GRATTAN Institute

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Queensland needs to cut pharmacy red tape

Grattan Institute submission to the inquiry into the establishment of a Pharmacy Council and pharmacy ownership in Queensland

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Overview

Pharmacies and pharmacists play a crucial role in the delivery of primary health care to the Australian community. Improving the ability of the sector to deliver efficient, high-quality care to all consumers is crucial to improving the sustainability of the Australian health system.

The local chemist shop owned and staffed by a friendly pharmacist was the industry model in the mid to late 20th century. This model of pharmacy provision is still enshrined in Queensland legislation - albeit allowing our friendly pharmacist to own another four pharmacies in Queensland.

But the current legislation governing ownership is a charade. The industry is being transformed with banner groups uniting the independent pharmacies, and big box discounters also providing added value to consumers. The largest chain, Chemist Warehouse, is estimated to account for 15 per cent of Pharmaceutical Benefits Scheme sales nationwide. There is no evidence that this transformation is causing consumers harm – in fact to the contrary, Chemist Warehouse's price discounts are benefiting consumers.

Industry aggregation, and industry innovation, is constrained by red tape which limits ownership of pharmacies to pharmacists. The ownership structure of the big banner groups is therefore franchise based, with the franchisees constrained to being pharmacists.

The onus to prove the benefit of anti-competitive regulation should always be on those who seek to benefit from limiting competition – typically providers rather than consumers. In the absence of compelling evidence that consumers benefit from regulation, the regulation should be repealed.

We recommend cautious removal of the pharmacy ownership rules. These rules appear much more effective in protecting the commercial interests of pharmacy owners than in serving the public interest. They also lock pharmacists into inefficient business models. Dispensing costs could be much lower if this were not the case.

However, international experience shows that the cost savings from liberalisation are unlikely to be shared with consumers and government if extreme concentration of ownership is the result. We do not need to preserve extreme dispersion of ownership in order to prevent oligopoly – we have the Australian Competition and Consumer Commission for that – but care must be taken to ensure that the benefits of deregulation are shared by all parties.

We also recommend that pharmacists be permitted to provide a much broader range of health services, including providing vaccinations, prescription repeats and chronic disease management. This would improve consumer access and convenience while reducing costs and some of the burden on general practice.

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1 The ownership rules should be cautiously lifted

The pharmacy ownership rules appear much more effective in protecting the commercial interests of pharmacy owners than in serving the public interest. They also lock pharmacists into inefficient business models, elevating the cost of dispensing paid by consumers.

There is little justification for preserving the ownership rules, but care must be taken to ensure that the benefits of deregulation are seen by all parties. International experience shows that the cost savings from removing ownership restrictions are unlikely to be shared with consumers and government if extreme concentration of ownership is the result.

Australia currently has extensive restrictions on pharmacy ownership. In all states and territories, only pharmacists can own pharmacies.[1] In addition, there are restrictions in all states, but not territories,[2] on the number of pharmacies a pharmacist can own or have a financial interest in.

1.1 There is no public interest in restricting pharmacy ownership to pharmacists

The only justification for restrictions on ownership of pharmacies is that no one other than a pharmacist can be trusted to run the pharmacy and the risk of allowing doctors, brewers or bakers to own pharmacies is too great.[3] However, it is unclear what these potential risks are, and whether pharmacy ownership controls add any value to other existing controls.

As Table 1 shows, the main risks often advanced for limiting pharmacy ownership to pharmacists are mostly mitigated by existing alternative regulatory mechanisms.

Further, contemporary pharmacy ownership regulation assumes that large corporations which own, franchise, or manage multiple pharmacies act as if they are professional pharmacists. This belies all the evidence about the way large corporations operate.

[1] This includes corporate entities controlled by pharmacists. However, in all jurisdictions except the Australian Capital Territory, there are varying provisions to this rule, for example permitting friendly societies, relatives of pharmacists, and Aboriginal Health Services to own or co-own a pharmacy. Hattingh (2011)

[2] There are no restrictions on the number of pharmacies a pharmacist can own or have a financial interest in both the Northern Territory and the Australian Capital Territory.

[3] The allusion here is to Adam Smith (2007) who argued that the interest of the shopkeeper was aligned to the interest of the consumer: 'It is not from the benevolence of the butcher, the brewer, or the baker that we expect our dinner, but from their regard to their own self-interest. We address ourselves not to their humanity but to their self-love, and never talk to them of our own necessities, but of their advantage (page 16)'. Similarly, it is not on the basis of a pharmacist's professionalism that we should frame regulation of pharmacy ownership.

Table 1: Potential risks of non-pharmacist owning pharmacies and mitigation strategies

Risk	Comment
Doctor owners may over-prescribe if allowed to own pharmacies	Tightening of PBS pricing is reducing the profitability of prescription sales so this is a decreasing risk. Doctors who over-prescribe face professional sanctions by the Medical Board of Australia.
Non-pharmacy owners may place pressure on pharmacist	Pharmacists will still be covered by professional regulation through the Pharmacy Board of Australia. If ownership restrictions are removed, legislation should be introduced to make pressure to act unprofessionally an offence in Queensland.[4]
Non-pharmacist owners might close small rural pharmacies	Location rules are not under review so new pharmacies could be established in vacated locations.

Source: Grattan analysis.

A key role of boards of corporations is to establish the corporate culture.[5] There is no evidence that suggests that if the board has a majority of members who are pharmacists, it will act differently from any other board and pursue the interests of stakeholders, including shareholders, as it is statutorily required to do. Boards of companies which own medical practices, including pathology and radiology services, and private hospitals are not constrained in terms of their composition and there is no evidence that this leads to unethical behaviour.

1.2 How many pharmacies?

All states, but not the territories, have restrictions on how many pharmacies a pharmacist (or a corporation) might own (see Table 2). In Queensland, the cap is five pharmacies in the state. As the two territories have no restrictions on the number of pharmacies that might be owned, an individual pharmacist (or corporation) could own more than 30 pharmacies across Australia. It is hard to discern any logic for this limitation.

Table 2: A pharmacist can own up to 29 pharmacies across the various states

State	NSW	VIC	QLD	WA	SA	TAS	Total
Number of pharmacies potentially owned	5	5	5	4	6	4	29

Source: Issues Paper - Inquiry into the establishment of a pharmacy council and pharmacy ownership in Queensland.

[4] Section 23DZZIA of the *Health Insurance Act 1973 (Cwth)* provides penalties for inducements for referrals to pathology and diagnostic imaging providers.

[5] Schein (1992)

1.3 The ownership rules inflate costs

The ownership rules ensure that most pharmacies operate with high capital costs and low economies of scale.[6] This leads to higher dispensing costs, which put pressure on the PBS.[7]

If Australia were to abolish the pharmacy ownership rules, the cost of providing over-the-counter medicines would likely fall. Large groups of pharmacies (i.e. the retail point only) could also merge under a single owner, with economies of scale driving down their average procurement, logistic and marketing costs. Supermarkets could use their already large and well-established supply networks, retail outlets and customer bases to supply medicines at particularly low costs.

1.4 The savings may not be passed on

While significant cost savings could be achieved through the liberalisation of pharmacy ownership rules, it isn't at all clear that these would be passed on to consumers or taxpayers.

1.4.1 Government would not automatically save

With the exception of the optional 'dollar discount' (which pharmacies don't have to offer consumers) the prices of subsidised medicines are fully regulated by government. As such, dispensing would only fall if government ensured that reduced dispensing costs were reflected in lower dispensing fees.

The historically weak administration of the PBS suggests this may not eventuate. However, having large industry participants in subsidy negotiations (as opposed to government and the Guild alone) may strengthen government's hand in negotiations, or permit the establishment of a two-tier subsidy structure wherein large suppliers must charge a lower dispensing fee.

1.4.2 Consumers would not automatically save

It is unclear whether the (unregulated) prices of over-the-counter medicines would fall either. Price studies show this does not necessarily eventuate when countries remove pharmacy location and ownership restrictions.

The lack of price declines may be due to the concentration in market power that liberalisation permits. For example, in Norway, 81 per cent of pharmacy chains are owned by three large wholesale companies.[8] In the absence of effective regulatory action, markets may become concentrated leading to 'oligopolies'[9] to the detriment of consumers. Oligopolies can reduce competition by using their market dominance to deter new entrants, and align their product ranges to their suppliers rather than to the needs of the consumer.[10]

[6] Productivity Commission (2005), p 263
[7] Ibid.
[8] This means that the supply chain and the pharmacy are owned by the same entity. Vogler, *et al.* (2014)
[9] A state of limited competition, where the market is shared by a small number of producers and sellers.
[10] Vogler, *et al.* (2006)

1.5 Government needs to ensure that the benefits of increased competition are shared

We have not raised these risks of deregulation with the aim of discouraging liberalisation. There is little sense in preserving an extremely inefficient dispersion of ownership in order to prevent oligopoly. This is a job better left to the Australian Competition and Consumer Commission, as it currently is in most other industries.

Nevertheless, care must be taken to ensure that the benefits of deregulation are shared by all parties. Regulators must ensure that greater concentration of ownership does not lead to abuse of market power. Government must ensure that cost savings achieved by larger retailers are reflected in the dispensing fees they are paid.

1.6 Queensland should be rewarded for reform

The Commonwealth Government has indicated its interest in reform of the pharmacy market, and foreshadowed potential reward payments to states which do this. The Queensland Government should explore with the Commonwealth the potential size and timing of any reward payment.

2 Pharmacists should be allowed to provide more health services

Pharmacists are highly trained, have deep expertise in medicines, are among the most trusted of all professionals,[11] and are located in communities throughout Australia. Yet their role is far more limited in Australia than in many other countries.

Australians miss out as a result. People have to wait longer and travel further to see a GP for a service that their local pharmacist could have just as easily provided. Sometimes they become sicker in the interim, increasing costs on the individual and the health system.

There is good evidence that pharmacists can safely administer vaccinations, provide repeat prescriptions to people with simple, stable conditions, and work with GPs to help patients manage chronic conditions. Allowing them to do so would improve the Australian health system by reducing pressure on the primary care system and improve consumer access to care.

2.1 Pharmacists should continue to be allowed to administer a broad range of vaccines

Every year in Australia, nearly 1.3 million GP visits involve a vaccination to prevent a disease, with no diagnosis or other treatment involved. In many other countries, including Canada, England, Wales, Ireland and the USA,[12] these vaccinations would take place in a pharmacy, freeing up GPs to provide complex care more quickly to those who require it.

In Australia, historically only doctors, nurses and Aboriginal health workers can administer vaccinations – even though the international experience clearly shows that pharmacist-provided vaccinations are safe.[13] This has begun to change in recent years with pharmacists in most states now administering influenza vaccines.[14]

Queensland is to be commended for its policy allowing pharmacists to administer vaccines in line with its Queensland pharmacist vaccination standard.

Research in Canada[15] and the United States[16] shows that when pharmacists were allowed to provide vaccinations, patients reported improved accessibility, convenience and satisfaction. Successful trials in New Zealand showed that pharmacist vaccinators were far more convenient than seeing a doctor.[17]

Allowing pharmacists to vaccinate improves their income while saving the health system money. This is because vaccinating in a pharmacy setting tends to be cheaper and more convenient than

[11] After nurses and on par with doctors. Roy Morgan (2016)
[12] Houle, *et al.* (2013)
[13] Guidelines similar to those used by nurses and pharmacist immunisers overseas can be adopted in Australia to protect patient safety and privacy.
[14] In some states, pharmacists can also administer measles and pertussis vaccines.
[15] Papastergiou, *et al.* (2014)
[16] McConeghy and Wing (2016)
[17] McMichael (2012)

in a GP clinic.[18] It may also reduce hospital costs, since improved access to immunisations can reduce vaccine-preventable hospital admissions.

2.2 Pharmacist should be able to issue simple prescription repeats

Doctors generally write prescriptions for up to six months' supply of medicines. After this time patients must return to get a new script, even if their needs have not changed. For people with long-term health needs that are being successfully controlled by medication, these visits may not require the advanced skills of a GP.[19] Pharmacists could do it instead.

Pharmacists should be able to continue medications for more long-term conditions, when the patient and GP agree, and when the patient's condition is stable. It would be straightforward.[20] After a GP has made a diagnosis and created a treatment plan, they would be able to share the patient's record with the pharmacist, if the patient agrees. When a patient asked the pharmacist for a repeat script, the latter could look up the patient's record, confirm the medication, and issue the script.

Depending on the condition, the doctor could allow the pharmacist to issue continuing scripts for up to 18 months. Of course, if the patient's condition changed, they would return to their doctor to discuss their condition and review their medication.

Surveys of pharmacists in Australia suggest the majority are willing to take on these roles with further training.[21] In many other countries, pharmacists are already doing it. Canada, England, the Netherlands, Scotland and the USA have been expanding the scope of their pharmacy practice in regards to prescribing for a number of years.[22] Studies suggest that pharmacist prescribing can improve patient health and access to treatment,[23] and is positively regarded by both patients and pharmacists.[24]

2.3 Pharmacists should be able to assist with chronic disease management

Managing chronic care is a significant and growing part of GP workload. More than half of GP visits involve managing at least one chronic condition.[25] Many of these visits involve managing medications or making dosage adjustments, rather than diagnosing conditions.

[18] Prosser, *et al.* (2008) showed that in the US, pharmacists could deliver vaccines for around 40 per cent of the GP cost. Labour costs, as well as vaccine costs were lower in pharmacies, and people visiting pharmacies had a shorter wait than those seeing doctors.
[19] At least 3.4 per cent of all visits to the GP are 'less complex' visits that involve getting repeat prescriptions for problems previously treated by a doctor. The number could be higher. Depending on how missing data is treated, the proportion of visits that involve continuing medications (repeats) could be closer to 6.2 per cent.
[20] A number of GPs don't require seeing a patient for a repeat prescription – they might leave a copy at their front desk, with or without a charge. See Duckett and Breadon (2013), p 25.
[21] Hoti, *et al.* (2010)
[22] Including emergency prescription refills, renewing/extending prescriptions, changing drug dosage/information, therapeutic substitutions, prescribing for minor ailments, and prescription drug treatment. Mossialos, *et al.* (2015)
[23] Tsuyuki, *et al.* (2015); Backus, *et al.* (2015)
[24] McCann, *et al.* (2015); Makowsky, *et al.* (2013)
[25] Swerissen and Duckett (2016)

A large body of research suggests that chronic conditions are best managed in coordinated health care teams, which can deal with the complicated demands of treating chronic disease.[26] Australia has made headway in using practice nurses and chronic care coordinators, but there is also an important place for pharmacists in managing chronic disease.[27] They could:

- Review a patient's medication, check for any adverse drug interactions and ensure that patients understand the medicines they are taking.
- Adjust doses and discontinue or alter the medication.
- Help treat acute conditions in chronic care patients, while avoiding adverse interactions with their existing medication.
- Give patients compliance packaging (with all the pills they need to take each day packaged together).
- Inform GPs and other health practitioners of any relevant information about the patient's plan.
- Issue repeat prescriptions, as discussed above.
- Ensure medications are being used properly and safely, and are able to identify any potential adverse drug reactions.

In many other countries, pharmacists are starting to do this. England and Scotland appear to be at the forefront of transforming the role of pharmacists in chronic disease management, while Australia, Canada, the Netherlands and USA report more limited progress.[28] Both pharmacists and physicians appear to favour a more collaborative approach to chronic disease management, with agreement on the benefits for patients but uncertainty about the best ways of collaborating in the absence of changes to infrastructure and reimbursement.[29] Evidence found that pharmacist interventions significantly improve blood pressure management, blood glucose and cholesterol levels.[30] They can also improve medication adherence and self-care for patients with chronic conditions,[31] potentially leading to a reduction in hospital costs, with fewer admissions caused by errors in dosage and/or misuse of medication.[32]

[26] Proia, *et al.* (2014); Hirsch, *et al.* (2014)
[27] Some Australian pharmacies already offer partial chronic disease care (including smoking cessation and weight management) as part of their routine practice, but could do so more effectively if the care was more expansive and formally integrated into primary care based disease management.
[28] Mossialos, *et al.* (2015)
[29] Kelly, *et al.* (2013)
[30] Santschi, *et al.* (2014); Tan, *et al.* (2014)
[31] Zhong, *et al.* (2014); Ryan, *et al.* (2013)
[32] Malet-Larrea, *et al.* (2016)

3 Managing the transition

What we have proposed in this submission represents a substantial change in the way pharmacy services work in Queensland. In terms of ownership controls, Queensland would join the territories in removing ownership restrictions. In terms of roles, pharmacist would take greater responsibility.

These changes should be phased-in to allow industry time to adjust. If ownership controls are to be lifted, parliament might consider repealing ownership controls as from 1 January 2021, for example, rather than on passage of any legislation.

Changing roles should also be phased-in through a managed and evaluated process. A non-statutory pharmacy council might have a role here in advising on practice guidelines, supporting and sponsoring independent valuations, and reporting to the public about progress on reform and stimulating further innovation to improve Queenslanders' access to pharmaceutical services.

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