AMA

The future of dispensing

Ensuring Australians have affordable and accessible medicines into the future.

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Published 2021

PRESIDENT'S MESSAGE

As doctors, our top priority is the health of our patients. Patients attend our rooms and we listen as they discuss their concerns. Often, but not always, medications are prescribed to aid in the treatment of our patient's conditions. We generate a prescription, and this is in turn taken to their preferred pharmacy for dispensing. This is how it has been for decades, but is it the best way for us to provide care for patients? As consumers and active participants in their health care, is that what patients really want?

The purpose of this discussion paper is to explore alternative systems and models of dispensing medications to the Australian population. The AMA has two central policy positions that are relevant to this discussion paper:

- The current pharmacy ownership and location rules must be relaxed given the anti-competitive nature of the pharmacy sector, increasing access for patients and allowing non-pharmacists to own pharmacies; and
- The Government must allow pharmacies to dispense up to three months' worth of drug at a time for patient convenience if it is deemed safe by a doctor.

For the purposes of the paper, the models proposed are just that, proposals and food for thought. AMA, at this current time has not formally endorsed any or all of the proposed models of care. We would hope that they can form a starting point of discussion for what our healthcare delivery systems have the potential to evolve into in the coming years.

The AMA has a vision for the future of the Australian healthcare system that is based on the core principles of access, sustainability, and patient empowerment that is led by medical practitioners. While our current system works well, we can and should be striving to improve it. This paper highlights options and opportunities that we should consider as a community, focusing specifically on the dispensing of medicines. To that end, a good starting point is to consider these simple questions: How, where and why do we dispense medicines in Australia?

Australia has a workforce of highly trained pharmacists who are experts in their field of safe and effective use of medicines. Pharmacists will always have a central role in the provision of health care in Australia. We want to ensure that they are in environments that support this. In every model discussed in this paper, pharmacists will remain central to the ongoing Australian healthcare systems as experts in medication formulation and safe use of medicines.

While the primary focus of this discussion paper is to focus on dispensing, it must be noted that this is but one faction of the healthcare system that requires reform. With ageing populations and increasing incidence of chronic disease, pharmacists will continue to be key stakeholders within the Australian healthcare system. We hope to demonstrate how dispensing can fit our proposed model of future, better care for all Australians.

We invite comments, questions and critique from our members, doctors, other health professionals and consumers alike with respect to our proposed models. Consideration should be given to queries like why your GP cannot dispense antibiotics on the spot, or why there is only one pharmacy located in your town. Maybe you are a pharmacist who has always wanted to collaborate more closely with the local GP, but strict regulations have prevented this. These options are to encourage you to think about what we could have in Australia, and what would need to change to get there.

Dr Omar Khorshid
Federal AMA President

INTRODUCTION

The Seventh Community Pharmacy Agreement (7CPA) was signed in July 2020. 18.35 billion dollars of Government funding will be spent from 2020 to 2025, which is expected to equate to just under $700,000 per pharmacy per year of the agreement.[1] The rules are largely set in place for the next five years, however this does not prevent discussions from taking place on how improvements can be made. In fact, now is an important time to highlight what opportunities our communities have been denied under this new deal.

A major failing of the 7CPA is that it is an old model of healthcare delivery that limits patients access to essential medicines and promotes fragmented delivery of care. It stares firmly into the past when we as a community need to be looking into the future. The rules are complex and designed to limit competition.

The AMA is just one of the many voices that has been calling for deregulation of the community pharmacy arena for many years now. The Competition Policy Review conducted by an independent panel of experts in 2015 identified pharmacy as an "area for immediate reform". Among other recommendations, the removal of pharmacy location and ownership rules were central to the report.[2]

Furthermore, the report concluded that these laws countermand the National Medicines Policy:

> "The Australian Government's National Medicines Policy establishes objectives against which medicines are provided and regulations set. The current anti-competitive regulations on the location of pharmacies, or the requirement (with limited exceptions) that only pharmacists own pharmacies, do not appear to serve the objectives of the National Medicines Policy, including the quality of advice provided to consumers. Such restrictions limit both consumers' ability to choose where to obtain pharmacy services and suppliers' ability to meet consumers' demands."[3]

Moving forwards one of the AMA's foremost priorities is ensuring that Australia has a sustainable healthcare system now and into the future that promotes access and patient-centred care. This is clear when focusing on Australia's archaic pharmacy ownership and location rules, and how medications are dispensed nationwide.

Australians pay $10.8 billion out of their own pockets for prescription and non-prescription medicines – over one third of out-of-pocket health costs and the largest contributor to it by a large margin.[4] As a starting point for options for change, we can compare our current system to those of other developed economies and countries with publicly subsidised pharmacy schemes like Australia.

1 TACS Healthcare (2019), Surviving Community Pharmacy. https://tacshealthcare.com.au/surviving-community-pharmacy/

2 Harper, Anderson, McCluskey and O'Bryan (2015), Competition Policy Review Final Report. https://treasury.gov.au/sites/default/files/2019-03/Competition-policy-review-report_online.pdf

3 Ibid

4 AIHW (2018), Patients' out-of-pocket spending on Medicare services, 2016–17. https://www.aihw.gov.au/getmedia/f6dfa5f0-1249-4b1e-974a-047795d08223/aihw-mhc-hpf-35-patients-out-of-pocket-spending-Aug-2018.pdf.aspx?inline=true

Online pharmacies already provide a significant portion of medicines to Americans and Europeans. In the UK, remote dispensing by machines provides access to patients who otherwise would not be able to visit a pharmacist. In the UK, supermarkets have pharmacies with pharmacists on site to dispense medicines to patients.

One of The AMA's models of healthcare innovation is the pharmacists in general practice program which has proven highly successful in its initial phases. Under the AMA's plan, pharmacists working in general practices assist in areas such as medication management, patient education, and by supporting GP prescribing with advice on medication interactions and newly available medications.

Economic modelling by Deloitte Access Economics demonstrated that for every $1 invested in the program, $1.56 in savings is delivered to the health system.[5] General practices are now supported to employ pharmacists under the Workforce Incentive Program. Practices employing pharmacists have reported improved patient outcomes and high levels of provider satisfaction.[6]

Under a different model, these pharmacists in general practice could dispense medication to patients immediately after a visit with their GP.

There are many potential pitfalls and issues with some of these models – patient safety must always be a priority and convenience should never supersede access, but careful planning and well legislated protections could easily allow modifications to our pharmacy model.

The AMA's goal is to stimulate discussion on this topic. We want a health system that is equitable and efficient, that delivers excellent health outcomes with high provider satisfaction.

5 Deloitte Access Economics (2015), Analysis of non-dispensing pharmacists in general practice clinics. https://ama.com.au/sites/default/files/documents/DAE_Report.pdf

6 Ines Rio (2019) "General practice and pharmacists working together", Stethoscope. https://amavic.com.au/news---resources/stethoscope/stethoscope-archive-2019/-54-general-practice-and-pharmacists-working-together

HOW MEDICATIONS ARE DISPENSED IN AUSTRALIA

In Australia medicines are dispensed by pharmacists. In general consumers visit their GP for a health issue and the GP writes them a prescription for a medicine to manage the issue. The patient then takes the script to a community pharmacy where it is dispensed by a pharmacist.

The process of dispensing as it currently works in Australia includes two further steps. First, the pharmacist reviews the prescription to ensure that it is safe and will not interact with patient allergies or react with other medications. In some cases the pharmacist will contact the prescribing doctor to discuss the prescription. Second, after the medicine has been issued, the pharmacist will provide important information about the correct and safe use of the medicine.

Safety checks and clear communication with patients about their prescribed medicines are important processes. These checks are essential inclusions in any model of dispensing medicines. Pharmacists are the health professionals with the training and experience to perform this role, however community pharmacy is not necessarily the best avenue for dispensing in every context. In fact, community pharmacies under the current anti-competitive ownership and location rules have been found repeatedly to limit patient access to medicines.

The 2015 Productivity Commission report "Efficiency in Health" stated:

> "Restrictions on the location and ownership of retail pharmacies limit competition, raise prices and make it harder for some consumers to access pharmacy services. There is much to gain from the Australian Government removing location restrictions, and state governments removing ownership restrictions, while targeting safety and access objectives more directly."[7]

The current rules are explained below.

Ownership rules

Pharmacy ownership laws are set at the State/Territory level (for example, see the Queensland Act, or the Western Australia Guidelines). While there are slight differences between jurisdictions, they essentially prohibit anyone other than a pharmacist or a pharmacist's family member from owning a pharmacy, and limit the number of pharmacies an individual can own or have a share in to four to six pharmacies. The stated intention of this rule is to prevent larger corporations from owning pharmacies.

Changes to the restriction under the ownership rules have been suggested by other pharmacy groups, the Productivity Commission, research institutes, Independent researchers, consumers and other organisations representing doctors.

Defenders of these rules say that they are essential to keep pharmacies owned by the community. Unfortunately that is no longer the case. In 2011, 81.5% of pharmacies were independently owned or owned by smaller chains. In 2018, this was less than 27%, the other 73% being owned by one of four major retail pharmacy chains.[8]

Doctors cannot own pharmacies unless they are also a pharmacist. The AMA believes that patient access and convenience in obtaining medications that they require can be improved by non-pharmacists being permitted to own pharmacies provided such ownership is managed ethically, addresses conflicts of interests and maintains the clear distinction between prescribing and dispensing.

7 Productivity Commission (2015), Efficiency in Health. https://www.pc.gov.au/research/completed/efficiency-health/efficiency-health.pdf p. 3

8 KordaMentha (2018), Pharmacy: An industry at a crossroads. https://www.kordamentha.com/getmedia/31d44993-40bb-49ae-a3ec-dd3e4eded14d/Pub_181121_Pharmacy-industry-paper_Final.pdf.aspx

Location rules

The current location rules require new application to meet the following requirements:

a. *the proposed premises are at least 1.5 km, in a straight line, from the nearest approved premises; and*

b. *the Authority is satisfied that, at all relevant times there is, within 500 m, in a straight line from the proposed premises, either:*

   i. *both the equivalent of at least one full time prescribing medical practitioner; and a supermarket with a gross leasable area of at least 1,000m^2; or*

   ii. *a supermarket that has a gross leasable area of at least 2,500m^2*

These rules were established to encourage a geographical spread of community pharmacies to promote access to Pharmaceutical Benefits Scheme (PBS) medicines.

Location rules for pharmacies were last reviewed in 2017[9]. Applications for new pharmacies and the relocation of existing pharmacies is approved by the Secretary of the Department of Health under Section 90 of the *National Health Act 1953* (the Act), though these responsibilities are delegated to staff within the Department. The decision is made on advice of the Australian Community Pharmacy Authority which has two Pharmacy Guild of Australia representatives and one from the Pharmaceutical Society of Australia (PSA) as well as a Chair, officer of the Department, and a consumer representative chosen by the Minister.

The current rules make it particularly difficult for a pharmacy to be opened in a medical centre, despite the increased access this would provide for patients and the increased opportunities for collaboration it would create within the centre.

The rules for opening a new pharmacy in a "Large medical centre" state that there must be at least eight full time PBS prescribers working in the practice in the two months preceding the application. A large medical centre is defined as *"A medical centre that is under single management; and operates for at least 70 hours each week; and has one or more prescribing medical practitioners at the centre for at least 70 of the hours each week that the medical centre operates."*

More detailed rules are available in the Pharmacy Location Rules Applicants Handbook.

Much like ownership rules, restrictions on pharmacy locations has come under severe criticism. Even the Federal Government has acknowledged that the location rules should be examined to promote competition in the pharmacy sector.[10] Despite this, the rules remain largely unchanged.

Exceptions

Medicines are supplied to patients outside of pharmacies in Australia in limited cases. Doctors are allowed to dispense medicines to patients if there is no pharmacy available within a reasonable distance.[11] Doctors also often carry a limited supply of medicines for use in emergencies which are supplied to the patient free of charge, with instructions for use provided by the doctor. Aboriginal Health Services are provided with stocks of medicine to be supplied to their patients, often by an Aboriginal health worker.

These protocols exist because access to medicines is not guaranteed by the current community pharmacy arrangements. The AMA wants all Australians to have ready access to medicines when they need them in their community.

9 Commonwealth Department of Health (2017), Report of the Review of Pharmacy Remuneration and Regulation, https://www1.health.gov.au/internet/main/publishing.nsf/content/7E5846EB2D7BA299CA257F5C007C0E21/$File/review-of-pharmacy-remuneration-and-regulation-final-report.pdf

10 Australian Government (2015), Government response to the Competition Policy Review, https://treasury.gov.au/publication/government-response-to-the-competition-policy-review p.14

11 *National Health Act 1953* (Cth) s 92.

HOW MEDICATIONS ARE DISPENSED OVERSEAS

In Australia the vast majority of medications are dispensed in pharmacies by pharmacists or pharmacy assistants qualified in dispensing who are overseen by pharmacists. The exceptions to this occur through precise legislation to ensure Australians have access to medications. This is not the universal approach as evidenced by markedly different practises across the globe. Different funding models, ownership and dispensing rules give us scope to consider what we could have in Australia.

Ownership

In Australia, ownership of pharmacies is limited to pharmacists. Similarly, this is also the case in Spain and France. New Zealand and Denmark allow non-pharmacists to have a part ownership of a pharmacy if a pharmacist is the majority owner. The number of pharmacies an individual can own in Australia range from four to six depending on State/Territory regulations. Restrictions also exist in Denmark, France, New Zealand, and Norway. A Norwegian pharmacy chain can own more than 40% of pharmacies in the country.

Ireland, Canada, Japan, the Netherlands, the UK and the USA have no restrictions on who can own a pharmacy. The US, UK and mainland European supermarkets are allowed to own pharmacies and dispense medicines.

Restriction of Locations

There are no restrictions on location of pharmacies in Canada, Japan, Netherlands, Norway, New Zealand, Sweden and the USA. Like Australia, Denmark, France and Spain have restrictions on where pharmacies can be located based on the population of proximity to other pharmacies. Approval is required for pharmacies in the UK and Ireland but the proximity to other pharmacies is not considered in the process.

Dispensing rights

In Japan and most states in the USA, doctors can dispense directly to their patients. Patients are allowed to have their scripts filled over the internet in Denmark, Netherlands, Norway, Sweden and the UK. Dispensing by doctors in rural areas is also permitted in France, Ireland, Netherlands, Norway and the UK as it is in Australia.

LOOKING TO THE FUTURE OF DISPENSING IN AUSTRALIA

The purpose of this paper is to start a discussion about how we can improve the dispensing of medicines in Australia. The AMA is not advocating for any one model over the other with the knowledge that trials and due diligence in the application of various models must be followed. With this in mind, one simple change that could be introduced tomorrow (improving access to medicines but still maintaining safety) is allowing three months' worth of medicines to be dispensed from a single script.[12]

Prior to implementing any new or innovative models of care with respect to changing of dispensing practices within Australia, it is paramount to uphold the following ideals and principles:

- The primary purpose is for the benefit of the patient in terms of improved access, quality of care and patient safety.
- It is important to ensure that the line between prescribing and dispensing is maintained. Commercial interests are separated from professional values and decision-making.
- GP oversight of patients must be maintained to ensure that patients initiate their course of medication as directed.
- This is about improving patient access to vital medications, not about profits for the owners of retail chemist shops.
- Any model must be value-based, demonstrating appropriateness, effectiveness, and efficiency.
- Patient choice is guaranteed.
- Transparency regarding prescribing, dispensing and patient outcomes is vital.

Reforming ownership and location rules

Walking out of a consult with your GP, into a consult with the practice pharmacist and then having your medicine dispensed to you on site.

Stopping by the supermarket on the way home from netball practice with the kids and having the supermarket pharmacist fill your script while you pick up some groceries for dinner.

Scanning the QR code on your script to see the nearest community pharmacy and comparing costs with internet pharmacies that can deliver your medicine to your home.

These are all options if we reform the current outdated ownership and location rules.

There are dozens of reviews, reports, evaluations and recommendations from government agencies, independent research institutes, and health organisations and associations calling for pharmacy location and ownership restrictions to be changed.[13]

12 Pharmaceutical Benefits Advisory Committee (2018), August 2018 PBAC Outcomes. https://www.pbs.gov.au/industry/listing/elements/pbac-meetings/pbac-outcomes/2018-08/Outcome-Statement-August-2018-Increased-MDQ.pdf – Note that PBAC has recommended an increase to two month's supply per dispensing, but the AMA position is that three month's is safe if the patient's GP has determined it to be.

13 Harper, Anderson, McCluskey and O'Bryan (2015), Competition Policy Review Final Report.; Hattingh, H.L. 2011, 'The regulation of pharmacy ownership in Australia: The potential impact of changes to the health landscape', Journal of Law and Medicine, vol. 19, no. 1, pp. 147–154.

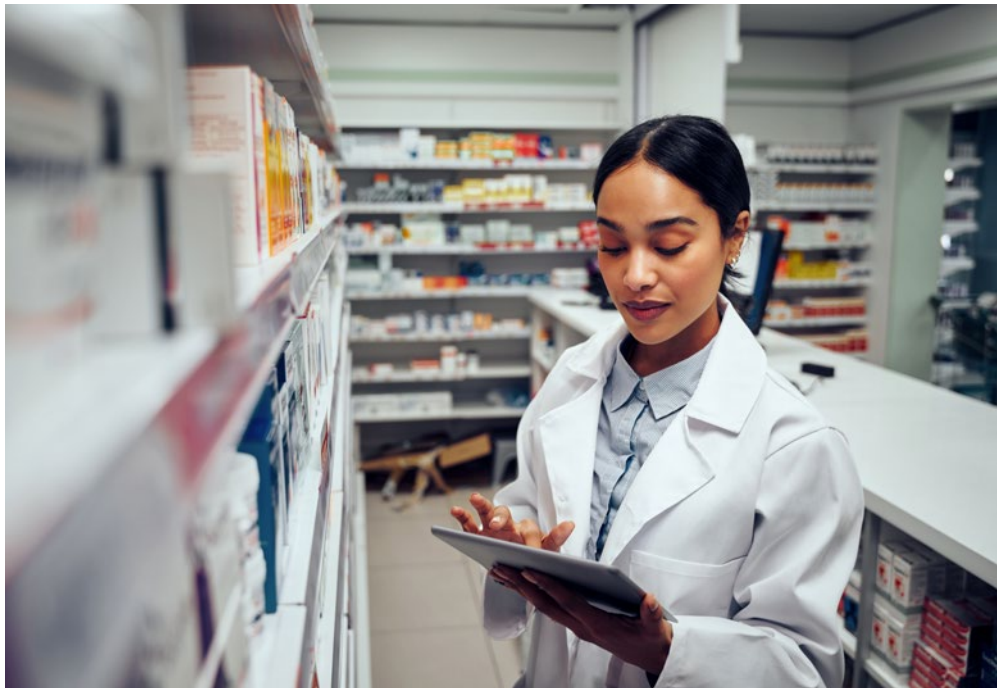
The most common defence of the current anti-competitive regulation is that the ownership and location rules guarantee access and safety for all Australians. However, the 2015 Competition Policy Review recommended removing ownership and location rules in the interest of consumers. It also detailed a list of alternatives that would ensure safety and access. These included:

- imposing obligations directly on pharmacies as a condition of their licensing and/or remuneration;
- tendering for the provision of pharmacy services in certain rural or remote areas; or
- a community service obligation, as currently applies to pharmacy wholesaling.[14]

The 2015 Productivity Commission "Efficiency in Health" paper outlined a series of reviews and submissions dating back to 1999 that highlighted concerns with the anti-competitive impact of pharmacy location and ownership regulations. Citing their own submission to the Wilkinson review, the Productivity Commission argued that "restrictions on competition accordingly inflate the costs of pharmacy services and reduce consumer convenience."[15]

The findings of the Wilkinson Review concurred that the location rules were anti-competitive.[16]

The Productivity Commission highlighted in 2005 that in addition to the rules increasing costs for the community, they are also much stricter than pharmacy regulations in other countries and in comparison to the rest of the health sector.[17] The example of Europe shows us that the increased competition from relaxing ownership and location rules of pharmacies benefits consumers.[18] Removing these restrictive rules would bring important changes to the retail space that would reduce costs and increase access.



14 Harper, Anderson, McCluskey and O'Bryan (2015), Competition Policy Review Final Report.
15 Productivity Commission (1999), Productivity Commission Submission to the National Review of Pharmacy. https://www.pc.gov.au/research/supporting/pharmacy-review/pharmacyreview.pdf
16 COAG (2000), National Competition Policy Review of Pharmacy, Final Report. https://www1.health.gov.au/internet/main/publishing.nsf/Content/pharmacy-ncpr-index
17 Productivity Commission (2005) Review of National Competition Policy Reforms, Report no. 33. https://www.pc.gov.au/inquiries/completed/national-competition-policy/report
18 OECD (2014), Competition Issues in the Distribution of Pharmaceuticals. https://www.oecd.org/competition/competition-distribution-pharmaceuticals.htm

Retail options

There is clear demand to change the rules. Importantly, this is also coming from within the pharmacy sphere. In their submission to the Competition Policy Review, Chemist Warehouse stated that the rules reduce access to pharmacy services in some communities and inflate prices.[19]

Increased competition in the community pharmacy sector would be welcome. However, there are other retail spaces and models that would improve access while driving down costs.

Supermarkets

In the US, UK and mainland Europe, supermarket pharmacies are everywhere. In the UK, scripts are able to be filled at participating Tesco's[20] supermarkets and in the US, medicines are available to be dispensed at Walmart.[21] Walmart runs over 3,000 pharmacies and employs more than 10,000 pharmacists. They run 24-hour pharmacy services.[22]

There are two primary models of supermarket pharmacies:

- straight-out ownership, where a supermarket owns a chain of pharmacies and employs pharmacists to run them, or
- a strategic alliance, where a pharmacy chain, like Chemist Warehouse, has smaller versions of its stores inside a supermarket.

Supermarket pharmacies in the UK have been demonstrated to lower prices of medicines while providing higher-quality advice to patients receiving their medicine than is provided in community pharmacies.[23]

In Australia, Woolworths has made numerous attempts to provide pharmacy services to the community only to be prevented by the current rules.

The reality is that we cannot know what developments or innovations we might have had in Australia had Woolworths been allowed to have collocated pharmacies. Consider the following statement from the Productivity Commission's 2015 "Efficiency in Health":

> "Pharmacy ownership rules also hurt consumers by reducing innovation and entrepreneurship in the sector. Excluding corporations (such as supermarkets and general retail outlets) and non-pharmacists from owning pharmacy businesses limits the scope to leverage specialised management skills and expertise that could reduce costs and improve service quality."[24]

19 Chemist Warehouse, (2014) Chemist Warehouse Submission to the Competition Policy Review. http://competitionpolicyreview.gov.au/files/2014/07/Chemist_Warehouse.pdf

20 Competition and Markets Authority (2016), Summary of hearing with Tesco plc on Friday 15 January 2016. https://assets.publishing.service.gov.uk/media/56e1a52d40f0b6037900001d/Tesco_hearing_summary.pdf

21 Walmart pharmacy website: https://www.walmart.com/cp/pharmacy-services/1088604

22 Mortimer and Grimmer (2019), A loaf of bread and a packet of pills: how supermarket pharmacies could change the way we shop. *The Conversation*. https://theconversation.com/a-loaf-of-bread-and-a-packet-of-pills-how-supermarket-pharmacies-could-change-the-way we-shop-122640

23 Department of Health (2014), Post-Implementation Review: Amendments to the *National Health Act 1953* to Extend the Pharmacy Location Rules to 30 June 2015.

24 Productivity Commission (2015), Efficiency in Health. Page 52.

Online

In 1999, the Productivity Commission noted that the strict rules around pharmacy had prevented the evolution of pharmacy in Australia, specifically noting that mail-order pharmacy, which was common in many other countries, had not been able to be effectively introduced for Australians.[25]

Over twenty years later the delivery of prescription medicines to our homes has only become an option due to a global pandemic. These deliveries, however, must still come from a community pharmacy.

Australians are already purchasing prescription medicine over the internet from foreign companies without a script. It is impossible to verify that these medicines are what they are advertised to be, that they are safe and that they are appropriate. This demonstrates that there is a clear demand that is going unmet.

Amazon Australia has recently trademarked the term "Amazon Pharmacy" in a sign of intent. Rosemary Health is another technology start-up entering the space. The model is home delivery of a patient's medication that is linked to a pharmacy. The platform will allow patients to scan their script, check prices, order and pay on an app on their phone. Other services the app provides include reminders for when to take medicines, dosage information and script repeat prompts. Rosemary Health is targeted at people with chronic conditions.[26]

New Zealand has two examples of online pharmacies. PillDrop allows patients to upload a photo of their prescription to an app and have them delivered. The service can contact the patient's GP and has a 24-hour phone line to pharmacists. Zoom has partnered with NIB insurers that operates in a similar way. Zoom's app provides personalised medicines information, daily dose reminders, and repeat and refill alerts. Both apps can arrange repeat prescriptions directly with the patient's GP.[27]

25 Productivity Commission (1999), Productivity Commission Submission to the National Review of Pharmacy. Page vii.

26 Rosemary health website: https://www.rosemaryhealth.com.au/; McDonald (2019), Rosemary Health hopes to get pharmacy ahead of Amazon, Pulse IT. https://www.pulseitmagazine.com.au/australian-ehealth/5001-rosemary-health-hopes-to-get-pharmacy-ahead-of-amazon

27 McDonald (2020), Digital pharmacy launches in Auckland to deliver medicines to patients' homes, *Pulse IT*. https://www.pulseitmagazine.com.au/new-zealand-ehealth/5300-digital-pharmacy-launches-in-auckland-to-deliver-medicines-to-patients-homes; McDonald (2019), NIB partners with Zoom to deliver medications to patients, *Pulse IT*. https://www.pulseitmagazine.com.au/news/new-zealand-ehealth/5039-nib-partners-with-zoom-to-deliver-medications-to-patients

Machines

The 2017 Productivity Commission "Shifting the Dial" report included the following recommendation:

> "The Australian Government should move away from community pharmacy as the vehicle for dispensing medicines to a model that anticipates automatic dispensing in a majority of locations, supervised by a suitably qualified person. In clinical settings, pharmacists should play a new remunerated collaborative role with other primary health professionals where there is evidence of the cost-effectiveness of this approach."[28]

Automated dispensing machines have been available since the 1980s. They are predominantly used in hospitals, however they could be utilised in other formats in Australia. Automated dispensing refers to the use of automated systems to dispense (package and label) prescription medications without an on-site pharmacist. In practice they operate in a similar manor to vending machines. These remote dispensing machines have been used throughout the US, Canada and the UK.

A simple way to incorporate remote dispensing in Australia would be to allow dispensing machines to be located in general practices. Practices could utilise the skills of a practice pharmacist who is able to perform medication reviews with patients and provide advice on the spot. In order to remove financial incentives, practices could receive flat fees from remote dispensing machine providers who make profit off individual sales.

Automated dispensing machines are common in hospitals around Australia, but hundreds of pharmacies have already installed automatic dispensaries too.[29]
One of the reported benefits for the pharmacies that have installed the automatic dispensaries is that it provides more time for pharmacists to consult with the consumer about their medicine.

Placing a dispensary like the one in the image above in a general practice could facilitate optimal outcomes by utilising the practice pharmacist. A general practice also has the advantage of not upselling patients or promoting items with no therapeutic value as retail chemist shops do.

The collocation of pathology collection centres in general practice could serve as a model for contractual arrangements which would ensure that no financial incentive was gained from prescribing. Under this model, a flat rate would be paid to the general practice for having a dispensing machine on site. Doctors or practices would not receive payments based on individual scripts.

Improving access for rural and remote Australia

One of the major challenges for rural and remote Australians is access to medicines. Pharmacists are concentrated in metropolitan centres to a higher degree than doctors and other health professionals. Rural and remote Australians also have less competition in the pharmacy sector because of the location rules.

A 2019 survey commissioned by Chemist Warehouse conducted in five regional towns in Victoria revealed that 65% of respondents had travelled to pharmacies in other towns, 40% of whom stated that price was the main factor for this decision. The survey also found that 77% supported a change in location rules to allow more competition in small towns.[30]

Rural Australians have lower life expectancy, worse outcomes on leading indicators of health, and poorer access to care compared to people in major cities. Death rates in regional, rural, and remote areas are higher than in major cities, and the rates increase in line with degrees of remoteness[31].

28 Productivity Commission (2017). Shifting the Dial: 5 Year Productivity Review. https://www.pc.gov.au/inquiries/completed/productivity-review/report. Page. 13.
29 Guest Author (2016), robots give rise to the future of pharmacy dispensing, *AJP*. https://ajp.com.au/features/robots-give-rise-future-pharmacy-dispensing/
30 Haggan (2019), The Great Pharmacy Debate, *AJP*. https://ajp.com.au/news/the-chemist-warehouse-survey-revealed/
31 Australian Institute of Health and Welfare (2019), Rural and remote health. Cat. no. PHE 255. Canberra: AIHW. https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health

The AMA believes that health care in regional, rural, and remote Australia deserves significant real funding increases. It is also important to note that models which function in cities will not always translate to rural towns. It is essential that government policy and resources are tailored and targeted to cater to the unique nature of rural health care and the diverse needs of rural and remote communities to ensure they receive timely, comprehensive, and quality health care.

The 2015 Competition Policy Review included this recommendation:

> "To secure access to medicines for all Australians, governments should consider tendering for the provision of pharmacy services in underserved locations and/or funding through a community service obligation. Since access to medicines is less likely to be an issue in urban settings, the rules targeted at pharmacies in urban areas should continue to be eased at the same time that mechanisms are established to address specific issues concerning access to pharmacies in rural locations."[32]

Automated dispensing, dispensing from general practice, allowing supermarkets to run pharmacies or changing the location rules would all improve access to medicines for rural communities. Ultimately, future policies or models of care must include stakeholder involvement from rural and remote communities.

32 Harper, Anderson, McCluskey and O'Bryan (2015), Competition Policy Review Final Report. Page 48.

WHAT ARE THE RISKS IF WE DON'T REFORM?

Australia is fortunate to have one of the best health systems in the world. However, much like most OECD countries, our population is ageing, incidence of chronic disease is increasing, and complex advances in care are entering the system.[33] The cost of providing care will increase with these trends, so it is imperative that we identify areas where we can effect change and improve our efficiencies. The system must be designed to promote value.

Competition in the pharmacy sector is one area where our efficiency can be improved. The 2015 Audit of the fifth community pharmacy agreement concluded that the lack of transparency and effective evaluation make it difficult to determine if the cost of pharmacy remuneration represents value for money.[34]

We can and should have a better system in Australia, one that improves access for all Australians, improves patient outcomes and ensures safe delivery while reducing costs. Right now, we are not using our resources to their full potential – for example we do not know whether patients are filling their prescriptions or if they are taking their medicines correctly.[35]

An opportunity exists to design a system that not only maintains current level of advice, care and safety but that exceeds current levels. The Productivity Commission recommended that ideally retail pharmacy should be part of an integrated care system.[36] The AMA supports this. Pharmacists can play a more significant role in the care of patients by utilising their knowledge and training as part of the GP-led primary care team. The role the pharmacists play in hospitals is an excellent example of how well coordinated multidisciplinary care can work.

Dispensing can safely occur in far more locations, increasing access for patients. It can occur at home with doctors and pharmacists directly communicating with patients via telecommunication. This is only now just happening due to the response to the COVID-19 pandemic. Prior to this, it was happening in innovative general practices around Australia, but patients still needed to visit the community pharmacy to pick up their prescription – and they needed to do so every month despite their doctor feeling confident that they could do it every three.

Alternatively we could accept the status quo and keep the same old rules and regulations we have now. They are undeniably anticompetitive; they drive up costs for consumers and governments and are even more punitive to rural and remote Australians. Now is our chance to actively plan for the future and have a say in how it might look. How long will we allow this current system to continue?

33 Commonwealth Fund (2017), Mirror, Mirror: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care. https://interactives.commonwealthfund.org/2017/july/mirror-mirror/

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