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Red Tape Reduction in the Pharmacy Industry – Senate Submission

Responding to an invitation on "Effect of restrictions and prohibitions on business (red tape) on the economy and community" to redtape.sen@aph.gov.au.

MICHAEL RHODES – NOVEMBER 2017

Reducing Red Tape in the Pharmacy Industry
"An Independent Perspective"

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1 Executive Summary

For the interests of time and brevity we refer readers to our prior submission to the interim King Review (TKR) which is available on their website under submissions. As such we will not be providing the necessary references as we have previously been quoted in this regard. Notwithstanding this all of our recommendations have been founded in deep analysis and research. Other reports we have authored are available upon request by emailing us.

For complete context we recommend these additional submissions are read in conjunction with this submission. With respect to our submission we note the terms of reference as follows:

The committee has decided to focus on specific areas of inquiry and will now inquire into the effect of red tape on pharmacy rules … The effect of red tape on pharmacy rules. As part of its inquiry into the effect of red tape on the economy and community, the committee will examine the effect of red tape on pharmacy rules, in particular:

a. *the effects on compliance costs (in hours and money), economic output, employment and government revenue;*
b. *any specific areas of red tape that are particularly burdensome, complex, redundant or duplicated across jurisdictions;*
c. *the impact on health, safety and economic opportunity, particularly for the low-skilled and disadvantaged;*
d. *the effectiveness of the Abbott, Turnbull and previous governments' efforts to reduce red tape;*
e. *alternative institutional arrangements to reduce red tape, including providing subsidies or tax concessions to businesses to achieve outcomes currently achieved through regulation;*
f. *how different jurisdictions in Australia and internationally have attempted to reduce red tape; and*
g. *any related matters.*

Our submission here will address most of the points above in a structured manner across Industry, Process and Systems. We ostensibly do so by advocating for complete structural reform enabled by digitising the industry to increase transparency, efficient and the quality of information. Our key points to reduce red tap are:

Industry

- ✓ Remove location and ownership restrictions as perpetuated by the Pharmacy Guild of Australia (PGA) and abolish the Community Pharmacy Agreements (CPA).
- ✓ Abolish the Community Service Obligation (CSO) payments. They fuel red tape and inefficiency instead of innovation.
- ✓ Introduce patient and government centric charters for the supply of and access to medicines in Australia. We have called them VABESMA and VABEAMA – the Value Based Efficient Supply and Access to Medicines in Australia.
- ✓ Open up pharmacist training and accreditation and ensure the Pharmaceutical Society of Australia (PSA) have no monopoly on this.
- ✓ Allow general practice integration into pharmacies
- ✓ Introduce a new body called PRISEA, the PBS Price Scanning and Enforcement Authority so as to operate as a price making and not a price taking authority for PBS medicines.

Processes and Systems

- ✓ Introduce a new Consultation to Collection portal (C2C), which tracks medicines prescribed at doctor's consultation with patients and medicines dispensed when the patient collects the prescription from the pharmacist.
- ✓ Introduce the Pharmacy Supply Chain Portal (PSCP) for trading, tracking and supplying all PBS medicines in the market.

At the time of writing the final King Review on the pharmacy industry is yet to be released. The interim review was released in June 2017.

We wait in anticipation if it will unlock and remove the restricting CPA agreements in favour of a patient and government centric industry charter for medicines supply and consumer access to medicines.

Inefficiency and red tape eventually bears an offspring called efficiency and innovation. Unless the government talks about true innovation nothing will change and a 10-year time horizon will further facilitate more palpable waste, red tape and inefficiency and ultimately that is not right for patients, of whom 80% (the elderly over 65) are the most vulnerable in the community.

It should be noted that our recommendations here to reduce or remove red tape are not exhaustive and that given further time to research the market our list would soon become substantially longer.

Notwithstanding this we do see the reduction of red tape as a key factor in structural reform in the industry and our recommendations in this document get to the heart of addressing both the substantial qualitative and quantitative red tape factors currently prevalent in the industry which prohibits its progress.

In closing, patients deserve better for it is only they who really matter.

Michael Rhodes
Director
Rhodes Management

2 Introduction

As a favour to employee pharmacist colleagues in April 2017 we were requested to independently review the pharmacy industry and provide a perspective for public comment. This resulted in our first report, which for many was controversial and confronting.

That controversy started because it challenged the inefficiency of the pharmacy industry and the perpetuation of that inefficiency by the Pharmacy Guild of Australia (PGA) under the auspices of the Community Pharmacy Agreements (CPA), currently 6CPA.

We rightly called the CPA a "PORPA" - Pharmacy Owners Restriction and Penetration Agreement. The term "Community Pharmacy Agreement" is an oxymoron because these words simply do not reflect the operational reality.

The term PORPA is more appropriate because until the CPA opens up supply and access to medicines to the whole community they will only ever be Pharmacy Owners Restriction and Penetration Agreements or "PORPA".

Our first and second reports have generated over 2000 downloads combined and the most common theme of feedback has been "thank goodness somebody is telling it like it is without fear, vested interest or undue influence".

Rhodes Management are happy to provide to the senate select committee a response to the request to remove red tape in the pharmacy industry.

However, our approach is different, we are advocating for complete structural reform and complete industry technology enabling before the things like tax concessions, subsidies and regulations are adjusted to make an inefficient system only slightly more efficient. What should be done is to set as the first agenda the ability to make the industry efficient and then introduce other "blunt" instruments to make it more efficient again.

We believe there is an extraordinary amount of red tape to be removed.

For clarity we sought out the definition of red tape and discovered the following:

1. Dictionary.com "excessive formality and notice required before official action can be taken"
2. Wikipedia.org "red tape is an idiom that refers to excessive regulation or rigid conformity to formal rules that is considered redundant or bureaucratic and hinders or prevents action and decision making"
3. Merriam.webster.com "official routine or procedure marked by excessive complexity which results in delay or inaction"
4. Google.com "excessive bureaucracy or adherence to official rules and formalities".

All are apt descriptions of the challenges facing the pharmacy industry. Never has a time been so important to change this.

The importance of independence cannot be underestimated. We are not a training, employee, employer, manufacturer or other sort of industry body whom have only a vested interest in everything they submit.

Our only interest in making our recommendations have been patient centric and societal value on behalf of government.

Government needs to be more efficient and patients need greater certainty of supply at cheaper prices than now.

3 Reducing Red Tape

3.1 Reducing Red Tape in Industry

This pharmacy industry is burdened by excessive red tape and the problems we outline below are certainly not exhaustive but they are material in their impact to the industry at large.

3.1.1 Problems

3.1.1.1 Community Pharmacy Agreements - CPA[1]

Top of our list of red tape problems in the pharmacy industry is the CPA, a 26-year-old dinosaur of market inefficiency. Through complex location rules it restricts the number of pharmacies allowed to operate, where they can be located, it locks out the opportunity for non-pharmacy businesses to sell prescription medicines with qualified pharmacists, keeps prices inflated and ultimately limits patient access to medicines because of this restricting practice. We have called the CPA a PORPA – or Pharmacy Ownership Restriction and Penetration Agreement.

Despite the claims of the Pharmacy Guild of Australia (PGA) that it serves the community well, our research reveals it simply does not. The CPA's are neither patient centric or government (value) centric.

They are negotiated by the PGA on behalf of pharmacy owners. Increasingly those owners are aggregated into discount chains and do not actually work in the pharmacies they own. In fact, 6 times more employee pharmacists work in pharmacies than pharmacy owners and they frankly know much more than their masters.

Increasingly the PGA lobby the government to extract more money for services, which are provided by employee pharmacists. The problem being there is typically a daily 2-hour time deficit to actually provide these services, *based on 150 scripts per day*. The problem is most urban pharmacies do 200-300 scripts per day. In simple terms the extracted money represents pure profit for owners who don't actually provide the service.

Current locations as they stand only have a 30% loyalty factor attached to them. So, despite what the PGA says 70% of customers value relationships and price well above pharmacy location loyalty.

What we have here are burdensome rules that restrict competition, ownership, restrict supply, restrict locations and only benefit pharmacy owners whom by and large are not even working in their pharmacies anyway.

How does that serve the needs of the community? Many of these rules are also burdened by state based sanctions in addition to complying with the CPA location rules guidelines.

It is simply inefficient to constrict or temper supply and demand under the auspices of location and ownership rules only to protect a few privileged owners, at the expense of the most vulnerable in society which are the elderly patients over 65 whom comprise over 80% of business volume for most pharmacies.

If the government wants to reduce red tape, remove the CPA and replace it with a patient centric charter for the supply of medicines and for the access to medicines.

[1] Community Pharmacy Agreement

3.1.1.2 Community Service Obligation - CSO[2]

The CSO is a $200M waste of money that funds inefficiency in the wholesaler supply chain under the auspices of guaranteeing supply mainly to remote or regional pharmacies. This waste of money could be easily handled via a consignment stock arrangement particularly for high cost and / or low demand medicines.

The problem is supplier's cherry pick larger orders over smaller orders so they can recoup the delivery costs incurred. Further, the self-monitoring and obligation based reporting of supply is fraught with error and manipulation.

Major manufacturers are now looking to supply directly to pharmacies in order to 1) reduce their own overheads and increase their own margins by removing third party logistics (3PL) suppliers like API, Symbion and Sigma from the supply chain. The simple fact is these companies can negotiate parcel supply rates that are more competitive and more efficient than the 3PL's currently and inefficiently serving the market.

Further as these wholesalers have vertically integrated to ownership or part ownership of certain pharmacy chains prices have remained inflated and the supply of PBS medicines has been to limited to those who pay more and have bigger orders. As the government seeks to increase price transparency and disclosure, generic medicines are growing in volume at lower margins which places pressure on wholesalers to be more efficient. Smaller order pharmacies have often had to wait additional time to receive their PBS medicines.

This whole arrangement is so burdensome on processes and totally devoid of innovation that it further embeds bureaucratic inefficiency in the supply chain.

If the government wants to reduce red tape, remove the CSO and divert the funds to innovation which a) tracks the supply chain demand and supply of all PBS medicines and b) ensures digitisation of the consultation to collection process within the industry. This diversion of funds should be done under the auspices of a patient centric charter for supply and access to medicines.

3.1.1.3 Price Taking

The government are at the mercy of price the manufacturers negotiate with them. These prices are subject to lack of competition because the market pricing mechanism is ostensibly a monopsony.

To this end with the government being the "1 buyer" manufacturers have no incentive to discount due to the lack of perceived competition.

If the government wants to reduce red tape it must better facilitate price monitoring and open up the market to competitive supply from local and global sources.

3.1.1.4 Hospital Doctor Pharmacy Overlap

There is simply nothing efficient or transparent about how former hospital patients are managed and treated with respect to their medicines and medical visits.

Too often patients are discharged from hospital without any reference to the medicines they need, the medicines they've been prescribed or the medicines they've taken.

No reference exists between in hospital medical consultations and out of hospital medical consultations and too often pharmacists are left deciphering what is best for the patient and in turn recommending what the patient must do. This deciphering results in phone calls, follow-ups, questioning and delays to the care or management of the patient.

If the government want to reduce red tape it must offer a portal that tracks all patient medicine management.

[2] Community Service Obligation

3.1.1.5 Training

The Pharmaceutical Society of Australia or PSA claims to be the peak body representing pharmacists in Australia, yet the PGA are more vocal in representing the pharmacy industry, albeit on behalf of 16% of total active pharmacists in the industry (namely pharmacy owners, many of whom are not working in their pharmacies). By and large employee pharmacists do not see the PSA as the peak body and many see them as a stooge of the PGA.

Too often under the auspices of "services" advocated for government reimbursement by the PGA, which in many cases simply cannot be provided the employee pharmacists anyway, these services then require some form of "accreditation", which must be provided by the PSA at some cost to the pharmacist. The PSA are a registered training organisation (RTO) and their collusion with the PGA is palpable and opaque.

If the government want to reduce red tape it must ensure that graduating pharmacists from university are trained in ALL AREAS of pharmacy including vaccines and inoculations, home medicines reviews, and all current services provided by pharmacists and ensure that if accreditation is required for certain additional new services then this be opened up to universities nationally whom provide pharmaceutical training as well as the PSA.

The PSA should not have a monopoly on training and accrediting pharmacists for current or future services.

3.1.2 Solutions

Calling out problems without recommended solutions is mere hope, and hope is not a strategy, hence our recommended solutions to the red tape that current exists in the pharmacy industry.

3.1.2.1 Patient Centric and Government Centric Charter for Medicine Supply and Access

As noted in our prior submissions, we recommend the introduction of 2 new concepts to replace the CPA agreement. This is broken down into the supply side and the demand side as both are fundamentally important and complimentary to each other. They are:

- ✓ **VABESMA** – The Value Based Efficient ***Supply*** of Medicines in Australia. Addressing the supply side of the industry.
- ✓ **VABEAMA** – The Value Based Efficient ***Access*** of Medicines in Australia. Addressing the demand side the industry.

The essence of the agreements is that they're a charter commitment with patients and the community at large. They are not agreements with employer bodies, training organisations or other industry representative bodies and their sole purpose is to ensure that everything done efficiently and effectively serves the needs of patients and the medicines consumer and is aligned to the NMP to the extent that this ensures best price and best access for consumers. It also serves to concurrently protect the interests of government.

As government funds the health system it has a right to ensure it is done so efficiently and effectively and in doing so it removes the vested and self-interest of any representative body in the pharmacy industry and puts ONLY at the centre of the agreement what is right for consumers.

The following list of recommendation points for each charter is not exhaustive but provides an indication as to what is possible. Our recommendations build generally on the answers we have provided to The King Review and our observations, research and analysis of the industry.

VABESMA (VS1) – Value Base Efficient Supply of Medicines in Australia

1. PBS Governance
   1.1. Governance of the PBS should reside primarily with the government under the VABESMA framework independent of any industry body.
   1.2. This governance and any term related changes should be clearly documented.

2. PBS Trading Prices
   2.1. All PBS prices should be dictated by a focus on global best price and be governed either under VABESMA or an independent pricing review and negotiation body.
   2.2. What is agreed should form a separate schedule in the agreement.

3. PBS Reimbursement Schedule
   3.1. We advocate a tightening of the reimbursement scheduled and a review of the products reimbursed for to ensure they actually deliver value to the community. Our general view is that they do but it is worth reviewing this. Again, this should be led by the pricing body mentioned above (or similar).

4. Services Reimbursement Schedule
   4.1. We also advocated a tightening of the services reimbursement schedule to actually determine whether patient centric quality of service is being delivered and to what level.
   4.2. The services agreed should be noted as a separate schedule in the agreement and also note changes from the prior term.

5. Entities to Trade
   5.1. All "entities to trade" should list all of the business types allowed to sell PBS pharmaceutical medicines
   5.2. It should list any changes to this from the prior term.

6. No restriction to trade
   6.1. It should list any restrictions to trade and where applicable make reference to the trade practices act.
   6.2. Any state base jurisdiction should be noted also.

7. Rural governance and reimbursement
   7.1. By exception any specific rural governance supply issues should be noted as should any specific product or services reimbursements.

8. Urban governance and reimbursement
   8.1. By exception any specific urban governance supply issues should be noted as should any specific product or services reimbursements.

9. Entity requirements in this charter agreement.
   9.1. PGA
      9.1.1. The PGA should outline for each VABESMA it's specific employer body objectives and how they believe they contribute to the NMP.
      9.1.2. A statement of key requirements for the PGA should be noted for reference.
   9.2. PSA
      9.2.1. The PSA should outline for each VABESMA it's specific training organisation objectives and how they believe they contribute to the NMP.
      9.2.2. A statement of key requirements for the PSA should be noted for reference.
   9.3. PPA
      9.3.1. The PPA should outline for each VABESMA it's specific employee body objectives and how they believe they contribute to the NMP.
      9.3.2. A statement of key requirements for the PPA should be noted for reference.
   9.4. Pharmacy board

9.4.1. The Pharmacy Board should outline for each VABESMA it's specific objectives and how they believe they contribute to the NMP.
9.4.2. A statement of key requirements for the Pharmacy Board should be noted for reference.
9.5. Other
9.5.1. Any other non-government parties should be encouraged to submit their requirements to each VABESMA term and in doing so those requirements should be summarised here.
9.6. Declared Interests and Preferences
9.6.1. All declared interests and preferences from all bodies should be listed here.
9.6.2. All state and national cross-office holder bearers should also be noted here as well to ensure completed transparency.

10. Price Scanning Entity
10.1. The notion of how prices and value is negotiated and delivered should be noted here.
10.2. International Supply and Sourcing Arrangement
10.2.1. All international supply and sourcing arrangements should be noted here for reference.
10.3. Local Best Price
10.3.1. Proof of local best price should be noted here for those PBS medicines that contribute to 80% of value of the PBS schedule over the term.
10.4. International Best Price
10.4.1. All medicines that deliver the same benefits as others should be pegged to the lowest best price.

11. Wholesaler Obligations
11.1. All wholesaler service and supply level commitment obligations should be clearly summarised in the VABESMA and form part of the participation to supply in the VABESMA.

12. Manufacturer Obligations
12.1. All manufacturer service and supply level commitment obligations should be clearly summarised in the VABESMA and form part of the participation to supply in the VABESMA.

13. Distributor Obligations
13.1. All distributor service and supply level commitment obligations should be clearly summarised in the VABESMA and form part of the participation to supply in the VABESMA.

14. Innovation
14.1. Innovation that clearly delivers value and efficiency in support of the NMP should be rewarded.
14.2. Non-Government Innovation Requirements
14.2.1. Innovation should be defined in specific terms
14.3. Non-Government Innovation Reimbursement Schedule (based on proven economic results or substantial projects to enable results)
14.4. Government Innovation
14.4.1. Current Innovation Projects and Expected Outcomes
14.4.2. Planned Innovation Projects and Expected Outcomes
15. National Medicines Policy (NMP)
15.1. How VABESMA meets or exceeds NMP requirements.
15.2. Recommended Changes to the NMP should outlined from each agreed VABESMA term.
15.3. Recommended Changes from the NMP should be documented in each VABESMA term.
15.4. How this agreement meets or exceeds the previous agreement in alignment with the NMP.
15.5. Outline what initiatives have achieved the NMP objectives.
15.6. Which ones are being carried over and from when (they were initiated).
15.7. Which ones are not being carried over and why.

16. Transparency in Negotiations
16.1. All parties should note how their commitment to transparency in negotiations has been met and ensure this transparency is auditable.

17. Who does each party represent?
    17.1. It should be clearly noted who each party represents and why – statements to be received from relevant and invited entities.

18. Declaration of cross entity representation
    18.1. It should be clearly noted if parties have cross membership in their management or boards of governance structure.

This supply charter has obligations on those whom want to supply the industry. Importantly it removes both the supply and location restrictions in place and ensures innovation is rewarded. As Australia moves forward in the 21st century the CPA is an analogue option in a digital world. The PGA claim the current arrangements are "just fine". They are not.

Proffering archaic ownership, location and supply restrictions does not serve the community and only serves to perpetuate inefficiency and high cost for a privileged few. Not once has the PGA offered any sort of market centric innovation. The only tool they have is more lobbying and more money. Both are blunt instruments designed to embed the inefficiency and high cost.

VABEAMA (VA2) - Value Based Efficient Access of Medicines in Australia

1. Entities who can sell pharmaceutical medicines
    1.1. Community Pharmacies
        1.1.1. Outline what a community pharmacy is
        1.1.2. Who represents them
    1.2. Supermarket and other allied retail (SOAR) Pharmacies
        1.2.1. Outline what a SOAR pharmacy is
        1.2.2. Who represents them
    1.3. Hospital Pharmacies
        1.3.1. Outline what a public hospital pharmacy is and who represents them.
        1.3.2. Outline what a private hospital pharmacy is and who represents them
    1.4. General Practitioner Pharmacies
        1.4.1. Outline what a GP pharmacy is, what the scale or size rules are for a GP pharmacy is and who represents them. This could be limited to 24-hour GP operations only whom have a size and scale to support a pharmacy dispensing business.
    1.5. Pharmacy GP's
        1.5.1. Outline how a Pharmacy can have GP consulting rooms in them, unrestricted and without segmentation.

2. Restrictions on selling
    2.1. For example, requirement for accredited pharmacists in all outlets that sell pharmaceutical medicines.
        2.1.1. Outline accreditation rules.
    2.2. Location Restrictions (to be nil)
        2.2.1. Outline SOAR guidelines that open up the market. For example supermarkets, petrol stations and convenience stores whom can be allowed to sell PBS medicines so long as a registered and accredited pharmacist is in store.
        2.2.2. By exception only, outline any physical location restrictions to any pharmacy being in operation (for example a heavy industrial area, a mine site, a mobile arrangement etc…)
    2.3. Opening hours Restrictions
        2.3.1. Outline any hours of opening restrictions for any pharmacies – will generally be nil.
    2.4. General Practitioner Size Restriction
        2.4.1. Outline the size and scope of a GP practice before it can sell medicines.
        2.4.2. For example, a minimum number of consulting rooms and doctors.
        2.4.3. Outline the rules of ownership in this regard.

3. Accredited 24 Hour Pharmacies

3.1. List conditions of 24 hours accreditation (and thus reimbursement)

4. Non-Accredited 24-Hour Pharmacies
   4.1. List conditions of 24 hours operation for non-accredited pharmacies (and thus no reimbursement)

5. Pharmacy Ownership Rules and Guidelines
   5.1. To be outlined for all pharmacy types.
   5.2. Ownership rules should not require accredited pharmacist ownership but ALL pharmacy related outlets must have accredited pharmacists.

6. Pharmacy Owner Obligations
   6.1. These are to be outlined and include a focus on quality of services.

7. Pharmacist Obligations (Practicing and Accredited)
   7.1. These are to be outlined, including the latest accreditations required.
   7.2. Outline any pending or future accreditations planned.

8. Service Level and Quality of Service Standards
   8.1. Dispensing charter
      8.1.1. These are to be outlined as minimum mandatory standards in the VABEAMA.
   8.2. Services charter
      8.2.1. These are to be outlined as minimum mandatory standards in the VABEAMA.

9. Communication and Patient Awareness Charter.
   9.1. This is to be outlined across a range of media channels to ensure consistency of message, consistency of awareness and a minimum standard for each.

10. Location Patient Awareness Guidelines
   10.1. A guide to in pharmacy patient messaging should be made available and clear in all pharmacies for all patients and consumers.
   10.2. It should be mandatory that this is displayed for all consumers.

We believe these 28 points (and over 70 sub points) represent just the beginning when it comes to a patient centric commitment to reducing red tape and vested interests for best price and best access in the market for PBS medicines consumers.

The VABESMA and VABEAMA charter agreement framework promotes societal value as a core tenet. It dilutes the self-interest and lack of transparency of any industry group so this can be achieved. As we advocate the entry of supermarkets and other allied retail into the industry we also advocate the integration of general practitioners into the pharmacy sector as well, but not into supermarkets or retail. Being patient centric for societal value and community outcomes is not only a noble outcome it is the right outcome.

Each VS1 and VA1 charter term should be for 48 months with review on performance and innovation tracking done yearly in February and any submissions for change receive by December 31st of the preceding year. Where applicable any adjustments should be made where it only serves the interests of patients and government.

3.1.2.2 Remove the CSO

To reduce red tape and inefficiency the government should remove the CSO arrangement in place under the current CPA. Ensuring high cost or low demand medicines are available can be done through a consignment stock arrangement and / or regional hub arrangement. Simply paying wholesalers for inefficiency and lack of innovation is money wasted which can ultimately be diverted to things that actually add value. Please also see our recommended solutions in other areas of this document.

3.1.2.3 Remove Supply Restriction

We have advocated in the VABESMA and VABEAMA charter recommendations for the removal of any supply restriction of PBS medicines to consumers. To reduce red tape and improve efficiency the government needs to introduce a supply trading hub portal for the whole industry. This portal would serve as the centre piece of both demand and supply that all participants use. We outline more on this in the Process section of this document. This portal would enable and allow manufacturers and wholesalers to openly and transparently participate in the market and not lock manufacturers to wholesalers and not lock wholesalers to pharmacists.

3.1.2.4 Remove Location & Ownership Restrictions

As we have advocated in the VABESMA and VABEAMA charter, location restrictions and the burdensome national and state base red tape that surrounds it under the CPA agreement should be removed. The CPA itself should be abolished and replaced with VABESMA and VABEAMA.

3.1.2.5 General Practice Integration

To reduce red tape doctors should be allowed to practice in pharmacies and subject to their size certain medical centres should be allowed to sell PBS medicines. Having restrictions in place limits the commercial viability of both operations and only perpetuates additional steps in consumers seeking to obtain an end to end solution to their health needs.

We have previously stated in other submissions rules around this however what is important is that patients' needs are first and foremost taken into consideration.

3.1.2.6 Price Making Body

So much red tape exists around tracking and supplying PBS medicines that nothing is in place to ensure the government obtains value from doing so.

A PBS Price Scanning and Enforcement Authority (PRISEA) should be setup to ensure Australian's are paying the lowest possible price globally for their medicines and this body should be actively tracking prices of medicines to ensure they do. The supply of PBS medicines should be open to international sourcing and best pricing as well.

When combined with the pharmacy supply chain trading hub portal one can see both the power and value that can be delivered for the benefit of the Australian consumer and the government who funds the health system. The Australian consumer through the Australian PBS health system should only pay the lowest price for the molecule they are purchasing irrespective of whether it is a branded or unbranded medicine.

3.2 Reducing Red Tape in Processes

The biggest impediment to overcoming red tape in the pharmacy industry is the lack of innovation and the perpetuation of inefficient business processes. In a world where we can send money and very complex financial transactions anywhere and have it available in minutes; we must ask why can't we send from a doctor's consultation the prescription for a patient so that patient can collect their prescription or repeat from any pharmacy anywhere in Australia (the consultation to collection process) in a completely open and transparent manner.

Similarly, we must also ask why can't we trade and supply all PBS medicines form a trading portal that is transparent, efficient and ensures the cheapest price available to consumers and pharmacy owners.

3.2.1 Problems

As the government funds both the health system, PBS and pharmacy services, surely, they have a right to demand transparency and efficiency in business processes. The problem is that transparency and efficiency does not exist.

It is burdened by red tape facilitated by the PGA and in some cases the PSA. What is required is the ability to glue everything together informationally and then through process so as to avoid the red tape involved of chasing information because of inefficient processes.

Firstly, there is no central information portal for prescriptions. Pharmacists cannot see any record of drug use (unless it is from their own pharmacy), the see no record of the doctor consultation, no electronic record of the prescription all of which makes it hard for the pharmacist to advise the patient about the medicines they provide, the impacts of long term use, the provision of services or even the recommendation to consult a doctor if required based on a history of the information at hand.

This is exacerbated by the confusion that exists when patients are admitted and / or discharged from hospitals as no history is available to medical, emergency or pharmacy practitioners as to what drugs patient has been on and what steps should be taken to manage their condition going forward. This is usually then very frustrating and sometimes intruding to the patient when asked.

The simple fact is the information that should be available is disaggregated and the processes they imbue are inefficient, timely and costly ultimately to the detriment of patient health.

An excellent example of the inefficiency is the debate on codeine use and making it a prescription only medicine due to the addictive nature the drug may have on some people.

All of this could be removed if the person seeking the drug had to provide their Medicare card and other form of identification so that no matter where they are anywhere in Australia codeine could only be dispensed if the time-based usage of the drug has not been exceeded by the unique identifier provided.

The simple fact is codeine should be available over the counter for what is usually and mostly legitimate pain relief for people however because there is simply no history to track this (or any) drug use it is being relegated to the prescription only process, which will actually hurt the majority of people who need strong pain relief for the right non-addictive reasons

When the information is not glued together the business processes are not glued together and this impedes the efficiency and efficacy of patient service in a time manner

Finally, stock availability can be a problem, particularly with the supply of some generic medicines, where even the wholesaler or manufacturer is out of stock.

How can it be in an era of digitisation that patients are required to revert to higher brand name medicines because the generic version is not available. This upsets patients because they have to bear the higher costs to get the drugs they need.

3.2.2 Solutions

If the government wants to reduce red tape they **nationally** need to glue the information together thus ensuring consistent processes exist Australia wide and uniform interpretation of drug use dispensation happens for all medicines, for all people everywhere. To this end the following solutions are recommended:

3.2.2.1 Digitise Consultation to Collection (C2C)

Digitisation of the Consultation to Collection (C2C) process must be undertaken.

For clarity this means capturing at the source of patient medical consultation with a doctor the prescription they (would normally write or enter into a stand-alone computer) provide which recommends the medicines, dosages, strength, intensity, quantity and repeats (if applicable) the patient should take. Then ensuring the patient has at their disposal the prescription number in both paper and / or digital form (for example on their mobile phone application and / or email) which they then take to the pharmacy for dispensing and medicine collection. To do so the pharmacist accesses the C2C cloud based portal holding the prescription information in order to analyse, process and dispense the medicine for the patient.

This digitised prescription is linked directly to a patient by a unique identifier (usually a Medicare number) as well as some other form of identification such as a mobile phone number, drivers licence number, passport number, national identification number, proof of age card number and student identification number. It must be noted that additional forms of identification are required if a Medicare number is not available (due to expiry or if the person is not an Australian citizen or of residential status). The name of the person would also be recorded as well.

The digitised prescription should mirror (and add to) the current prescription information, which includes medicine name, dosage and strength information, doctor prescriber number, doctor name, address and contact details, Medicare numbers (plus other forms of identification as mentioned above if applicable), generic use permission, name and address of the patient, time and date of consultation.

Please note our recommendations here are not to be confused with any current eHealth initiatives being undertaken by various state based health jurisdictions which aim to capture patient diagnoses and health records. For pharmacy efficiency we are talking about a process which ensures prescriptions from doctors at patient consultation are digitally available for processing and collection by patients from their chosen pharmacy.

Upon collection the prescription is either closed or left open if a repeat is available, and importantly the patient is kept informed as to the status of their prescription, including if they have not collected it after an agreed amount of time.

This C2C prescription can then highlight a complete history by patient of the medicines they've been prescribed and importantly the services that have been provided by the accredited pharmacist which can be codified at the point of dispensation. It will also track safety net and consumption details which can be provided direct to the patient. Upon doing so this would also allow for direct tracking and reimbursement of the AHI fee to pharmacies and as we have previously recommended, to pharmacists whom should be reimbursed part of the fee for the services provided in order to adequately compensate them (another issue). At the time the prescription is entered the patient may even be able to select the pharmacy they want to collect it from, thus ensuring that it has been dispensed with appropriate advice material even prior to the patient arriving at the pharmacy.

Once dispensed the medicine quantity of the noted item is then fed real time into the supply chain demand profiling portal for the respective pharmacy (see next section) as well as their own computer systems.

If the government wants to reduce red tape this solution substantially simplifies the consultation to collection process for patients. It binds the information and thus the processes together for an efficient, transparent and non-bureaucratic patient centric outcome. The rich information that can be mined from this portal would be very extensive. It could include, but is not limited to:

- ✓ The number prescriptions not collected – this aids in knowing patient adherence to doctor's consultation and thus ensure health outcomes of the patient through reminder messages and prompting. This information could also be fed back to the doctor or nearby pharmacists to be proactive in producing patient centric health outcomes.
- ✓ The lag time of collection – this aids in knowing if medicine collection delays cause greater health problems for patients or the community.
- ✓ The geospatial matching of consultation to collection – determines true location based loyalty to pharmacist services.
- ✓ The amount of services actually provided by pharmacists and the time they provide them – aids in tracking for and reimbursing those services and ensuring the government is getting value for money. Also aids in ensuring pharmacists do not claim for services they have not received. This can also be verified and validated by the patient receiving those services.
- ✓ True and real-time demand profiling both at consultation and collection – important for manufacturers and distributors of medicines to aid in accurate forecasting and demand planning thus ensuring stock is available and things like high cost medicines are planned for well in advance of supply so that consignment stock and hub storage measure can be undertaken efficiently.
- ✓ Geospatial concentration of medicine demand volume – exposes health issues, almost real time by location thus allowing preventative measures to be taken to improve community health outcomes.
- ✓ Outlines the level and frequency of participation of owner versus employee pharmacists – this aids in maintaining accreditation and determining who actually provides the services.
- ✓ Real time tracking on the volume of PBS medicines dispensed so the government knows exactly how much the PBS costs the community and what measure can be taken to extract greater value from it.
- ✓ Demand profiling of the different types of drugs being sold in the market thus allowing a highly detailed analysis and negotiating position going forward for what should be included or excluded from the PBS schedule.

The list above is merely scraping the tip of what is possible.

3.2.2.2 PBS Medicines Trading Portal (PPSCP)

Too much obfuscation exists when tracking the PBS supply of medicines to industry. Wholesalers are vertically integrated to some pharmacy chains and preferential treatment exists for some versus others.

Certainty and clarity need to be provided to remove red tape and inefficiency.

The diagram following outlines in summary form (and we stress summary) how the C2C and Pharmacy Supply Chain Trading Portal would operate to increase transparency, value and efficiency and most importantly remove red tape.

It shows the Consultation to Collection (C2C) process and how that integrates into the Pharmacy Supply Chain Trading Portal (PPSCP).[3]

[3] Note Rx is the shortened nomenclature for "prescription".

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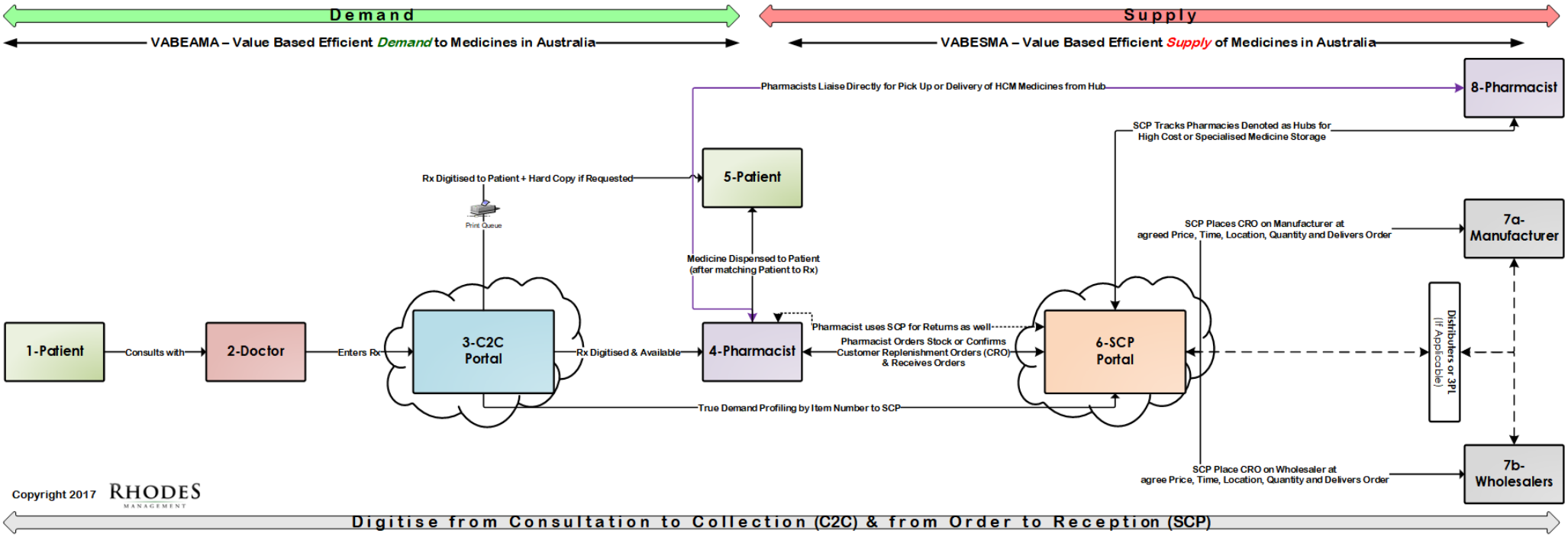
For a more detailed description of the information flows across this whole value chain please refer to the Appendix at the end of this document.



Along the C2C portal, the PSCP portal is the most innovative red tape reduction solution to bring innovation and transparency to pharmacy.

By linking true demand with supply, no longer will it be acceptable for pharmacies to be out of stock of anything burdening pharmacists and stock controllers with last minutes administrative tasks.

In addition, the PSCP should act as a trading portal for best price and best supply option no matter who provides the solution. Pharmacies will be able to source PBS medicines either from their own preferred suppliers or from other sources, including international suppliers to ensure they're receiving the best price and service possible for the PBS medicines they procure for their patients. The PSCP will also act as the information hub portal for the price monitoring we recommended by the PBS Price Scanning and Enforcement Authority we outlined earlier called PRISEA.

The PSCP aims to facilitate the patient and government charter objectives of VABESMA and VABEAMA. While the usage and operating parameters of the portal will need to be defined in detail[4] we recommend that the PSCP has (as a minimum) the following capabilities:

- ✓ PSCP to act as the flow through order/inventory management mechanism nationally for all pharmacies whom are reimbursed by the pharmaceuticals benefit scheme.
- ✓ True demand from the C2C portal fed into the PSCP portal at the point of dispensing in order to ensure demand forecasting by medicine group/item as well as pharmacy location/chain.
    - Forecasting and demand planning then creates suggested customer replenishment orders (CRO) for confirmation by each respective pharmacy.
- ✓ Facilitation of all order transactions (forward orders, back orders, stock returns, stock cancellations, CRO, order adjustments, order delivery parameters, order delivery confirmation, consignment stock processing) to allow open integration to any 3rd party related order and inventory management systems.
- ✓ Forward order stock recommendations through recommended CRO and confirmation
- ✓ Dynamic price monitoring of best price per PBS medicine and the ability to place an order with the supplier at the best price.
- ✓ Ability to allow suppliers to dynamically lower prices of medicines in order to drive demand when they deem it necessary.
    - Ability to notify portal customers of such price movements
- ✓ Confirmed lead time to supply parameters giving pharmacies certainty on when they'll receive their orders
- ✓ Consignment stock management by pharmacy and medicine grouping by location
- ✓ Hub management for High Cost Medicine (HCM) dispensing
    - Ability for pharmacies to interact via a deliver or pick up within a pharmacy to pharmacy hub in order to serve patient needs for specialised of high cost medicines
- ✓ Ability to lock in and or match pharmacies to their preferred suppliers.
- ✓ Ability to ensure the negotiated PBS price is always visible at point of ordering.
- ✓ Ability for pharmacies to setup their own scheduled delivery time preference, irrespective of who supplies them
- ✓ Ability to provide compliance reporting to ensure suppliers are meeting their VABESMA objectives.
- ✓ The provision of clear expiry date management per product supplied and prompts to notify both pharmacists and (possibly) consumers about medicines they have that are about to expire.

Unless the government get holds of the consultation to collection and order to reception processes in pharmacy bureaucratic inefficiency and red tape go on in perpetuity. The only way to arrest it is to understand the information and process flows to make them efficient, transparent and to drive value based outcomes for patients and for government. We have advocated for VABESMA and VABEAMA charters and the C2C and PSCP portals are the only way to enable and track it. Do this, and the legacy of red tape, obfuscation and lack of transparency will be eliminated and most important pave a new way forward for efficiency, value, transparency and patient centric outcomes. It is a 21st century digital solution that dwarfs the 20th century dinosaur obfuscating legacy that are the CPA agreements.

[4] And yes, Rhodes Management are happy to be engaged to lead this activity and implement it for the Government

3.3 Reducing Red Tape in Systems

3.3.1 Problems

We have outlined in this document the disaggregation of systems, information and processes within the pharmacy industry.

This disaggregation only serves to reduce transparency in services, PBS prescriptions, medicine supply and inform government about the real nature of the industry itself.

The PGA perpetuates this inefficiency under the auspices of the CPA which has never introduced any measures of increased efficiency or transparency industry wide. Why would they as it would not serve the purpose of their pharmacy owner members? Lack of transparency suits their purpose to continually try and extract money for services that increasingly employee pharmacists cannot provide and for which owner pharmacists reap the rewards.

This disaggregation manifests itself in excessive, duplicated, frustrating procedures and processes which simply do not serve the needs of the patients. *Imagine after receiving a doctor's consultation your prescription is available on your mobile phone, in your inbox and ready for processing at a pharmacy you have already selected prior to even arriving at the pharmacy where it is ready to collection when you arrive. You may even elect to pay for your medicine prior to collection and have the services explained in both hard copy, online or in person at the time of collection.*

And if you decide to not choose a pharmacy at the time of consultation, you can then walk into any pharmacy you like Australia wide knowing that your prescription is ready to be processed in partnership with the pharmacist you choose for, advice and service provision when you deem it appropriate.

Under the present CPA and current processes this is simply not possible, nor has it even been suggested.

This enables pharmacists everywhere to potentially have a more linear dispensing work flow instead of having to process a rush period at certain times of the day and compromise the very services they are meant to provide.

3.3.2 Solutions

The value chain of any business let alone any industry is first and foremost the information chain. When you understand and control the information chain you then begin to realise that the processes the information chain supports can be massively enhanced and streamlined.

Our recommendations to reduce red tape are ostensibly based on digitising the information flow of the industry from consultation to collection and order to reception.

The consultation to collection solution, or C2C, will singularly lead to the biggest reduction in red tape in the industry because it makes transparent everything that happens with respect to the supply and access to PBS medicines. Nothing is left to interpretation or follow-up because the information is simply there.

The pharmacy supply chain trading portal, or PSCP, will also lead to substantial patient centric outcomes by ensuring medicines availability is enhanced and increased. It will empower pharmacies to ensure they get supply of medicines as and when they need them based on true demand profiling.

This demand profiling occurring at the source is then fed directly to manufacturers and wholesalers, even on a daily basis if necessary. By facilitating spot price management of medicines this will enable the PBS to be managed within its limits and ensure that it reduces and removes waste in perpetuity.

As the government funds the health system, it has a right to track what it does, when it does it and with whom it does it.

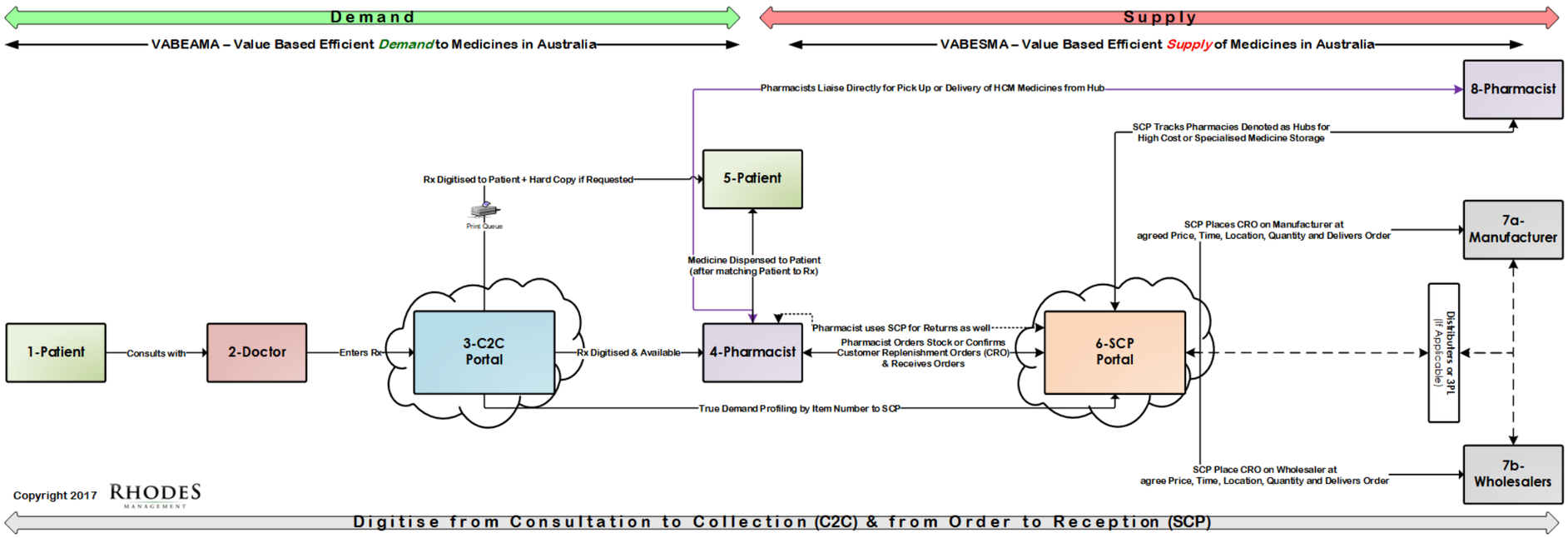
It is no longer acceptable to settle on bureaucratic red tape and inefficiency and let existing participants with vested interests improve patient centric outcomes, because it will simply not happen.

Initiatives that are planned are often manual in process, expect employee pharmacists whom have no time anyway to do the services and reaps very little for government and patients in the form of better service and better price.

The solution to red tape needs to be *horizontal* across the value chain of the industry glued together by information and processes. It must not be vertical within its constituent parts as this only obfuscates, delays and hinders information transparency, process improvement, accountability and most importantly patient outcomes.

The approach to achieving these outcomes should be iterative and agile with new capability and functionality coming online every quarter or 6 months. Because of the modular nature of the approach we are advocating it reduces risk and increases the success of transparent and valuable outcomes. This agile approach would also ensure that industry not only complied with the market solution they would also contribute to its functionality. Furthermore because of the nature of the solution all market participants would be kept abreast of what is planned for development and what is scheduled for deployment. Not only would the C2C and PSCP solutions be an innovative world first, the "crowd sourcing like functional input" to that solution approach would ensure engagement and understanding because those contributing ideas to the solution will in many cases be users of it.

4 Appendix – The C2C and PSCP Portal in Detail – Functional Requirements



Information and Process Flows – High Level Functional Specifications

1 – 2 Patient / Doctor

Patient visits doctor for medical consultation

2 – 3 Doctor / CSC Portal

A) Doctor prescribes patient the necessary PBS medicine/s.
B) The prescription (Rx) is entered into the C2C secure cloud based portal containing all full Rx details by unique identifier (Medicare number as well as some other form of identification such as a mobile phone number, drivers licence number, passport number, national identification number, proof of age card number and student identification number)
C) The Rx contains the current prescription information, which includes medicine name/ item, dosage and strength information, doctor prescriber number, doctor name and full contact details, generic use permission, name address and contact details of the patient, time and date of consultation and a unique prescription number for future or past reference.
D) All Rx entered into the C2C portal should be emailed to a nominated doctor email addresses and / or integrated to their own location based systems to ensure a backup copy always exists for reference in case the C2C portal becomes unavailable. If available the Rx should also be emailed to the patient and a text should be sent to their mobile phone.
E) Note that the portal is NOT for entering diagnoses, prognosis, analysis, test results or anything else related to the patients medical condition it is ONLY used for entering the prescription details and storing the prescription history.

3 – 4 C2C Portal / Pharmacist

A) The Rx entered into the C2C secure cloud based portal is now digitized and available for collection by patients from any registered pharmacy and pharmacist anywhere in Australia.
B) Patients can elect to forward notify their preferred pharmacists to dispense and pay for their medicines prior to collection to avoid wait times.
C) All pharmacist based service advice information for the Rx is to be available online (& printed if required) for the patient at time of collection. This advice should also be emailed to the patient and sent as a text message if the patient has email and mobile phone.
D) All medicine specific information should also available online for review by patients (at time of collection, emailed, text and online). All Rx history should also be available for review.
E) Portal tracks by pharmacy and pharmacist all services provided to patients.
F) Portal tracks by pharmacy and pharmacist all PBS products dispensed
G) Pharmacist has full Rx dispensing history of patient for analysis and consultation.
H) Portal allows for tracking by patients against safety net
I) Portal allows for pharmacist to make GP bookings for patients if recommended. This booking is sent electronically to the preferred GP where the time and date are confirmed and the patient is notified.
J) Portal allows for management of addictive medicines (e.g. codeine) to ensure no over dispensing occurs within a defined time period by patient.
K) In case the C2C portal becomes unavailable an offline version should exist so that Rx hard copy can be entered for processing at the local pharmacy and automatically syncs with the C2C portal once back online.
L) Where applicable in the future the C2C portal should also integrate to 3rd part dispensing robot technology.

3 – 6 C2C Portal / SCP Portal

A) Portal sends true order demand profile by pharmacy, of *dispensed* products by item number (can be EAN or UPC number) to the Pharmacy Supply Chain Portal (SCP) to assist in demand planning and forecasting of PBS medicines.
B) Dispensed Items which were on consignment stock with pharmacy immediately notify the SCP portal that the product has been dispensed, which in turn send a confirmations message to the manufacturer or distributor that they can invoice the pharmacy for the sale of goods.
C) The SCP will also advise the C2C of medicines that are out of stock at the manufacturer and / or distributor-wholesaler so that those drugs cannot be prescribed and an alternative can be used.

4 - 5 Patient / Pharmacist

A) Patient visits any pharmacist who then accesses the C2C portal to retrieve the Rx using the unique patient identifiers.
B) As mentioned earlier patients can elect to forward notify their preferred pharmacists to dispense and pay for their medicines prior to collection to avoid wait times.
C) Patient accesses (or is prompted to access) the medicine and pharmacists advice information for each prescription.
D) Patient is prompted and / or sent reminders to collect their prescription if they have not done so after set periods of time.

4 – 6 Pharmacist / SCP Portal

A) The SCP creates recommended CRO, or Customer Replenishment Orders, by pharmacy.
B) The CRO is based on the demand profile forecast by item for that pharmacy.
C) The CRO is then adjusted (if applicable) and confirmed by the pharmacy. Once confirmed it sends the equivalent of a purchase order through the portal to the selected or nominated supplier. Order and stock information is then integrated or sent to the pharmacy systems as required.
D) Order confirmation is sent to the pharmacy outlining price, lead time to supply, carrier, tracking number, quantity and all medicines item detail.
E) Once order is delivered to the pharmacy and received the SCP is updated to outline the status of the order has changed to delivered.
F) Once delivered and matched to the CRO a confirmation is sent to the supplier to invoice the pharmacy (if the invoice is not already with the item at time of delivery)
G) The invoice is also available online for processing by the pharmacist and the they can elect to pay the invoice online through the portal if they wish.
H) SCP Portal allows for pharmacies to deal with 1 or as many suppliers as they deem appropriate, including international suppliers (subject to qualification).
I) SCP Portal shows negotiated PBS medicines price as well as normal order price and does not allow for PBS medicines to be sold above the PBS price.
J) SCP Portal allows for suppliers to place "item on special sale" if they wish to create demand for products they have excess stock of. Pharmacies can access these offers on a first come and first served basis.
K) SCP Portal serves as a central point for the tracking and return of expired or unused medicines.

3 – 6 SCP Portal / 7a-7b Manufacturers and Wholesalers

A) All orders and all relevant inventory transaction are placed through the portal and sent to the preferred or chosen supplier. They may or may not elect to use 3rd party logistics providers.
B) Once each transaction is updated at the source an update is sent to the SCP to ensure it is up to date.
C) The SCP portal will be immediately updated if a certain drug cannot be supplied or is out of stock so that orders cannot be placed.

4 - 8 Pharmacist / Pharmacist

A) The portal will be able to be used as a pharmacy to pharmacy hub for those pharmacies that are happy to stock high cost medicines or low frequency medicines. Other pharmacies can then place order against the hub pharmacy for collection.
B) It can also act as a stock swap arrangement.

**** End of Document ****