

A PRESCRIPTION FOR PHARMACY REFORM

Pharmacists' stranglehold on PBS is anti-competitive, argues **Terry Barnes**

The National Medicines Policy (NMP), adopted by the Howard government in the late 1990s, codified the goals of Commonwealth government policy around the use and subsidy of prescription medicines and retained by its successors. According to a re-statement by the Gillard government, 'the overall aim of the NMP is to meet medication and related service needs so that optimal health outcomes and economic objectives are achieved.'¹ These objectives are:

- timely access to the medicines that Australians need, at a cost that individuals and the community can afford
- medicines that meet appropriate standards of quality, safety and efficacy
- quality use of medicines, and
- maintaining a responsible and viable medicines industry.²

This article looks at how the retail pharmacy industry³ has resisted unwelcome change, identifies key problems in the industry's competition fabric, and outlines some sensible but, for government, politically unpalatable policy prescriptions that could bring real reform into the one area of health care that has proven largely immune to a change.

The PBS and what it pays for

The Pharmaceutical Benefits Scheme (PBS) is an Australian health institution and the mainstay of the National Medicines Policy. Established by the Chifley government in 1948, the PBS has

evolved from supplying a limited number of 'life saving and disease preventing drugs'⁴ free of charge to patients into a broader subsidised scheme; in 2009–10, the PBS subsidised 184 million prescriptions at a cost of \$8.4 billion and an average dispensed cost of \$45.77 per prescription.⁵

From small beginnings, the PBS now provides subsidised access to more than 760 types of medicine, available in more than 1,900 forms, and marketed as more than 2,700 different drug brands.⁶ Most out-of-hospital prescriptions dispensed in Australia now are covered by the PBS.⁷ The sheer scale of government involvement as a payer gives it a de facto monopsony at all levels of the pharmaceutical industry, allowing the PBS to use its purchasing power to achieve budgetary and policy change.

Putting aside some highly specific cases—highly specialised drugs, and private and public hospitals issuing medicines on discharge—the

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PBS-dispensed price for a listed medicine consists of:

- The cost to pharmacists (i.e. the manufacturer's list price and a mark-up for the wholesaler). This includes therapeutic or brand premiums and discounted prices for generic versions of listed medicines.
- A standard mark-up for the pharmacist.
- Dispensing fees and any other fees to which the pharmacist may be entitled.⁸

The benefits of PBS price reductions flow not to the taxpayer but to retail pharmacists.

As at June 2011, the national permitted wholesale mark-up was 7.52% of a medicine's list price up to \$930.06, and capped at \$69.94 thereafter—but the mark-up is open to negotiation and discounting (or gaming depending on one's point of view) between wholesaler and pharmacist. Pharmacist mark-ups are also linked to medicine price, but with the highest mark-ups, 15%, applying to medicines priced at \$30 or less: in other words, the cheaper the medicine the more lucrative it is for the pharmacist.

The other major pricing components are dispensing and related fees paid to pharmacists for filling patient prescriptions. As at June 2011, the dispensing fee for a ready-made item was \$6.42, and for extemporaneous preparations (requiring a pharmacist to prepare an item for patient use) was \$8.46. Over and above these are government imposed 'paperwork' fees, including dangerous drug handling fees, PBS safety net recording fees, and electronic prescription incentives. Given that these fees apply to already marked-up items, and mostly involve taking packaged items off a shelf and handing them to the patient without adding much professional 'value,' dispensing fees is effectively a double-dip into the PBS pool.

Since 1960 there has been some form of patient contribution under the PBS, with 'safety nets' evolving to ensure that serious illness or chronic medicine-taking does not cause financial hardship. As at June 2011, the maximum patient contribution per item was \$34.20 for general

patients and \$5.60 for concessional (notably Health Care Card holder) patients. For the 2011 calendar year, the PBS safety net cumulative patient contribution threshold—above which the full cost of medicines is a government responsibility—is \$1317.20 for general families and \$336 for pensioner and concession families.

Financial impact of recent reforms

In an ideal policy world, the PBS would be pared back to its original conception as a scheme to ensure all citizens' access to otherwise unaffordable life-saving medicines, or to shift medicines from public to private insurance. This is now impossible practically and politically; instead, successive governments since that of Malcolm Fraser have sought to make the PBS as economically and clinically efficient as possible.

Nevertheless, and despite significant tweaks over the years—notably periodic sharp rises in co-payments that led to significant but short-lived dips in volume and real cost growth—there had been relatively little major substantive reform of the scheme before the 2004 federal election, when the Howard government announced a mandatory minimum 12.5% price cut in the first generic version of a listed brand medicine—an out-of-the-blue measure taken to fund other election promises.⁹

Since 2004, however, major changes have come at a steady clip, including:

- Implementing the mandatory 12.5% discount on new generic products from 2005.
- New formularies for PBS listed medicines: F1 for drugs with only one brand and F2 when two or more brands are listed.
- From 2009, significant statutory price reductions on F2 drugs, including a 25% reduction on drugs subject to a high level of discounting by pharmacies.
- Mandatory price disclosures on F2 medicines, introduced progressively from August 2007.
- A structural adjustment package for retail pharmacies and wholesalers 'recognising the potential impact of the statutory price reductions,¹⁰ including the restructuring of pharmacist mark-ups; fee incentives for online processing of prescriptions and dispensing lower-cost brands of 'substitutable' PBS medicines; and an increase in the

Community Service obligation funding pool to compensate wholesalers for the costs of rapid and just-in-time distribution of PBS medicines to pharmacists.

- A 2010 memorandum of understanding between government and pharmaceutical manufacturers on pricing and related changes from 2010 to 2014, including increasing the rate of the generic and F2 price reductions from February 2011, and increasing the mandatory generic discount to 16%.

In 2009, both the government and pharmaceutical industry commissioned independent modelling of the financial impact of the 2007 reform package. Both looked at savings and offset spending under the agreed structural adjustment measures. Looking at the period from 2009–10 to 2017–18, the respective findings (*net increases* in parentheses) were:

Table 1: Estimated financial impact of PBS reforms (2009–18)

	Government ¹¹ (billion)	Industry ¹² (billion)
Manufacturers	\$6.4–\$8.5	\$8.1
Wholesalers	\$0.2–\$0.3	\$0.6
Retail pharmacists	(\$2.2–\$2.4)	(\$2.3)
Consumers	(\$0.6–\$0.8)	(\$0.4) ¹³
Net government outlays	\$3.6–\$5.8	\$6

The different estimates reflect variations in modelling assumptions about dispensing volumes and related factors, including the terms of trade negotiated between manufacturers, wholesalers and pharmacists. But both analyses make it perfectly clear that manufacturers are huge losers and wholesalers are moderate losers from PBS reform. In contrast, retail pharmacists clearly are shown as massive winners in both models. The benefits of PBS price reductions flow not to the taxpayer but to retail pharmacists, who have not only have dodged a fusillade of financial bullets but also have used their collective clout to deflect and even seize control of the Commonwealth PBS monopsony.¹⁴

Anti-competitive restrictions

Retail pharmacy is the friendly face seen by consumers. High street pharmacies commonly are seen as stand-alone small businesses, not as part of a large conglomerate. John Howard reflected this view in his autobiography, *Lazarus Rising*:

Big companies could look after themselves and unions were strong, but the little bloke got squeezed ... I confess to usually siding with the small operator, even if some violation of free-market principles may be involved: my support for newsagents and pharmacies come readily to mind.¹⁵

Howard overlooked that behind the friendly men and women in their white smocks in approximately 5,000 retail pharmacies across Australia is the Pharmacy Guild of Australia (the guild)—superbly resourced and staffed, supported by its highly disciplined membership of pharmacy proprietors, and with a fearsome reputation for mobilising voters to support its campaigns. In terms of market power and political influence, it welds its members’ small businesses into a single big business to wield disproportionate market power and political influence.

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As a centralised federation of state and territory organisations, with a strong national council and secretariat, the guild represents most retail pharmacy owners, although precise numbers (and their membership fees) are closely guarded secrets. The guild’s leadership welds its members into a highly disciplined lobbying unit that is extremely capable of using its members’ local community presence as a formidable advocacy weapon to pursue their commercial and professional interests.

This has enabled the guild to secure and defend a range of severely anti-competitive arrangements and practices that benefit a relative few (retail pharmacy proprietors) against wider public and commercial interests. These include:

- A series of five-year Australian Community Pharmacy Agreements (the agreements), of which the fifth commenced in 2010. These memoranda of understanding are made exclusively between the guild and the Commonwealth, setting out mark-ups, dispensing fees, and related pharmacist remuneration under the PBS, as well as other professional and quality assurance measures affecting retail pharmacy (placing substantial public funding under the guild's control—an industry protection and assistance plan the likes of which other industries can only dream of);

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- Pharmacists having a near-monopoly on the ownership of retail pharmacies, even if they are retired. Only grandfathered exceptions, notably friendly societies, are permitted.¹⁶
- Highly restrictive pharmacy location rules¹⁷ (enshrined in the agreements) making it all but impossible for new pharmacies open in a less than 1.5 kms radius from an existing pharmacy; there are equally stringent conditions on pharmacies in shopping complexes and medical centres. These rules ostensibly are designed to ensure rational distribution of pharmacy businesses, but in practice, they simply strangle more efficient competition with red tape.
- Wholesale distribution being subsidised through the agreement regime, a taxpayer-funded \$650 million funding pool propping up 'full-line' wholesalers (i.e. having a distribution network that maximises daily or better deliveries of most PBS-listed items)

that are struggling to survive in an overcrowded market.

- State and territory pharmacy legislation that protects the commercial accountability of retail pharmacies and scrutiny in their business relationships that other small and medium businesses take for granted.

The guild is a powerful force

The guild aggressively defends the interests of the proprietors of 5,000 community pharmacies across Australia. It alone negotiates five-year Australian Community Pharmacy Agreements, with their implications for pharmacy remuneration paid under the PBS, and micro-reforms of pharmacy practice linked to that remuneration. Although the guild affects materially the interests of other parties, including manufacturers and wholesalers, these can only influence agreement outcomes through the guild. Its national president, Kos Sclavos, was rated the top lobbyist in Australia recently, although such credit is much more due to the superb and highly paid staff of the guild's national secretariat.¹⁸

Other health professionals, especially doctors, look enviously at retail pharmacists. Can GP practices only be owned by medical practitioners? No. Can competition from other GP practices be beaten off with the force of a signed agreement with the Commonwealth government on Medicare eligibility? No. Can GPs override contractual obligations because third parties are prohibited from benefiting directly from investing in their businesses? No.

The guild's power to control the policy environment was demonstrated by the 1999 National Competition Policy (NCP) review of pharmacy regulation. Under NCP, the Commonwealth, states and territories were obliged to review their own legislation to remove anti-competitive regulation and red tape; for the states, a huge pool of federal funding was also at stake. The guild was terrified that the pharmacists' grip on pharmacy ownership and PBS pharmacy location rules would not survive forensic scrutiny of multiple reviews, particularly as Victoria's de-regulationist Kennett government was keen to overturn them. In 1998, the guild

easily persuaded the Howard government to establish a single national review (the Wilkinson review)¹⁹ of pharmacy legislation knowing, as did Prime Minister Howard, that there was no appetite for change outside Victoria.

The guild was satisfied with the result. With considerable logical dexterity, Wilkinson upheld the key restrictions on ownership and location as being in the public interest, and not much has changed since. What's more, other Wilkinson recommendations to deregulate less controversial protectionist practices were largely ignored.

More recently, the guild has steadily preserved its members' proprietorial and financial interests, even as the wider 2004–07 PBS reforms were underway under the guise of 'structural adjustment.' An example of the victory of power over policy was the guild gaining over-generous compensation for pharmacists, which significantly increased their PBS revenues at the expense of manufacturers and wholesalers. The Rudd government contented itself by harvesting relatively modest net savings, mostly from slashing ex-manufacturer prices, but clearly was afraid to take on pharmacists and their incomes as it did manufacturers.

A six-point prescription for retail reform

Each of the problem points outlined above has a corresponding solution. If seen as a prescription for change, the following six-point policy plan, while being politically (in the Sir Humphrey Appleby sense) courageous, would go a long way in curing the competitive ills of the retail pharmacy industry, and realise efficiencies that can be invested elsewhere in meaningful health care reform.

End the exclusive Australian Community Pharmacy Agreement regime

The Australian Community Pharmacy Agreement is a private bilateral arrangement. It buys the Commonwealth political and policy peace and quiet; for the guild, it neuters the Commonwealth's ability to exercise its PBS monopsony to the financial detriment of guild members. Moreover, the bilateral agreements shut out pharmaceutical manufacturers and wholesalers, employed pharmacists, the

pharmacists' professional association (the Pharmaceutical Society of Australia), and medicine consumers. Any agreement-based changes that these groups want in relation to financial or other government support (such as PBS quality assurance standards) have to be approved by the guild. These allied interests effectively are subordinate supplicants and the guild their patron—and the guild can present itself as a professional as well as the industrial representative.²⁰

Retail pharmacists receive professional fees above the mark-up, so that consumers and taxpayers are effectively being charged twice for the same service.

Ending the agreement regime, or at least its exclusivity, would not only bring greater openness and cooperation into the medicine industry but also dilute the power of one interest—the guild—over the PBS and government's freedom of policy action by creating a more balanced negotiating environment, where the PBS monopsony can be used to further the interests of the many, and not just the few.

Dispense with dispensing fees

In retail terms, a dispensed medicine is just another good. Normally, the retail price of such goods includes the ex-manufacturer price, wholesale and distribution costs, any value added at point of sale, and allowance for a reasonable retailer profit on the transaction.

There is no reason why the same cannot apply to dispensed medicines. Under the Community Pharmacy Agreement, however, retail pharmacists receive professional fees above the mark-up, so that consumers and taxpayers are effectively being charged twice for the same service.

Instead, why not charge a simple PBS list price for each listed item consisting of an ex-manufacturer price and a single mark-up? It would be adjusted, as necessary, for item-specific factors such as whether the medicine is a generic or a premium brand and any

additional government-mandated compliance costs. With industry advice, government then could, if justifiable, further weight an item's PBS list price for any special actions expected of the retail pharmacist, such as mixing a paste or ointment, cold chain or other special storage requirements, or creating Webster packs of multiple medicines for a patient's safe use. While the Commonwealth would subsidise only to the level of the PBS list price, retail pharmacists would be free to set their own price to consumers above or below it. This could reflect the terms of trade negotiated with manufacturers and wholesalers, or simply respond to local price competition.

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In this way each listed medicine would be treated the same. There would be no complex and opaque percentage formulas on mark-ups, the mark-up/dispensing fee double dip would be abolished, and there would be no retail profiteering on low-volume or low-cost medicines. This would mean a more coherent PBS price structure, with price competition between pharmacies being opened up without compromising professional and safety standards.²¹

Similarly, any other guaranteed payments to retail pharmacists for doing what is part of their normal job description, such as online processing and providing essential information about dispensed medicines to consumers, should also be discontinued. No professional should be paid extra to do his or her basic job.

Open up pharmacy ownership

Over many decades the guild and its allies have protected exclusive pharmacy ownership zealously, responding aggressively to even the slightest suggestion that it should be challenged. Nevertheless, the ownership monopoly is undeniably an anti-competitive dam that holds back the waters of free and open competition;

breaking it would lead to much wider change for the better.

Besides the problem of the near-monopoly, there is also a long-standing issue with related legislative restrictions on how many pharmacies can be owned. These have failed to stop entrepreneur pharmacists from maximising their own permitted holdings in a state, as they can partner with other pharmacists to create large groupings well above those local limits. Furthermore, national registration now allows entrepreneur pharmacists to expand holdings across state borders, and even hold the aggregate of the maximum number of pharmacies permitted in each jurisdiction—something poles apart from the espoused concept of personal and professional supervision that justifies ownership privileges.

Everyone agrees that medicines, whether under PBS, private prescription, or off-the-shelf, should be dispensed and sold only under the direct professional supervision of a registered pharmacist, and that the operator of a pharmacy should be accountable to the community for the safe and competent operation of their pharmacy businesses. Provided this does not change, surely pharmacy ownership can be opened to non-pharmacists.

In defending the status quo, the guild and retail pharmacists argue that non-pharmacists are more likely to fall under external pressure to toe the line in, for example, 'pushing' particular product lines. The almost certain reality is that in an open ownership environment, non-pharmacist owners would be commercially as well as professionally irresponsible if they tried to interfere with the professional conduct of their pharmacists or the professional services provided in their pharmacies. Indeed, the guild itself, in recently doing a much-criticised deal on behalf of its members to promote certain alternative medicine products,²² severely exposed the emptiness of its core argument for pharmacist-only ownership.

The 1999 Wilkinson review came up with two approaches that address the 'risks' of open ownership: a) negative licensing²³ or accrediting a corporation or person as a pharmacy owner if they could be disqualified by having certain

undesirable characteristics or records of conduct; and b) creating a statutory offence of exercising improper or inappropriate influence over a pharmacist in the course of his or her professional practice, with potentially huge financial penalties as deterrents against professionally corrupt behaviour.²⁴

With such safeguards, ownership could be opened up without compromising public confidence. Indeed, in an open regime, pharmacist-owned retail pharmacies would still dominate, and would even have a relative competitive advantage if, borrowing an old advertising slogan, ‘the man who owns the store runs the store.’ What’s more, if new commercially minded operators can bring economies of scale and scope into the retail pharmacy industry, more efficient operation and relatively lower overheads can flow through to the bottom line of both the businesses and PBS medicine subsidies. And perhaps pharmacists working in those businesses would have better pay and career prospects than many do now under the pharmacist-only ownership regime.²⁵

Deregulate pharmacy location

Despite claims that orderly location rules ensure a rational distribution of pharmacies—and therefore reasonable and timely access to PBS medicines across the nation, the restrictions on establishing pharmacies in close proximity to other pharmacies have little or nothing to do with efficient PBS outlays. Instead they have everything to do with shutting down competition in local pharmacy markets, and sheltering existing owners from new and potentially more efficient entrants to their market.

Put bluntly, location rules protect the privileged position of the relatively few retail pharmacists who have PBS provider approvals in commercially desirable locations against the many who don’t. This is compounded by desirability factors hugely inflating the value of PBS approvals—making the aspiration of owning their own pharmacy almost impossible for young pharmacists to attain without crippling debt. Indeed, many non-owning pharmacists are like potential first home owners—they dream of a place of their own but may never be

able to afford one. Arguably they would do better if ownership was opened up, PBS approvals were no longer tradeable commodities, and there were no restrictions to opening a business of their own when they see an opportunity.

Beyond this, deregulating pharmacy location rules has three benefits. First, deregulation supports genuine price and service competition in the retail pharmacy industry. If a retail pharmacist knows that a strong-performing competitor is opening shop at his doorstep, it helps discourage Basil Fawlty-esque customer service, and there would be incentive to offer consumers significant discounts on the retail price. Second, the hot breath of genuine competition would shake poor performers out of the industry. Third, especially when coupled with open ownership, customers’ needs would be put before the professionals’ business interests.

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There will always be problems in attracting sufficient pharmacists to own or operate pharmacies in suburban, regional and remote areas. Addressing such misdistribution is in the public interest, and arguably justifiable as an externality under market failure theory. Therefore, if government is so concerned about misdistribution of pharmacies and PBS access, it should be offering more direct financial and other incentives to pharmacists to open up in under-served localities.

Deregulate pharmacy business practices

A retail pharmacy is not exclusively a clinical practice like a doctor’s surgery. It is in effect a mixed health care and general business (for example, selling cosmetics and, more questionably, often acting as lottery and dry cleaning agencies) with its principal line being its professional service. Nevertheless, the Wilkinson review found that pharmacy

legislation imposes severe restrictions on normal business practices in relation to external parties having interests in, or doing business with, retail pharmacies.²⁶ State and territory governments largely chose to ignore related recommendations to deregulate when the Wilkinson report was shelved.

Retail pharmacy is a classic case of determined interests using their political power to resist and deter rational policy change affecting them.

Such practices include voiding contracts giving non-pharmacists a pecuniary interest in a pharmacy (i.e. a share of turnover or profit) in a pharmacy business; exclusive supply or purchasing agreements between pharmacist and pharmaceutical wholesalers, even when extensive assistance in kind is provided (for example, as part of a pharmacy 'banner group' quasi-franchise operated by a wholesaler²⁷); imposing conditions on supplying pharmacy goods and services; creditors and guarantors being unable to impose enforceable conditions on the operation for a pharmacy business in return for financing; limiting the rights of parties providing external business finance; and linking rents of a pharmacy premise to dispensing turnover.

Provided that medicines are dispensed safely and competently, such heavy interference in normal business conduct is unnecessary. Eliminating such interference would bring a greater commercial reality to retail pharmacy and would, combined with open ownership, also give external partners greater incentive to help small pharmacy operators to become more efficient.

Remove specific subsidies for pharmacy wholesalers

There are three full-line pharmaceutical wholesalers in Australia serving retail pharmacies and other outlets such as public and private hospitals.²⁸ The relatively small size and marginal viability of the Australian wholesale market led the Howard and Rudd-Gillard governments to invest hundreds of millions of dollars in a Community Service Obligation (CSO) pool to dole out subsidies under the rationale of guaranteeing full-line and timely medicine distribution.²⁹

In late 2010 a leading manufacturer, Pfizer, chose to withdraw from the wholesale network to distribute directly and *without* recourse to government CSO subsidy. The instinctive reaction of the wholesalers, with guild and widespread pharmacist support, has been to lobby government to force manufacturers to supply all PBS listed products to CSO-eligible wholesalers, not to look to their own competitiveness. Deloitte Access Economics, commissioned by wholesalers, claimed that the withdrawal of major manufacturers would undermine the CSO, lead to big increases in wholesaler costs while leaving them with the least lucrative products to distribute, and '(shift) from a system orientated toward patient need to one driven by commercial imperatives.'³⁰

If wholesale costs are factored fairly into a simple PBS list price, however, the CSO pool will become redundant. The Pfizer experiment admittedly is still a work in progress and has had some hiccups along the way, but in its operation does not appear to be the bogey portrayed by the threatened interests. If manufacturers do succeed in distributing their own products directly, with clinically reasonable intervals between ordering and delivery, clearly there is room for reducing or removing the CSO

subsidy without threatening patient access to medicines. More open competition—not subsidy or protectionism—will inevitably lead to greater efficiency flowing to the PBS bottom line, even if that threatens the viability of individual wholesalers, or even simply challenges complacent industry notions of timely ordering and distribution.

Will there ever be genuine retail pharmacy reform?

Extensive and rapid changes in the Australian medicines industry since 2004 have done much to increase the sustainability of the PBS and its long-term capacity to subsidise emerging medicines. But successful reform means ensuring that the burden of change is shared fairly among all the affected parties. This has not happened with recent PBS reform.

Retail pharmacy is a classic case of determined interests using their political power to resist and deter rational policy change affecting them. Indeed, the six-point prescription offered here only scratches the surface of the labyrinthine business dealings and policy restrictions cosseting the retail pharmacy industry. It's time for a fresh look at the community pharmacy settlement, especially the ownership monopoly underpinning it.

Yet those who like the status quo shouldn't worry—whatever politicians think of it privately, no office-minded government or opposition will dare challenge it. Whether their power is real or imagined, the Pharmacy Guild and other

retail pharmacy interests will continue to hold political sway through their superb organisation and collective discipline, ever-confident of bending the Commonwealth's PBS monopsony to its will at the expense of industry partners and the paying public.

Although the opportunist Australian Greens have moved for a 2012 Senate inquiry into the Australian Community Pharmacy Agreement,³¹ a comprehensive and apolitical Productivity Commission inquiry is best equipped to consider ownership and other contentious industry issues in both an apolitical and authoritative manner. Only such a fiercely independent inquiry is capable of making compelling recommendations that cannot be buried or blocked easily.

Regardless, the swept-aside Wilkinson report reminds us that the status quo continuation should not be taken for granted:

The Review concludes on balance that there is a net public benefit in leaving pharmacist ownership regulations in place. It does not, however, see ownership as an inalienable and perpetual right for pharmacists. It is a privilege, conferred by the community in return for the high and consistent quality provision of pharmacy services at a reasonable cost. Pharmacy proprietors need to work hard to maintain and justify the ongoing need for that privilege.

The Australian public deserve no less.

Endnotes

- 1 Department of Health and Ageing, *The Impact of PBS Reform: Report to Parliament on the National Health Amendment (Pharmaceutical Benefits Scheme) Act 2007* (Canberra, 2010), 1.
- 2 As above.
- 3 As used in this article, ‘retail pharmacists’ refers to the pharmacists who own and operate what the Pharmacy Guild of Australia calls ‘community pharmacies,’ whose prime purpose as proprietors is to make commercial judgments in relation to their pharmacy businesses as much, if not more, than exercise their professional role as a trained pharmacist. This is distinct to the vast majority of non-owning pharmacists who are working professionals in those pharmacies, hospitals and other institutional pharmacy settings, and whose interests are often assumed in government circles to be represented by the guild.
- 4 Amanda Biggs, *The Pharmaceutical Benefits Scheme—An Overview*, Commonwealth Parliamentary Library e-brief (Canberra, 2003).
- 5 Department of Health and Ageing, *Expenditure and prescriptions, Twelve Months to 30 June 2010* (Canberra, 2011), v, 1, 2.
- 6 Department of Health and Ageing, *Submission to the Senate Inquiry into the National Health Amendment (Pharmaceutical Benefits Scheme) Bill 2010*, (Canberra 2010), 4.
- 7 Australian Institute of Health and Welfare, *Australia’s Health 2010* (Canberra: 2010), 440.
- 8 Medicare Australia, *Explanation of PBS Pricing* (Canberra: June 2011), 1, has a very comprehensive and easy-to-follow overview of PBS pricing and is the principal reference for this summary. The arrangements summarised in this section are drawn from this official document.
- 9 The 12.5% measure drew on a similar savings proposal at a considerably lower discount rate that was considered for but not included in the 2004 Budget.
- 10 *The Impact of PBS Reform*, as above, 3.
- 11 Study by PriceWaterhouseCoopers reported in *The Impact of PBS Reform*, as above, 12–14.
- 12 Study for Medicines Australia by the Centre for Strategic Economic Studies, *The Impact of PBS Reforms on PBS Expenditure and Savings* (Melbourne: Victoria University, 2009), 9–11. Medicines Australia has indicated that this study is being updated to incorporate pricing and other environment changes arising out of the 2010 memorandum of understanding.
- 13 The identified ‘benefit’ to consumers effectively is the projected net savings in patient contributions from the reform measures, notionally leaving more money in patients’ pockets.
- 14 It can be argued that manufacturers can overpower the Commonwealth monopsony when they have a high-cost or breakthrough drug, especially when there is media and public awareness of the availability of that drug and political pressure is applied. Nevertheless, these are the exceptions not the rule, as both the government and industry-commissioned impact modelling bears out. The pharmaceutical wholesalers, operating in an overcrowded industry, and with their supply chain role poorly understood by ministers and bureaucrats, are the group most vulnerable to monopsony pressure and most dependent on their “great and powerful friends” to get a good hearing from government.
- 15 John Howard, *Lazarus Rising* (Sydney: 2010), 20.
- 16 This ownership qualification simply is being a registered pharmacist. Being an active practising pharmacist is not necessary, which is why many pharmacist proprietors are retired and maintain their registration to ensure their holdings are part of their retirement nest egg. While most such pharmacists keep at least a loose eye on their businesses, and/or employ pharmacists-managers to exercise this role on their behalf, more than anything else, the retired pharmacist phenomenon highlights the absurdity of the ownership regime being based on personal-professional supervision. It is hard to deal effectively with professional issues while lying on a Queensland beach or travelling on extended overseas holidays.
- 17 Department of Health and Ageing, *Australian Community Pharmacy Authority Applicant’s Handbook* (Canberra, 2011): www.health.gov.au.
- 18 *The Power Index*, Kos Sclavos (November 2011).
- 19 Warwick J. Wilkinson, *National Competition Policy Review of Pharmacy* (the Wilkinson review) (Canberra: Department of Health and Family Services, 1999).
- 20 The guild and the Pharmaceutical Society of Australia (PSA) have long worked in conjunction, but the PSA made a fateful move in making a joint submission with the guild to the Wilkinson review in 1999. Effectively, the PSA allowed professional considerations to be considered intertwined with commercial considerations, compromising its

- reputation as defender of pharmacy as a health care profession—something that goes far beyond the ownership and operation of pharmacy businesses. The PSA's standing with government, and even in some quarters of the profession, has never been the same since.
- 21 It is, however, difficult to model the effects of a single mark-up regime on PBS outlays. Published data do not disaggregate the cost of the individual components making up the total costs of dispensed items. Nevertheless, it could be assumed that the removal of specifically dispensing fees alone would mean a significant net saving on ex-manufacturer medicine costs.
 - 22 Julia Medew, 'Pharmacies to push supplements as "fried and coke" to prescriptions,' *The Age* (26 September 2011). The guild quickly backed down under a public and media outcry, but the damage to its reputation had been done.
 - 23 The Wilkinson review, as above, 44. On negative licensing, the Wilkinson review suggested that possible prohibitions on pharmacy ownership could be:
 - A person not being of good character or a fit and proper person to practise pharmacy
 - A person or corporation convicted or specified criminal offences
 - A person or corporation found to have directed or influenced a pharmacist so that he or she engages in unsatisfactory personal conduct or professional misconduct, and
 - A person who has been found in breach of a provision of a Pharmacy Act (which would now include national registration standards) and is under a specific penalty such as suspension or deregistration).
 - 24 As above, 65–66.
 - 25 Anecdotally, employed pharmacists have a relatively hard time in terms of salaries and working conditions. Not only are the hopes of many of them becoming owners remote but pharmacist-proprietors seeking to eke out their margins look to business costs that can be cut relatively easily, especially staffing. Furthermore, the pharmacist labour market is relatively well-supplied relative to demand, putting further downwards pressure on pharmacist salaries and related working conditions—it's not surprising if the expectation of many proprietors seems to be that employed pharmacists should be paid less to do more.
 - 26 As above, 61–66.
 - 27 The Amcal brand owned and operated by Sigma Pharmaceuticals is an example of a banner group. The wholesaler offers assistance with branding, signage, shop fit out and even assistance with financing. Yet even then a pharmacist cannot be compelled to sign an exclusivity agreement with the banner operator, and therefore can shop around for better terms of trade with competitors. The best of all worlds!
 - 28 Australian Pharmaceutical Industries, Sigma, and Symbion.
 - 29 Incorporated into the fourth and fifth Australian Community Pharmacy Agreements.
 - 30 Deloitte Access Economics, *Economic Analysis of Exclusive Distribution of PBS Medicines* (June 2011), 1–2.
 - 31 Motion tabled in the Senate on 24 November 2011.