Committee Secretary
HCDSDFVPC
Parliament House
George Street
Brisbane Qld 4000
Via email: pharmacy@parliament.qld.gov.au

Dear Mr Hansen,

RE: Inquiry into the establishment of a pharmacy council and transfer of pharmacy ownership in Queensland

I write this submission to the inquiry in my capacity as Managing Director of Owen Pharmacy Group (OPG). I am a third-generation pharmacist/pharmacy proprietor and OPG is a collective between myself and my parents, Neil & Helen (both pharmacists). OPG wholly owns or are partners in eight (8) pharmacies in Queensland, mostly located on the Darling Downs. We have been serving our communities, optimising health outcomes and have employed well over 1500 Queenslanders since 1972; with current employees totalling around 200.

Community pharmacists/proprietors are seen as pillars of the community, especially in rural areas. Being one of only a few professionals' located in the town, you are called upon to assist in many facets of community life and are at the coalface of primary healthcare issues; even before the doctors or local hospital. From advice on wound care, pain, cough or cold, the pharmacist is involved with everyday ailments without appointment. In rural areas, you may also be called upon to assist in veterinary, industrial, agronomical medicine (or practice!) and all manner of after-hours calls. Having a pharmacist who is also the proprietor in a town means these communities have an invested person or family, lived and contributing to the local economy. By shopping and employing locals, supporting and donating to local sporting teams and community groups, e.g. Rotary/Lions, the pharmacist proprietor helps secure the future of country towns and doesn't take the profits to back corporate headquarters in other states. Corporate pharmacy ownership would not only bring poorer clinical outcomes for those in rural areas, but the community itself will suffer as the reinvestment into local production will be diminished as the profits go to Sydney based executives and shareholders.

Corporate ownership threatens to rip apart the very fabric of community pharmacy in Australia, which has existed as one of the world's leading health systems for many years. The mainstay of this system is that the pharmacist proprietor is personally responsible for the clinical decisions and administrative process of drugs and poisons in line with state and federal legislation. Without this personal responsibility, companies have a fiduciary duty to act in the best interest of the shareholders, not the health of the patient. That is – profit at all cost.

Community Pharmacies are small business' where the primary motivation is not profit, but the welfare and health outcomes of the patients they treat. I make decisions on a daily basis which are not in my best interests financially, but assist patients having better access to medications in a timely manner. Just today, I agreed to pack a Dose Administration Aid for a month for free as the patient has short term cash problems due to bills being due. Yesterday I delivered medications to a house-bound patient after hours at no cost. Can you imagine Woolworths, Coles or even Ramsay Health doing this?

The public supports this model of ownership as the health outcomes are better, the cost burden to the state is reduced (due to improved community health) and rural communities are more prosperous. Several better resourced reviews have been conducted into pharmacy ownership over the past years and the

conclusion is unanimously that all Australians, including Queenslanders, are better off when community pharmacies are owned by pharmacists.

The general tenet of this submission is that some pharmacy groups who operate within Queensland are blatantly disregarding the intent of the Pharmacy Business Ownership Act (PBOA) 2001. For example, the use of proxies as well as elaborate accounting and legal structures, to maintain proprietary and pecuniary interest of the business. The current Queensland Health administration of the Act has failed to uphold the legislative instrument of the PBOA by not clearly establishing who holds the true financial and managerial control of the pharmacy.

There is a 'Tick and Flick' exercise currently in place by Queensland Health for registrations of pharmacies. This is easily bypassed by corporates and groups whilst the 'true' owners are never known. These organisations use complex contracts and financial strategies such as unit trusts, sub-leases, marketing fees, administration fees, franchise fees, etc and exist only to funnel profits from the proxy of the business to the true owners. The test for these strategies to be legitimate business transactions is to test whether the conditions are market competitive. Without adequate industry expertise, it would be impossible for a statutory body to determine this.

The way to enforce the intent of PBOA is to have a body which has the industry expertise and knowledge to ask the right questions of applicants and to study the evidence on a forensic level to ensure proprietary and pecuniary interest remains, at all times, with the pharmacist applicant. The current standards of practice employed by Queensland Health in administering this instrument is alarming. This is evidenced by the state approvals granted in recent years, particular, the Malouf group sale to Ramsay Healthcare. Queensland Health processes do not have the ability, industry expertise or resourcing to properly administer the legislation. A Queensland Pharmacy Council (QPC) with industry representation, adequate resourcing and transparency will allow Queenslanders to be safe in the knowledge that the legislation is being upheld.

Governments in other states already use their pharmacy council/board in a multi-factorial capacity. Other areas an established QPC would assist include: environmental health, currently administered by the Hospital & Health Service's (HHS) around the state; premises legislation, to ensure standards are met for the physical space of the pharmacy; and to uphold the Pharmacy Board of Australia (PBA) guidelines, for example with mandatory reference texts.

Currently, each HHS employs their own environmental health officers and there is little to no co-ordination across the state. A QPC would have to ability to provide uniform interpretations of the environmental health act, and possibly – depending of budget constraints, employ QPC officers to also administer the environmental health requirements of the state.

Premises legislation governs the physical premises of the pharmacy to ensure it complies to all codes, is safe and effective to be used as a health facility. All other states and territories have some level of premises legislation to enforce a safe and fit for purpose environment for health care provisioning of drugs and poisons.

The Pharmacy Board sets guidelines for industry specific practice issues which are not legally enforceable in their own right. In all other states or territories, the state body has implemented these guidelines as mandatory for pharmacy practice. One area of particular note is the enforcement of Guideline 1: Mandatory reference texts. Currently in Queensland, there is no minimum standard of references equired to be available to pharmacists. In most cases, the Quality Care Pharmacy Program (QCPP) which is assessed by EY (previously Ernst & Young), does have a requirement for mandatory reference texts which covers most pharmacies, but as QCPP accreditation is not mandatory, not all pharmacies in Queensland.

Establishment of the QPC cannot set a burden on the state where one does not currently exist. It would have to be self-funding, independent, transparent with adequate expertise and knowledge. Particular areas include industry specific intelligence, practice issues, legal and account expertise (or at call), environmental health liaison and legal/technical ability to maximise pharmacist scope of practice . Speaking on behalf of my Group, I would be happy to contribute financially, via an annual license fee, to ensure the objectives of the QPC.

Furthermore, I offer the following points in relation to the Issues Paper released as part of this Inquiry:

1. **Are pharmacy ownership restrictions imposed by the *Pharmacy Business Ownership Act 2001* (Qld) (Act) necessary to protect consumers and deliver accessible and affordable medicines and services? Why or why not?**

   I question the relevance of this question as this was not in the Terms of Reference provided by the Health Minister. Many pharmacy inquiries, much better resourced and with greater investigative powers than this, have come to the same conclusion: That pharmacy ownership restrictions are vitally important to the safe, timely and cost effective provisions of drugs and poisons across both the state and country. To allow any vertical integration of any of the corporates, doctors, payers (ie. insurance companies) or hospital owners would ultimately reduce choice of patients and lead to higher costs, both financial and health outcomes, to both the individual and the health system over many years.

   The easiest way to protect the public health of Queenslanders is to ensure that pharmacists themselves are the ones who own and control the practice of pharmacies. I.e. The pharmacist proprietor, as an individual, assumes responsibility for the professional conduct of the pharmacy. This ensures the focus is the health of the patient and not just commercial terms.

2. **Are the ownership restrictions sufficiently clear, particularly regarding the restrictions on corporations owning pharmacies? If not, how could the restrictions be made clearer?**

   As mentioned above, the current legislation and processes to administer the Act are vastly inadequate. The Queensland Health 'tick and flick' exercise is being abused by groups and corporates using complex accounting and legal structures. An independent body with industry expertise needs to administer the Act to ensure all applicants comply with the intent of the act – for this, a QPC with industry specific knowledge of the issues should be put in place. Compliance to the act is paramount and this structure works effectively in other jurisdictions. Although some jurisdiction are better than others, all are superior to Queensland in this aspect.

   It is vitally important for all pharmacist's operating in Queensland that the statutory body ensures that the entity itself and the shareholding structure is one where the applicant pharmacist is in control.

   The key characteristics of this council would be that it is:
   - Robust
   - Transparent
   - Accountable

- Consultative with industry
- Fair and balanced
- Facilitates practice change

3. Would changing the pharmacy ownership restrictions under the Act improve community outcomes? If so, how should the restrictions be changed?

As outlined above, the overriding principle is that pharmacists should have proprietary and pecuniary interest in the pharmacies they operate in the interests of the patients and more widely, population health. The Terms of Reference (TOR) for this inquiry do not question this notion. What is asked by the TOR is the ability of a body, to transparently see the structure of pharmacy ownership and this is how it occurs. E.g. who are the shareholders and who are the directors?

This question implies that transparency equates to restrictions and the notion that removing restrictions makes it easier for the pharmacy to operate. Transparency and a rigorous independent body ensures that Government officials and third parties can accurately see the business structure. It has nothing to do with the operations or community outcomes.

Currently, limited liability companies are the most effective tax structure for a business in Australia. The intention is not to remove companies as a vehicle for business but ensure the proprietary and pecuniary interest in the pharmacy is held at all times by the proprietor pharmacist and they are the ones responsible for operations of the store within their community.

4. Should the Act be amended to allow any party to own a pharmacy, subject to requirements for dispensing only by a qualified pharmacist? Would the community be better off under such a scenario? Why or why not?

This has been covered in previous answers and preamble. Corporates act in the interest of the shareholders, not the patient. In a corporate ownership structure, pressure from management can lead to a less efficient, stressed and dollar driven workforce. This can be seen in a UK example, where a Boots pharmacist committed suicide due to management pressure and job security concerns. (https://www.chroniclelive.co.uk/news/north-east-news/boots-accused-failing-county-durham-13816751 accessed: 6/7/17). These corporations, despite being in the industry of health, do not put the patient at the core of company objectives.

The community would definitely not be better off by a simple notion that required the dispensing to be by a qualified pharmacist. If anyone could own and control a pharmacy, it would compromise:

- Operations of the pharmacy
- The health resources it provides
- The way it acts ethically
- How it facilitates medicines
- The support of patients with their medicines

We also need to ensure the division of the prescriber and dispenser of medicines. From a public safety lens, having this division means another professional is engaged to ensure that the right

medication is going to the right person, at the right dose at the right times, whilst confirming it won't cause harm due to interactions or allergies.

USA and Canadian examples of vertical integration and financial disincentives has shown that provider freedom of choice is virtually non-existent. For further on this point, I would invite you to read Diebel's Vertical Integration in the U.S. Health Care Market: An Empirical Analysis of Hospital-Insurer Consolidation (http://seradiebel.com/files/documents/AyseSeraDiebel_JMP.pdf accessed: 9/7/18)

5. **Is there any difference in performance of pharmacies owned by non-pharmacists in Queensland (such as those run by friendly societies or the Mater Misericordiae Health Services Brisbane Limited) in relation to protecting consumers and delivering accessible and affordable medicines and services?**

This question seems to be a little cheeky by the authors of the issues paper. Looking at the history of pharmacy in Queensland, these pharmacies existed at the time of legislation change and the use of grandfathering was the way the government of the time dealt with these outliers in the Act.

For example, PBOA s139B b) e) names the Mater and friendlies societies as specific entities who exist outside pharmacist owned pharmacies. Other submissions may have knowledge on why the government dealt with these outliers this way at the time.

In this area, it is important to note that owning a friendly society can provide a loophole to corporate ownership. E.g. the Gance and Verrochi families in Melbourne bought the East Yarra Friendly Society Pty Ltd in Melbourne in the early 2000s as a vehicle to bypass the intent of the pharmacy ownership legislation in Victoria. After this, all states legislated against the use this tactic; including Queensland. Ironically, friendly societies exist as a not for profit entity and yet given the dominance of the Chemist Warehouse/My Chemist group in Australia, I wonder the legitimacy of that structure under state law and use of grandfathering in the Act against the intent of its provisioning.

6. **Does the Act provide adequate protections to promote the professional, safe and competent provision of pharmacy services, and to maintain public confidence in the pharmacy profession now and in the future? If not, what additional protections should be included in the Act and why?**

The current provisions allow professional, safe and competent practice because the pharmacist owner is responsible for the ethical and safe practice of dispensing medicines. If this principle did not exist, a huge number of provisions would need to be implemented simply to restore the status quo.

For example, when very expensive Hepatitis B medications were listed on the PBS, the cost to the pharmacy was in the order of $23,000 + GST, the pharmacist then had to wait until the end of the PBS claiming period to receive reimbursement, as well as claiming the GST back at the end of the month/quarter when they submitted their BAS statement. All of this cash-flow negative and angst for a professional service and distribution fee of $70 – less than 0.3% ROI. However, pharmacist's continued to supply this medication despite the financial impacts and viable nature of the service. It was only because it was in the best interests of the patient to continue to supply these medications. Pharmacist's could have chosen to not supply due to fiscal concerns and although they may not have breached corporate provisions, they may have breached professional conduct provisions.

Would a corporate model be willing to override these professional obligations with hiding behind the corporate veil? They legally could – which is why the ethical instincts of pharmacist proprietor are crucial to ensuring safe, professional and efficient provisioning of pharmacy services.

7. Are you aware of any transfers of pharmacy ownership which have not conformed to the requirements under the *Pharmacy Business Ownership Act 2001* (Qld) (Act)?

I believe there are several transactions which have proceeded but may not have conformed with the PBOA. As mentioned in the preamble, there are several ways to divert pecuniary or proprietary interest in a business. Complex company and legal structures such as unit trusts, accounting practices such as sub-leases, management fees, advertising fees, franchise fees, etc., all of which are not market competitive and exist solely to divert profits to the true ownership/controlling entity of the business.

One particular transaction of concern is the sale of the Malouf group of pharmacies to Ramsay Healthcare. There are a few peculiar items for this transaction. Firstly, the timing of the approvals, i.e. in caretaker mode of the state government. Secondly, all the nominated pharmacist "owners" were employees of Ramsay Healthcare. Most, if not all, of these pharmacists do not even own their home outright, let alone have enough capital to provision $120 million in cash on short notice, for the sale to proceed. Thirdly, these 'owners' went from being employees in the hospital pharmacy sector, to owning 4-5 community pharmacies seemingly vendor financed. It would seem very strange that all of these people already existed with the current employment of Ramsay Healthcare. If Ramsay supplied the money, who controls the pecuniary interest of the store? If it looks like a duck and quacks like a duck....

8. Are the offences prescribed in the Act necessary and sufficient to ensure the objectives and intent of the legislation are being met, and are the maximum offences that apply appropriate?

As per question 6 – the key principle is when the pharmacist has proprietary and pecuniary control of a pharmacy, they have an overriding ethical obligation to the patient. Should they not uphold this obligation, they have the threat of deregistration and being forced to sell their pharmacy. A corporate ownership model does not have this patient centred focus as its objective, only the fiduciary responsibility to the shareholders.

The offences as they exist are sufficient for the current ownership structure of community pharmacy. In a deregulated market, it is unlikely the current penalties would be a sufficient deterrence.

9. Do you think there should be restrictions on the number of pharmacies a pharmacist may own in Queensland? Are the current restrictions under the *Pharmacy Business Ownership Act 2001* (Qld) appropriate?

I think the current restrictions on the number of pharmacies is entirely appropriate to foster a healthy competitive environment whilst not providing the ability buy, for example, 15 pharmacies in a region and have a geographic monopoly. Anti-competitive behaviour has a direct impact on patients with higher prices for: over-the-Counter medicines, general and unscheduled medicines mainly available in the pharmacy channel and practitioner only vitamins. Current provisions are adequate to protect the regions throughout Queensland.

This question also comes back to the core point of pharmacist owned pharmacies and what is effective control of the provision of medicines? As the pharmacist is personally responsible for the operations of the business, he has to be in effective control at all time. If the number of pharmacies was unlimited, how could a pharmacist act ethically and prove he was in effective control at all times? To my best knowledge, the number of Five (5) was brought about through a national review and was adopted by most states. I believe the current number is sufficient to ensure a pharmacist is in effective control.

10. Given there are no restrictions in the Australian Capital Territory and the Northern Territory, are community outcomes in the Australian territories different from the Australian states? If so, how are they different?

Partly covered in question 9. Given the size, population and decentralised nature of Queensland, the requirements for pharmacy provision cannot be compared to ACT (size, decentralised) and NT (population).

As above, number of restrictions prevent local monopolies in geographical regions. As the PBS medicine supply is a subsidised service, competition between pharmacist's still exist heavily in areas such professional services, scheduled medicines, general medicines and other pharmacy services. The current restrictions stop monopolising of large geographical areas of Queensland which would disadvantage patients.

11. Has pharmacy ownership regulation in other Australian jurisdictions improved community outcomes (relative to Queensland)? If so, how?

There is currently no transparency for structures of ownership in Queensland. Fundamental suspicion of government institutions and instruments means that good governance is required to ensure trust is maintained by the public. Transparency is one of the override principles of good governance and can be used to maintain the trust of the Queensland public. I believe WA have one of the better governance processes in Australia for this topic.

12. What functions might a pharmacy council perform in Queensland? How would these functions differ from the current functions performed by Queensland Health?

The core functions are listed below, but not limited to:

- Administer the licensing of community pharmacies to ensure compliance with the PBOA
- Maintain a register of all pharmacies in Queensland and what services they provide
    - Useful for the public at all times but also for government in times of pandemic, natural disaster, population health initiatives
- Enforce the requirements of Environmental Health legislation, Premises legislation and Pharmacy Board of Australia guidelines
- Provide expertise to Office of Health Ombudsmen with respect to complaints made about pharmacists
- Advise the Chief Health Officer on practice change. Specifically, facilitate practice change to full scope of practice and training.

Currently,

- The Queensland Health administration of the PBOA is lacking in quality and resourcing to adequately uphold the intent of the act. A council must exist with industry expertise, clinical knowledge, specialist expertise in both legal and accountancy areas.
- No register exists in Queensland leading to poor public health outcomes in times of pandemic and natural disasters. Existing services for pharmacies is patchy at best with the Pharmacy Guild database the most complete
- The environmental health officers currently employed with the HHS system could be reassigned and pick up areas such as Premises legislation and Pharmacy Board Guidelines. Currently there is no mechanism in Queensland for the latter two items.

13. How would the establishment of a pharmacy council in Queensland improve community outcomes?

Beyond those covered previously, a database of pharmacies and services could allow patients to have more knowledge of services available at particular pharmacies including: Languages other than English, Opening Hours, Clinic services such as: Opioid Replacement programs, Absence from Work Certificates, Sexual health testing and specialities (HIV/Hep C), Medicinal Cannabis access, Diabetes Australia agency among many, many others.

14. What would be the costs and benefits to the community of establishing a pharmacy council in Queensland?

As mentioned above, this council needs to impose no financial burden to the taxpayer and should be entirely industry funded. Thus, all the benefits outlined in Question 13 are at nil cost to the taxpayer. To maintain the council and to support its infrastructure, an annual pharmacy license fee would be levied in Queensland.
This is an important principle that we don't want to add a cost to Queenslanders for this service and it must also maintain transparency to give trust in the regulation of the PBOA.

16. If a pharmacy council was established in Queensland, what issues would need to be considered in its interactions with other agencies or individuals involved in regulating pharmacy businesses and practice? What legislation would need to be changed?

I don't believe substantial changes to legislation is required. The move to an annual licensing provision, providing transparency and expertise would not be a huge burden. Moving of HHS's environmental health officers may require retraining but given their capacity at the moment, probably not a bad thing.

17. What effect would relaxing pharmacy ownership restrictions have on community outcomes (such as protecting consumers and delivering accessible and affordable medicines and services) in Queensland? What are the potential risks to consumers?

This has been covered in many of the previous questions.

Fundamentally, the health outcomes of the patients are not at the forefront of a corporate ownership model. Under a corporate structure, services such as Hepatitis C provisions will not continue as they are not in the financial interest of the pharmacy. Methadone services would not provided because of the perceived quality of the clientele. These are the types of services that have

borderline viability or may create a process where the corporate can have discriminatory behaviour whilst technically not being in breach of any laws. This will be disadvantaging at-risk Queenslanders, requiring them to go elsewhere and add potential strain to other service providers including public hospitals. Equitable access to health services in Queensland would be seriously compromised if a corporate owned a pharmacy where they have no obligations for particular services, no obligations to maintain particular products. The professional conduct of the pharmacist themselves adds another layer of safety and affordability to patients.

With Queensland being a decentralised state, relaxing of ownership restrictions would create clustering in city areas where pharmacies would be more profitable. However this approach would come at the expense of small and rural pharmacies, in particular small towns where the pharmacy would no longer be viable. Ultimately, if ownership restrictions were relaxed, the quite competitive environment that currently exists would cease as the major players would nullify competition and then raise prices once they have market share. Given Coles and Woolworths already account for a huge percentage of every retail dollar spent, I don't believe adding to this market abuse will enhance competition or access to medicines/services.

In 2014, the Pharmacy Guild commission a geo-spacial analysis which showed that community pharmacies were more accessible than all major supermarkets combined. If restrictions were relaxed, I can say unquestionably that this would not be the case after a few short years. Equitable, timely and cost effective access to medicines and pharmacy services is a fundamental principle to the Queensland community.

18. **Should the scope of practice of pharmacists and pharmacy assistants in Queensland be extended? If so, in what areas of practice?**
19. **What additional training for pharmacists/pharmacy assistants, or other risk reduction measures, should be implemented to ensure patient safety?**

I fully support and endorse the Pharmacy Guild of Australia's view with respect to the scope of practice – Questions 18/19

Kind Regards,

Chris Owen B.Pharm (Rural)
Managing Director
Owen Pharmacy Group