The PHARMACY GUILD of AUSTRALIA

Submission to the

Productivity Commission Inquiry

on the

Impact of Competition Policy Reforms on Rural and Regional Australia

January 1999

Contents

Executive Summary

Community pharmacies are regulated under State Pharmacy Acts which restrict their ownership to qualified pharmacists. The Prime Minister has announced that there will be a national review of pharmacy ownership legislation in early 1999, in accordance with national competition policy.

The Pharmacy Guild of Australia is concerned that the public benefits of pharmacy ownership and the way these provisions address market failures in the broader health system, are not widely appreciated. Instead, there have been a number of reports which have asserted that pharmacy ownership laws lift pharmacy costs, without presenting sound evidence to support this assertion, and without comparing these alleged costs with the public benefits of ownership.

In the face of this misinformation, the Guild welcomes the opportunity provided by this inquiry to raise community awareness of the benefits of pharmacist ownership of pharmacies. The Guild considers there are four principal benefits:

- pharmacist ownership contributes to safe pharmaceutical use;
- pharmacist ownership enables the economical treatment of minor ailments and the provision of health advice;
- pharmacist ownership supports a wide range of public health programs; and
- pharmacist ownership helps cut the price of pharmaceuticals to patients.

This broader health care role performed by pharmacists is particularly important in rural and regional Australia, given the shortage of doctors, and therefore the danger that patients may otherwise miss out on these important health messages. The recently released report from the Australian Institute of health and Welfare, *Health in Rural and Remote Areas*, found that rural communities had a poorer health status than urban communities which was probably due to their restricted access to GPs and specialists.

Ownership restrictions support better health outcomes by restricting competition to the profession, which fosters service competition, and supports the provision of unfunded health services. Service competition encourages pharmacists to invest in advising on safe pharmaceutical use and family health care, and encourages pharmacists to participate in Guild-Government initiatives to improve health outcomes.

The public benefits of ownership restrictions stem from market failures in the broader health system. These market failures are the public subsidisation of health care and pharmaceuticals, consumers' lack of information about pharmaceuticals, and consumers' inability to detect quality pharmacy services. It is difficult to address these market failures directly, given that the community values access to health care irrespective of means, and has adopted a health system with large public subsidies.

The business of community pharmacy in Australia is quality health care. Maintaining pharmacist ownership of pharmacies will keep it that way.

1. Introduction

The Pharmacy Guild of Australia welcomes the opportunity to make a submission to the Productivity Commission's inquiry into the impact of competition policy reforms on rural and regional Australia.

The Guild is a national employers' organisation which represents the owners of over 4,000 community pharmacies throughout Australia. A key part of our mission is to maintain community pharmacies as the most appropriate primary providers of health care to the community through optimum therapeutic use of drugs, drug management and related services.

The Guild provides a range of services to members including industrial relations, marketing, staff training, management and economic analysis and representing the interests of members in negotiations with governments, manufacturers, and wholesalers. The development of policy is the responsibility of the Guild's supreme governing body, the National Council, on which all State Branches and the Australian Capital Territory are represented.

The Guild has a commitment to providing pharmacy services in rural and regional Australia. In the Guild-Government Agreement on the Commonwealth price of pharmaceutical benefits (April 1995), the Guild stated its commitment to:

> "... maintain the benefits of restructuring and continue to enhance the development of an effective, efficient and well distributed community pharmacy service in Australia. The Parties undertake to maintain pharmaceutical services in remote and isolated areas of Australia". (section 3.1)

However we are concerned that the services our members offer generally, and particularly in rural and regional Australia, could be downgraded if national competition policy leads to the removal of restrictions that reserve pharmacy ownership to pharmacists. We welcome the opportunity provided by this inquiry to raise awareness of the benefits of pharmacist ownership of community pharmacies, prior to a full debate of these issues in the forthcoming national review of pharmacy legislation.

The outline of this submission is as follows:

- section 2 provides background information about community pharmacies and the goods and services they provide;
- section 3 briefly describes the regulation of community pharmacies;
- section 4 outlines the national competition policy process as it relates to community pharmacies; and
- section 5 outlines the benefits of pharmacist ownership of community pharmacies, especially as it relates to rural and regional Australia.

2. Background Information on Community Pharmacies

There are 4,950 community pharmacies in Australia, each servicing an average of 3,700 people. The average pharmacy dispenses about 37,000 prescriptions annually and has sales of about $1.2 million. The sector as a whole employs about 39,000 people, with the average pharmacy employing 3.8 people full time and 4.8 people part time and casually.

There is good representation of pharmacies in country areas. About 30 per cent of all pharmacies are located in non-metropolitan areas. Surveys of Guild members indicate that country pharmacies have broadly similar levels of total sales as their metropolitan counterparts, and are more profitable, possibly because they are open for less hours per week (52 hours compared to 62 hours for metropolitan pharmacies).

A typical community pharmacy carries up to 8,000 product lines, which includes 2,500 pharmaceutical lines. Prescription sales make up about 64 per cent of pharmacy turnover. Other products sold at community pharmacies include over the counter (OTC) pharmaceuticals, toiletries, cosmetics and disability aids.

However, to focus on products is to overlook the vital health services that community pharmacists provide to the community. Most of these services are provided on an unpaid basis, although often in conjunction with the sale of products. The most important of these services is the advice that pharmacists provide when dispensing prescription medications. This advice is central to the safe and effective use of pharmaceuticals. It includes advice on how often to take a drug, possible side effects and drug interactions.

Pharmacists also provide general health advice. They advise on appropriate OTC pharmaceuticals for minor ailments, first aid, dietary supplements, and are often the community's first point of contact with the health system.

Increasingly, governments are using the skills of professional pharmacists and the network of community pharmacies to deliver and promote a range of health programs including immunisation, methadone and needle exchange, smoking cessation and folic acid in pregnancy.

In a nutshell, the business of community pharmacy in Australia is quality health care.

3. Regulation of Community Pharmacy

Community pharmacy is regulated under both State and Federal legislation and programs. State Pharmacy Acts establish Pharmacy Boards with wide powers to regulate the standards required by pharmacists for registration, the number of pharmacists registered, practices within the industry and to approve pharmacy premises. The legislation requires registered pharmacists to be of good character, to have completed a specified course of training which includes practical experience. All jurisdictions require a pharmacy to be personally supervised by a pharmacist at all times that the pharmacy is open.

State Pharmacy Acts also restrict who can own or have a pecuniary interest in a pharmacy. In all States and Territories, only pharmacists can own pharmacies, and some States and Territories also prevent pharmacists from incorporating or limit the number of pharmacies a pharmacist can own. The ownership provisions applying in the States and Territories are detailed in Table 1.

Table 1: ***Provisions in State legislative restricting pharmacy ownership to pharmacists***

Legislation	**Only Pharmacists Can Own**	**No Corporations**	**Limit on No. of Pharmacies**
NSW Pharmacy Act 1964	S 25 (1)	S 25 (1)	S 26 (1) (2) 3
Vic Pharmacy Act 1974	S 21 (1)	S 21 (1)	S 21 (2) 3
Qld Pharmacy Act 1976	S 30 (1)		S 30 (2) 4
WA Pharmacy Act 1964	S 23 (1) (2)	S 23 (1) (2)	S 28 (1) 2
SA Pharmacists Act 1991	S 26 (1)		S 34 4
Tas Pharmacy Act 1908	S 30 (1)	S 30 (1)	S 30 A (1a) 2 S 30 A (1b) 1
ACT Pharmacy Act 1931	S 42		
NT Pharmacy Act 1980	S 32		

State Poisons legislation also affects the practice of community pharmacy. The retail distribution of drugs which are potentially hazardous, or which require professional advice to ensure correct use, is restricted through scheduling. For example, schedule 4 drugs are restricted to supply by prescription, schedule 3 drugs can only be supplied under the direct supervision of a pharmacist or doctor, and schedule 2 drugs can only be sold through pharmacies.

The Commonwealth Government influences community pharmacy through the operation of the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Benefits Scheme (RPBS). Prescription sales make up 64 per cent of the total revenue of community pharmacies, and over 70 per of all prescriptions sold are subsidised under these schemes.

To facilitate industry restructuring and to continue to enhance the development of an effective, efficient and well distributed community pharmacy service in Australia, the Commonwealth Government established the Australian Community Pharmacy Authority. Pharmacies are required to gain approval from the Authority to dispense drugs under the PBS and RPBS, or to change the location of their pharmacy. To reduce the number of pharmacies so that remaining pharmacies can take advantage of economies of scale, the Authority generally does not approve new pharmacies where there is an existing pharmacy within two kilometres.

Remuneration to pharmacists for dispensing drugs under the PBS is determined by the Pharmaceutical Benefits Remuneration Tribunal. Pharmacists' remuneration is made up of a wholesale mark-up of 10 per cent (a lower mark-up applies to drugs over $180), a dispensing fee of $4.13 and an administration fee of $0.21 (known as the composite fee), and an additional fee for items under $20.

Additional allowances known as the Isolated and Remote Pharmacy Allowances are paid by the Commonwealth so that approved pharmacists can maintain a pharmaceutical service in isolated and rural areas to provide access to pharmaceutical benefits. The 1995 Guild/Government Agreement provides that the Isolated Pharmacy Allowance will be paid to pharmacies that are located 10 kilometres from the nearest pharmacy. The allowance is an additional 20 per cent of the dispensing fee (ie bringing the total dispensing fee to $4.96) and is paid for each claimable PBS and RPBS prescription up to a 1000 prescriptions in any month.

The Remote Pharmacy Allowance is paid to pharmacies that are at least 25 kilometres from the nearest pharmacy. The allowance ranges from $1,106–$3,100 per year depending on how far the pharmacy is from the next nearest pharmacy, and is paid in addition to the Isolated Pharmacy Allowance.

4. National Competition Policy and Community Pharmacy

The Productivity Commission's inquiry is about the impact of competition policy reforms on rural and regional Australia. State pharmacy legislation has not yet been reviewed under national competition policy. However, we welcome the opportunity presented by this inquiry to present our concerns about the possible impact of competition reforms in community pharmacy on rural and regional Australia.

The Prime Minister, Premiers and Chief Ministers have agreed to a national review of State pharmacy legislation, followed by a review of the Community Pharmacy Agreement. The review is due to commence in early 1999, so that any reforms flowing from it can be implemented by the end of 2000. Despite this agreement, the Western Australian Government has commenced reviewing its pharmacy legislation as part of a broader review of Western Australian health practitioner legislation, and the NSW Government has announced that it will be conducting a review of the NSW Pharmacy Act 1964. It is anticipated that aspects of these reviews will form part of the submission of these State Governments to the national review.

The guiding principle governing national competition policy legislative reviews is that legislation should not restrict competition unless it can be demonstrated that:

- the benefits to the community as a whole outweigh the costs; and
- the objectives of the legislation can only be achieved by restricting competition.

The Guild supports this guiding principle, and recognises that there are a number of provisions in State pharmacy legislation that restrict competition. However, we consider that a range of public benefits flow from these restrictions. We are concerned that unless these public benefits are recognised, the welfare of the Australian community - and rural and regional Australia in particular - will be reduced.

One of the key issues in the forthcoming national review of State pharmacy legislation will be whether provisions restricting pharmacy ownership to pharmacists are in the public interest. The Guild is strongly of the view that ownership restrictions are in the public interest.

The Guild welcomes the commitment to pharmacy ownership shown by all major political parties during the 1998 federal election campaign. In an open letter to pharmacists (14 September 1998), the Prime Minister said:

> "Before the 1996 election I wrote to you about the Coalition's vision for health care and the role of pharmacists. ... I would like to reaffirm the commitment that I gave in 1996, and repeated since, that the Coalition Government will work to maintain ownership and control of pharmacies by pharmacists. We are committed to preserving the tradition of pharmacy that has served Australia well. That tradition includes a strong partnership between pharmacy and Government, underpinned by the Community Pharmacy Agreement with the Pharmacy Guild and the Pharmaceutical Benefits Schemes."

While the Prime Minister has recognised the contribution that pharmacists make to national health care, the Guild is concerned that this contribution is otherwise not widely appreciated outside the health profession. In addition, to date most policy makers have not appreciated how pharmacy ownership legislation helps address the market failures in the health system.

Instead, there have been a number of reports which have asserted that pharmacy ownership laws lift pharmacy costs, without presenting evidence to support this assertion, and without comparing these alleged costs with the public benefits of ownership. The only reports that have presented any empirical evidence on pharmacy costs are the Bureau of Industry Economics' (BIE) 1985 report on the pharmacy industry and the Industry Commission's (IC) 1995 report on the growth and revenue implications of competition policy reforms.[1]

The relevance of the BIE's results to the current debate is questionable given that its empiricism was based on 1981-82 data, and in light of the changes in pharmacy over that period. In addition the BIE used a flawed methodology to measure pharmacy costs. It assumed that returns to scale did not vary with the level of pharmacy output, in contrast to the classical assumption that firms exhibit economies of scale up to some output level, and then diseconomies of scale beyond this point (a U-shaped average cost curve).

The IC's report estimated the claimed benefits of removing legislation restricting the number of pharmacies a pharmacist could own, and removing the role of the Australian Community Pharmacy Authority in pharmacy location. The IC had no evidence on pharmacies, so made conclusions about pharmacy on the basis of estimated savings achieved by removing restrictions affecting newsagents. Given the substantial differences between pharmacies and newsagents, this jump in logic casts doubt on the validity of the IC's estimates.

In the face of this misinformation, we welcome the opportunity provided by this inquiry to raise community awareness of the benefits of pharmacy ownership. These benefits are outlined in section 5.

[1] The BIE, the Industry Commission and EPAC have now merged to form the Productivity Commission.

5. Benefits of Pharmacist Ownership of Community Pharmacies

The Guild considers there are four principal benefits of pharmacist ownership of pharmacies:

- pharmacist ownership contributes to safe pharmaceutical use;
- pharmacist ownership enables the economical treatment of minor ailments and the provision of health advice;
- pharmacist ownership supports a wide range of public health programs; and
- pharmacist ownership helps cut the price of pharmaceuticals to patients.

Pharmacists' health care role is particularly important in rural and regional Australia, given the shortage of doctors, and therefore the danger that patients may miss out on important health messages.

Ownership restrictions support better health outcomes by restricting competition to the profession, which fosters an environment of service competition rather than price competition, and supports the provision of unfunded health services. Service competition encourages pharmacists to invest in advising on safe pharmaceutical use and family health care, and encourages pharmacists to participate in Guild-Government initiatives to improve health outcomes.

The public benefits of ownership restrictions stem from market failures in the broader health system. These market failures are the public subsidisation of health care and pharmaceuticals, consumers' inadequate knowledge about the clinical properties and effects of pharmaceuticals, and consumers' inability to detect and appreciate quality pharmacy services.

It is difficult to address these market failures directly. In the interests of access to health care irrespective of means, successive Australian governments have implemented a health system with large public subsidies in order to ensure equal access to all Australians. Removing public subsidies might address market failures but would be contrary to this equity objective. In relation to information failures, it would not be practical to sufficiently increase consumers' understanding of pharmaceuticals.

These market failures lead to sub-optimal health outcomes, such as consumers not investing sufficiently in quality pharmaceutical advice. Ownership restrictions help counter these outcomes by creating an environment which fosters the delivery of quality pharmacy services.

In economic terms, this is an example of the theory of second best. This theory states that in the face of one market failure, such as the moral hazard created by the subsidisation of health expenditures, the public interest in not always best served by making all other markets competitive. A government intervention such as imposing ownership restrictions, may lead to a higher level of welfare, given the existence of other market failures.

These issues are elaborated further in the following sections.

5.1 Pharmacist Ownership Contributes to Safe Pharmaceutical Use

5.1.1 Benefits of a high level of pharmaceutical care

Inappropriate use of prescription and over the counter (OTC) medicines is a leading cause of ill health in Australia and imposes large costs on our health system. Pharmaceutical related problems include:

- drug interactions in cases where patients take a number of prescription and OTC drugs;
- side effects of drugs;
- changes in a patient's physical condition that make their drug therapy unsafe;
- poor compliance with drug therapy by patients;
- overdoses of prescribed and OTC drugs; and
- errors in prescribing, dispensing or administering drugs.

Quality care by community pharmacists can reduce the incidence of these problems:

- by documenting and scrutinising patients' current and past drug therapy, community pharmacists can reduce the incidence of drug interactions and duplication of drug therapy;
- by alerting patients to possible side effects, patients are more likely to seek early attention to their problems, reducing the severity of adverse reactions;
- by monitoring a patient's overall health, a community pharmacist can assess the ongoing appropriateness of the patient's drug therapy;
- by counselling patients about how drugs should be taken, community pharmacists can increase the incidence of treatment compliance;
- by providing a second check of prescriptions, community pharmacists can help counter dispensing error by doctors; and
- by appropriate selection, packaging and labelling of drugs (eg selecting capsules with different colours), community pharmacists can reduce the likelihood that patients will become confused with their drug therapy, and take overdoses or skip treatments.

Quality care by pharmacists is important for all Australians, but is particularly important for Australians living in rural and regional areas. This is because doctors and pharmacists both play important roles in ensuring safe pharmaceutical use - counselling patients, monitoring health status and carefully selecting drugs. However, country doctors are likely to have less time to devote to these functions than their city colleagues, because of the shortage of doctors in country areas.

The high turnover of staff (particularly GPs) in rural and remote areas, the under-resourcing of state-funded health services such as hospitals, and large distances means that the care received by patients in these areas is often disjointed (Wolfenden et al, 1996). Patients see doctors less often. The AIHW (1998:43) states that "The rate of GP consultations in 'other remote areas' in 1995-96 was less than 50% of the rate in 'capital cities' ..." The statistics show that there are over 1,900 people for every GP in remote areas, and 1,160 for every GP in small rural centres, compared to just 967 people per GP in the capital cities.

This makes it all the more important that country pharmacists devote the time to counsel patients, to ensure that patients get the information they need to take prescription medications safely.

An Australian study by Larmour et al (1991) found that 2.4 per cent of hospital admissions were considered to be pharmaceutical-related:

> This study confirms that drug related hospital admissions are a significant problem in our community. One in forty admissions to the Monash Medical Centre over a six month period could be attributed to a drug-related admission. In our hospital, adverse drug reactions (ADRs) were a more common cause of admission than drug overdoses. ... It appears from the results of our study, and those of others, that the patient at particular risk of experiencing an ADR is the elderly patient with multiple medical problems including renal or hepatic dysfunction, who is taking a large number of different medications.

Drawing on these findings, the National Health Strategy (1992) concluded:

> Each year sub-optimal drug use (due to inappropriate prescribing, unavoidable reactions or deliberate or accidental misuse) results in between 30,000 to 40,000 hospital admissions and between 700 to 900 deaths.
>
> A lack of continuity of care and poor communication between health care professionals can place patients at risk of poor drug use outcomes. Many people receive care from a large number of doctors and institutions which makes co-ordination of their care, including medication management, difficult. For example, more than 10 per cent of pensioners have prescriptions filled at three or more pharmacies. Similarly in 1989–90 over 33,000 people aged over 60 received medical services from six or more general practitioners – this does not include specialists, other health care professionals or public hospitals whom they may have also visited. (p. 12-13)

Studies in Australia and the US have documented the effectiveness of interventions by pharmacists in reducing the human and financial cost of pharmaceutical complications. An Australian study by Benrimoj et al (1997) showed that of 87,130 prescriptions received by community pharmacists, there were 375 prescriptions (0.4 per cent) where the community pharmacist could have dispensed the prescription but noticed a clinical problem (eg incorrect dose, drug/drug interaction). 194 (0.2 per cent) of these interventions were found to be clinically significant, with two interventions rated as potentially life saving. Extrapolating these rates to the level of prescriptions Australia-wide, indicated that the number of life-saving interventions by community pharmacists is in the order of 3,752 per year.

To realise the benefits of integrating community pharmacists into overall patient care, the Pharmaceutical Society of Australia has developed a practice model called Pharmaceutical Care. Pharmaceutical Care involves community pharmacists providing an expanded level of patient care, focusing on disease prevention and wellness, including monitoring disease states, evaluating treatment, counselling, intervening and directing patients' medication.

Bero et al (1997) examined the role of pharmacists in delivering a wide range of professional pharmaceutical care services to domiciliary patients, including clinical information and medication reviews, as well as clinical advice, to other hospital health professionals. The pharmacists' delivery of these services led to a 67 per cent decrease in hospital admission and a 500 per cent decrease in total ambulatory care visits. The services also led to a decrease in the number of and cost of drugs and general improvements in patient conditions.

5.1.2 Market factors militating against a high level of pharmaceutical care

The evidence indicates that a high level of involvement by community pharmacists in managing patients' drug regimens would be in the public interest. However, a range of market failures militate against this outcome.

While community pharmacists have a professional and ethical commitment to providing a high level of pharmaceutical care, they receive few financial rewards for doing so. The PBS fee for dispensing prescriptions is fixed irrespective of the level of counselling provided. A study by Ortiz and Thomas found that community pharmacists spent 18 per cent of their time counselling, and a study by Benrimoj et al (1997) found that the cost to pharmacists of prescription interventions was $2.50.

The risk of legal sanction or torts action does not provide sufficient commercial incentives for pharmacists to invest the time in always advising patients or checking medication history. The main reason for this is that patients rarely take action in cases of medical negligence (DCSH 1995).

Patients also lack adequate incentives to patronise community pharmacists that provide a high level of pharmaceutical care. The main reason for this is that a large share of the costs of adverse drug reactions and overdoses are borne by other parties. For example most medical costs are borne by the public health system or private insurers, and lost earnings are often covered by employees' sick leave. Because patients do not bear the full cost of pharmaceutical problems, they lack adequate incentives to invest in avoiding them. Another reason why patients are not willing to remunerate and reward community pharmacists who provide a comprehensive level of care is because they are not aware of the risks of pharmaceuticals, and lack the professional expertise to fully appreciate a high level of pharmaceutical care.

In summary, patients presently lack the incentives to patronise community pharmacies that provide a high level of pharmaceutical care. As a result, community pharmacists that invest the time in providing comprehensive care are not commensurately rewarded with a larger customer base or the ability to recover these costs through higher prescription prices. Commercial incentives, rather than encouraging the practice of comprehensive pharmaceutical care, actually provide incentives to cut services and drive standards down. This is because the costs of practising comprehensive pharmaceutical care exceed the marketing benefits of doing so. This is one of the market failures in the community pharmacy industry necessitating regulatory intervention.

It is only countervailing forces, such as community pharmacists' professional commitment, supported by the current ownership restrictions, that ensure the quality of pharmaceutical care that Australians currently enjoy.

5.1.3 How ownership restrictions support a high level of pharmaceutical care

The ownership restrictions support a high level of pharmaceutical care by encouraging service competition and supporting the retention of under-priced services.

The direct effect of the ownership restrictions is that they restrict competition to within the profession. It is well recognised that the values and ethics of professions generally support competition on the basis of service rather than price. This encourages community pharmacists to provide a higher level of service than they would in a more competitive environment. And given that high levels of service by community pharmacies lead to broader public benefits, such as lower levels of hospitalisation, this bias in favour of service competition is in the public interest.

In addition, the restriction on competition allows community pharmacists to continue to provide uncommercial services. One of the reasons why community pharmacists can afford to provide counselling and other unpaid services is because competition is restricted to the profession - that is businesses with a common set of values, including a commitment to pharmaceutical care. Deregulation would force pharmacies to rationalise uneconomical services such as patient counselling.

This factor is supported by a study undertaken by Rivers et al (1998), who identified that no advice or questioning is provided to patients who purchase "off the shelf" or general medications from non-pharmacy outlets, compared to patients receiving advice approximately 50% of the time through purchasing the same medications through a community pharmacy.

By strengthening competitive commercial incentives, and weakening professional influence, deregulation would move community pharmacy further away from the ideal of achieving an optimal level of pharmaceutical care.

5.1.4 Conclusion

In conclusion, the Pharmacy Guild of Australia recognises the difficulties in achieving a high standard of pharmaceutical care in the face of a formidable set of commercial incentives to the contrary. Achieving comprehensive pharmaceutical care is particularly difficult in regional and rural Australia given the shortage of doctors. This makes it all the more important that country pharmacists counsel patients to ensure safe pharmaceutical use.

While ownership restrictions are not fully effective at achieving an optimal level of pharmaceutical care, their removal would drive Australia even further away from this ideal. In a more competitive environment, there would be strong financial incentives to rationalise unpaid services, such as counselling, and to lift dispensing rates, making it difficult for pharmacists to prudently check prescriptions, dosage levels, adverse drugs reactions and to practise counselling. Given that around 30,000–40,000 hospital admissions and 700–900 deaths a year are pharmaceutical related, even a small reduction in pharmaceutical care would impose large human and financial costs on the Australian community. The Pharmacy Guild considers that the higher level of pharmaceutical care provided by the current ownership restrictions is a significant public benefit.

5.2 Pharmacist Ownership Enables the Economical Treatment of Minor Ailments and the Provision of Health Advice

There are around 5000 community pharmacies in Australia, spread throughout the community staffed by qualified health professionals. Community pharmacists, with their knowledge about health, medicines and natural therapies, are uniquely placed to provide a first point of contact for people in the community with health queries. Community pharmacists advise on OTC medicines that are effective for the treatment or alleviation of symptoms for a range of conditions. Community pharmacists frequently provide advice on the treatment of minor ailments, such as colds and sprains, and also alert people to the need to obtain medical attention when their symptoms indicate more serious conditions.

There is substantial evidence on the extent to which people seek health advice from their community pharmacist. A survey by Ortiz (1991) found that 79 per cent of community pharmacists said that people frequently came to their pharmacy as their first point of contact for their health related problems. More than half of the community pharmacists said that in three out of four cases, they could deal with the problem without needing to refer on to a doctor.

Community pharmacists' role in providing advice and treatment of minor medical ailments is particularly valuable in rural and regional Australia. Again, this relates to the shortage of doctors in country Australia. If minor medical ailments are dealt with by pharmacists, then country doctors have more time to deal with patients with significant health problems. Clearly community pharmacists can not take the place of doctors. However there is a role for home treatment of minor ailments, supported by the advice and products provided by community pharmacists.

Pharmacists' role in community health care has been recognised by all Australian political parties. For example, in an open letter to pharmacists during the 1998 Federal election campaign, the Leader of the Opposition said:

> "Labor supports the continuation of pharmacy ownership by pharmacists because the professional health care provided by pharmacists is a vital part of delivering quality health care to all Australians, wherever they live. ... Australia's community pharmacy network is a unique resource with its 5,000 shopfronts in highly accessible locations. Enhanced services, ranging from professional counselling to encourage the better use of medicines, to advice about preventive health and the management of chronic illnesses, are part of the quality care the public increasingly receives from their local pharmacies."

While the medical services provided by community pharmacists are clearly of value to the community, patients would not be willing to pay for them. This is because they can obtain free consultations with a general practitioner under the Medicare system. This market failure arises because the cost of consultations with a doctor is borne by the general community through higher Medicare expenditure, rather than the individual. Therefore the market price that pharmacists could command for providing health advice would be well below the value to the community of the health advisory services provided by community pharmacists.

The ownership restrictions support the provisions of health advice by community pharmacists by:

- supporting service competition
  - which encourages community pharmacists to provide health advice as a way of distinguishing their service from other competitors;
- supporting the maintenance of unfunded services such as health advice
  - in a more competitive environment, pharmacists would be forced to rationalise services which did not recover costs, such as health advice;
- supporting an accessible network of community pharmacies
  - if deregulation forced some pharmacies to close, people might consider it is just as convenient to seek advice on minor medical ailments and first aid from their doctor, at greater cost to the community.

In summary, community pharmacists provide health advice and treatment of minor ailments. This advice is accessible, economical and leads to significant savings in Medicare. It is particularly valuable in rural and regional Australia, as it allows over-worked country doctors to focus on patients with more significant health problems.

While the treatment of minor ailments by community pharmacists delivers significant public benefits, pharmacists cannot seek payment for these services, because people can also receive free medical advice from a doctor - this is the market failure created by a publicly funded health system. The ownership restrictions support the provision of accessible and economical health advice and treatment by community pharmacists by encouraging service competition and enabling community pharmacists to maintain unfunded services.

5.3 Pharmacist Ownership Supports a Wide Range of Public Health Programs

The Commonwealth Government has recognised the advantages of promoting a range of health initiatives through community pharmacies. These advantages include:

- community pharmacies are staffed by *health professionals* whose advice is trusted and respected by the public;
- community pharmacies are accessible to the community; and
- community pharmacies are an economical way of delivering health information and programs.

Given these advantages it is not surprising that the Government has established a partnership with community pharmacies to deliver and promote a range of programs including:

- immunisation, particularly in areas such as childhood vaccines and flu vaccine;
- methadone and needle exchange to assist addicts to give up illicit drugs, and to arrest the spread of other diseases such as AIDS and hepatitis;
- folic acid in early pregnancy to reduce the incidence of spina bifida births;
- information on the treatment of genital herpes;
- smoking cessation;
- drugs and driving;
- return of unwanted medicines program;
- Continence Aids Assistance Scheme;
- medication reviews by community pharmacists of nursing home residents, hostel residents, aged in the community, and at risk veterans in the community; and
- establishment of Medicare *easyclaim* agencies in community pharmacies.

Pharmacists' role in delivering these public health programs is particularly important in rural and regional Australia. This is because of the lack of alternative information dissemination points in the country (eg community health centres, infant welfare centres, Medicare offices) and the shortage of doctors in the country, which bears on the amount of time doctors have to promote these initiatives.

Rural and remote pharmacists fill an important role for regional communities in arranging other health car providers to visit the local area. In a study undertaken by Emerson (1996), up to 40 per cent of pharmacies in remote areas arrange for health staff to visit their local area in a regular basis, usually working from the pharmacy in a consulting room. These visiting health staff include optometrists, podiatrists, audiometrists and community nursing staff. Such arrangements are made free of charge to the consumer and are an essential service to local communities.

An important economic feature of all these programs is their high pay-off. That is, the benefit to the community from, for example, higher levels of immunisation, far exceeds the cost of immunisation programs. Therefore failure to maintain these programs, or reduced levels of community participation, lead to significant losses in community welfare.

It is voluntary for community pharmacists to participate in these programs, and in most cases community pharmacists are directly remunerated for providing these services. However, in many cases, the costs incurred by community pharmacists in providing the services exceed the reimbursement from the Government. Nevertheless, community pharmacists provide these services as part of providing a comprehensive health service to the community and out of a sense of professional responsibility. These services are cross-subsidised by other fee generating activities, such as the dispensing of prescription and OTC medications.

Removal of the ownership restrictions would increase competition and open the industry to non-pharmacists, lessening professional influence over the industry. Competitive pressures would force community pharmacies to drop health services that did not cover costs.

Governments would need to increase funding to provide community pharmacies with the incentive to continue to provide these services. If this did not occur, the Guild is concerned that the progress that has been made in encouraging needle exchange, folic acid, immunisation etc, may be lost. This would result in large losses in public welfare, because the benefits of these programs, particularly in terms of reduced health expenditure, far outweigh the costs.

The Guild's other concern is that even if these programs are fully funded by government, if deregulation reduces the number of community pharmacies and pharmacies become less accessible, then the community's participation in these programs may fall. This would reduce the size of the public benefits flowing from these programs.

In summary, governments have formed a partnership with community pharmacies to promote and deliver a wide range of health programs from immunisation to needle exchange. This role is particularly important in rural and regional Australia, given the lack of alternative information sources and the shortage of country doctors.

The gains to the community from these programs far exceed their costs. The ownership controls assist in the delivery of these programs by enabling community pharmacists to maintain loss-making services and by supporting a highly accessible community pharmacy network throughout Australia. The Pharmacy Guild of Australia is concerned that the progress made through these programs could be compromised in a deregulated environment if governments fail to fully fund these services, or if industry rationalisation reduces the accessibility of community pharmacies.

5.4 Pharmacist Ownership helps cut the Price of Pharmaceuticals to Patients

5.4.1 Government initiatives to reduce pharmaceutical expenditure

In Australia, more than three-quarters of prescription drug sales are subsidised under the Pharmaceutical Benefits Scheme (PBS). The PBS has been one of the fastest growing areas of Commonwealth outlays. Over the period 1991–92 to 1995–96, the scheme experienced average real growth of 15 per cent annually, and cost $3,112 million in 1997–98.

Since 1990, the Commonwealth Government has introduced various initiatives to constrain growth in PBS expenditure:

- in 1990, the Commonwealth Government introduced a Minimum Pricing Policy;
- in 1994 the Minimum Pricing Policy was enhanced by allowing brand substitution by community pharmacists; and
- in 1998, the Commonwealth Government introduced the Therapeutic Group Premium policy.

Under the Minimum Pricing Policy, the Commonwealth Government only subsidises a pharmaceutical to the level of the lowest priced brand (the benchmark level). Manufacturers of other brands of that drug are able to set a price above the benchmark level, and the patient pays the brand premium, namely the difference between the benchmark price and the manufacturer's price. The Minimum Pricing Policy was enhanced in 1994 when community pharmacists were permitted to supply a generic substitute for items with a brand premium without reference back to the prescriber. The Therapeutic Group Premium Policy extended the practice of price premiums beyond individual brands of drugs with identical chemical make-ups, to groups of medicines which have very similar clinical activity.

These policies have constrained Government expenditure on the PBS by restricting subsidies to the lowest priced brand. However, in the absence of changes in prescribing and dispensing practices, this change would simply lead to cost shifting - that is, savings in subsidies by the Government would be offset by the payment of price premiums by consumers.

Economy-wide savings from these policies will only occur if the price signals provided by the policy actually cause doctors and community pharmacists to change from prescribing and dispensing brand drugs, to prescribing and dispensing cheaper, generic drugs. This would generate economy-wide savings in two ways:

- firstly, the Government's savings in only subsidising drugs up to the benchmark level would be savings to the whole community, as purchasers of generic drugs would not pay any brand premiums; and
- secondly, increasing the market share of generic drugs would encourage greater competition between branded and generic drugs and strengthen the position of the Government in negotiating listed prices with pharmaceutical companies, both of which would exert downward pressure on the price of brand drugs.

However, here lies the conflict in the policy. While the economy-wide benefits of the policy hinge on changes in prescribing and dispensing behaviour by doctors and community pharmacists, the price signals created by the policy act on consumers, who lack the information to respond to them.

Consumers are poorly equipped to respond to pharmaceutical price signals for two reasons. Firstly, they lack understanding of the PBS, and therefore they cannot distinguish price increases that are unavoidable, such as periodic increases in patient co-payments, from price increases that are avoidable such as brand premiums.

Secondly, pharmaceuticals are a very specialised area of knowledge, and so consumers lack knowledge of the brand names of chemically identical or equivalent pharmaceuticals. For this reason, even if they were knowledgeable about the PBS, they would rely on the advice of their doctor or community pharmacist to inform them of alternative drugs. These information problems, which in part exist to ensure the quality use of medicines policy rather than creating a market driven demand for pharmaceuticals which could lead to abuse, are examples of market failure.

5.4.2 Role of community pharmacists in containing PBS expenditure

Despite the fact that consumers are poorly equipped to respond to the price signals provided by the brand premium policy, the evidence indicates that the policy has been very effective. Since December 1994, when community pharmacists were allowed to substitute generic drugs for chemically identical branded drugs, the percentage of prescriptions at the benchmark level (ie prescriptions not attracting a brand premium) has increased from 17 per cent to 32 per cent. The Government expects the Therapeutic Group Premium Policy to yield an estimated $561 million in savings over the next four years.

Community pharmacists have played an important role in implementing these policies and reducing the cost of pharmaceuticals to the community. Following the introduction of the Minimum Pricing Policy, community pharmacists advised patients of the pricing changes and the generic alternatives to the branded drug they had been prescribed. This equipped consumers with the information they needed to discuss how to save expenditure on pharmaceuticals with their doctor.

These processes were streamlined in 1994, when community pharmacists were allowed to substitute branded drugs without reference back to the prescriber for brands that had been identified as being interchangeable in the Schedule of Pharmaceutical Benefits. However, community pharmacists have exercised their professional judgement in balancing patients' interest in reducing pharmaceutical costs, against factors such as the packaging and form of drugs that could affect the likelihood of patient compliance with drug therapy, especially when patients are taking a number of drugs.

Community pharmacists' role in containing pharmaceutical expenditure is particularly important in rural and regional Australia. Information about generic substitutes can be provided by doctors or community pharmacists. However, with a larger case load, country doctors may have less time to explain about generic alternatives to brand drugs. This makes it all the more important that pharmacists play this role, to ensure that information reaches patients.

5.4.3 How ownership restrictions contribute to lower priced pharmaceuticals

The provision of advice by community pharmacists on generic alternatives to brand drugs imposes costs on community pharmacists (principally time) but is not remunerated, despite its benefits to the community.

Advice about generic drugs delivers mixed marketing benefits. While consumers appreciate this advice, and would patronise pharmacies that provided it, they are not aware of it when it is not provided. That is, community pharmacies that did not offer this service would still attract patronage, because most consumers would not be aware that they were unnecessarily paying too much for pharmaceuticals. Therefore market mechanisms alone are unlikely to provide sufficient incentives for pharmacists to provide unfunded advice on generic alternatives to brand drugs.

As discussed above, community pharmacists' participation in the scheme is central to its success, as it means the difference between the scheme simply being a cost shifting device to delivering genuine savings to the community. The ownership restrictions support community pharmacists' participation in the scheme by:

- constraining competition such that community pharmacists can continue to provide unfunded services such as advice about generic drugs;
- restricting competition to the profession, which encourages service competition such as the provision of advice; and
- fostering a partnership between the Commonwealth Government and the Pharmacy Guild of Australia, such that members of the Guild assist in the implementation of Government policy.

In conclusion, pharmaceuticals are a significant cost to the community. The Government has introduced schemes to reduce this cost, but consumers lack knowledge about pharmaceuticals and pricing under the scheme to respond to these incentives by themselves. Community pharmacists play a key role in ensuring that these schemes translate to savings for the community by advising patients about generic alternatives to brand drugs. This role for pharmacists is particularly important in rural and regional Australia, given that country doctors have less time to explain to patients about generic alternatives to brand drugs. Ownership controls assist community pharmacists in this role by encouraging service competition, supporting the provision of advice, and fostering a partnership between the Government and the Guild and community pharmacists in implementing government policy.

6. Conclusions

In summary, there are a number of public benefits of pharmacist ownership of pharmacies:

- pharmacist ownership contributes to safe pharmaceutical use;
- pharmacist ownership enables the economical treatment of minor ailments and the provision of health advice;
- pharmacist ownership supports a wide range of public health programs; and
- pharmacist ownership helps cut the price of pharmaceuticals to patients.

Pharmacists' health care role is particularly important in rural and regional Australia, given the shortage of doctors, and therefore the danger that patients may miss out on important health messages and services.

The public benefits of ownership restrictions arise because of market failures in the broader health system, namely the public subsidisation of health expenditure and consumers' lack of information about pharmaceuticals. The ownership restrictions address these market failures and improve community welfare by fostering service competition and supporting the provision of unfunded health services. It is difficult to address these market failures directly, given the equity objective of public funding of health care, and the practical difficulties of raising consumers' understanding of pharmaceuticals.

These significant public benefits compare with the alleged costs of ownership restrictions. These alleged costs are based on theoretical arguments, rather than empirical evidence. The empirical work that has been done on pharmacy costs is dated, based on faulty methodology or rests on assumptions drawn from unrelated industries.

The business of community pharmacy in Australia is quality health care. Maintaining pharmacist ownership of pharmacies will keep it that way.

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