturer Price then this price will be captured by the Price Disclosure mechanism and the Government will decrease the AEMP to that which exists in the market. This is how Price Disclosure works – the price is linked to what PBS medicines are really selling for, that's why the price of medicines comes down annually.

P 15 – Paragraph 5

Mr Rhodes: *Right now with PBS medicines, there are about, I think from memory 1,600 medicines—1,600 different drugs or molecules there.*

Fact: According to the 2014–15 Department of Health Annual Report - the most recent report that breaks down the PBS listings - as at June 2015, the PBS included 793 medicines in 2,066 forms and dosages, sold as more than 5,300 differently branded items.

P 15 – Paragraph 7

Mr Rhodes: *Secondly, one of the things I called for in my submission was an authority called the PRISEA, which is the PBS price scanning and enforcement authority. This is not a new idea. It was also, I think, recommended by Professor Harper when he did his review in 2015.*

Fact: There is no reference in the final report by Professor Harper to this.

P 15 – Paragraph 8

Mr Rhodes: *One of the problems we have in the market at the moment is the delay with which price reductions come through the system. For certain molecules, say, in the generic space, often the price is pegged to the highest-cost medicine, not the lowest-cost medicine. If you have a solution that says, if we're going to sell medicines and that's pegged at the lowest price, what is that lowest price worth?' That could be two per cent, five per cent or 10 per cent of savings in a $16 billion funded PBS scheme right now.*

Fact: Price Disclosure is for brands of F2 drugs. This is generally multi-branded drugs but it can be for single branded. Specifically:

A. Where the drug is new to F2:
• existing brand (usually moving from F1 or combo list) – starts price disclosure from the day the drug is on F2
• new brand on day drug moves to F2 – starts price disclosure from listing date

B. Where the drug is already on F2
• New brand – starts price disclosure from listing date.

Generally, two Weighted Average Disclosed Price (WADP) calculations are performed: 1) WADP calculation with all brand data and 2) WADP calculation without originator brand data. Then the WADP calculation that results in the lowest price proceeds.

Pharmaceutical benefits and services expenses were $13.4 billion in 2016-17, representing 18% of Federal Government expenses related to health.

P 15 – Last Paragraph

Mr Rhodes: *They are who benefit, ultimately. Right now, the government pays a pharmacist or a pharmacy—the AHI fee per dispense went from $7.50 to $10.50 in the last budget. That extracted $600 million extra until 2020 to fund the industry. That AHI fee stands for the admin handling and inventory fee. Let's look at that: it's actually paid to the pharmacy owner, yet it's the pharmacist who bears the cost and liability to provide that service. Let's extend this out a little bit further. If I'm a pharmacist and I own two pharmacies, three pharmacies, four pharmacies, and I'm doing 200 scripts a day—multiplied by $10 per script dispensed, multiplied by four pharmacies—that's 8,000 bucks a day that I'm giving to a very privileged ownership group to support the industry.*

Fact: The AHI for 2016-17 is $3.54 for Tier 1. The statutory AHI rises to $3.94 for 2017-18, an increase of $0.08 due to CPI indexation and $0.32 additionally in the most recent Budget in

recognition of less than expected volumes, with a total cost over 3 years of $200m. The $600m was for the allocation of existing CPA funding for new and expanding patient programs

The average pharmacy dispensed approximately 140 prescriptions per day in 2016-17 according to Date of Supply and official pharmacy figures, with only ~100 of these being above co-payment dispenses

P 16 Paragraph 15

Mr Rhodes: *The two portals that I've talked about enable a pharmacist to provide that service. If you're doing 200 scripts a day, that's dispensing once every 2.4 minutes. That's why, when you go to the pharmacy, you're waiting 15, 20 or 30 minutes to get your prescription. You wouldn't have that problem if you had the portal that enabled the pharmacist to look at your medicine consumption history and the interactions. It would give them time to do this.*

Fact: This scenario happens now – that's what applications like eRx Express do – the patient leaves the rx at the pharmacy and places an order using their phone app.

P 17 Paragraph 1

Mr Rhodes: *Well, no, it's not. It's a much better solution than the eRx. The eRx is a bit of software provided by a software company. The problem with eRx is that it's an opt-in solution; not everyone uses it. Not everyone can afford to use it, because you have to pay for the software. We're saying this should be a solution that government lead, that the Department of Health lead, so that doctors and pharmacists can access that solution at no cost.*

Fact: eRx is not just a 'bit of software'. It is a Prescription Exchange Service (PES) that provides for the 'exchange' of electronic prescriptions (barcoded) between the prescriber and dispenser 'activated' by the patient when they present the hardcopy prescription at the pharmacy. Currently the PES service fee ($0.15) is paid for by the pharmacy and subsidised under the 6CPA. eRx (used by GPs and pharmacists) or eRx Express (eRx ordering app used by patients) is free of charge to prescribers and cost neutral to pharmacies. Pharmacies already have scanners for other barcodes – eg to verify the accuracy of dispensing so this is not an additional cost.

P17 – paragraph 21

Mr Rhodes: *That's exactly right. Right now, though, that's what they do, except they've got to go into three or four systems to do that. They might get the Lipitor from the manufacturer. They might get one or two generic equivalents from another manufacturer. And what they do is: they have to go into three different systems for three different suppliers to see three different prices.*

Fact: There currently are a number of ways community pharmacy can place orders with wholesalers or manufacturers. Most of these involved electronic ordering via a pharmacy's Point of Sale or Dispense computer systems. In fact there is already a portal that would appear to operate in a similar manner to what Mr Rhodes is suggesting. The PharmX Gateway provides an electronic process for pharmacies to order and receive invoices from suppliers who are connected to the PharmX Gateway. More information is available online at **http://www.pharmx.com.au/index.html**

P19 Paragraph 16-18

Mr Rhodes: I *don't know what the opening hour restrictions are. In fact, I'm not aware of any. I think any pharmacy can open for as long as they like…. Maybe there are some restrictions there, yes.*

Fact: Pharmacy opening hours must be 'reasonable' under the National Health Act but there are no other restrictions under State or Federal regulations. Pharmacies operating in major retail/shopping centres usually have opening hours stipulated in their retail leases.