RAMSAY HEALTH CARE

Submission to the
National Competition Policy Review

November 2014

Introduction and executive summary

This 2014 Competition Policy Review is an opportunity for market sectors across the Australian economy to reflect on how efficient and competitive they are, and how they can improve their competitiveness in the future.

As Australia's leading provider of private hospital services, Ramsay Health Care (Ramsay) strives to do whatever it can to improve its own competitiveness, and to provide healthcare consumers with real quality choices. Increasingly, this commitment applies not only to hospital services, but to the range of healthcare services which we provide or with which we partner.

This includes pharmacy services, which are the focus of this submission. While inpatient dispensing is an integral part of what Ramsay does, there are great synergies in encouraging community or retail pharmacy services – local chemists – to operate on our campuses and providing services not only to inpatients, but to outpatients and members of the community generally.

We have found, however, that our ability to operate retail pharmacies in our hospitals has been held back by Commonwealth, State and Territory legislation.

We welcome, therefore, the findings of the Review's Draft Report on the over-regulation of and lack of competition in the retail pharmacy market. We especially welcome Draft Recommendation 52 that advocates ending the pharmacy ownership monopoly and removing the pharmacy location rules from the Pharmaceutical Benefits Scheme (PBS).

With this and the Review's upcoming Final Report in mind, this submission principally addresses three areas of pharmacy legislation and regulation that have significant implications for competitiveness and a free pharmacy market, notwithstanding the public policy justifications for retaining them. These are:

- Pharmacy ownership;
- Who can have a pecuniary interest in a pharmacy; and
- Pharmacy Location rules for the dispensing approvals under the Commonwealth's Pharmaceutical Benefits Scheme.

In addressing these regulatory barriers, Ramsay Health Care proposes that:

- Pharmacist-only ownership of pharmacies, and grandfathering arrangements for friendly society and similar operators, are no longer necessary and beneficial to the public interest in and should be abolished;
- Non-pharmacist pecuniary interests in pharmacy businesses are deregulated, subject to negative licensing safeguards and offences that punish the inappropriate interference in the professional practice of pharmacy in a retail pharmacy business; and
- Pharmacy location rules are abolished forthwith and, from July 2015, pharmacies can be set up wherever the operator deems it can run a viable business.
- Even if the location rules are not abolished altogether, that the location of pharmacies in or within private hospitals is deregulated, and pharmacy sites determined by commercial judgment and clinical need.

We also make observations about the complexity of Federal, State and Territory regulation, and recommend that, just as professional registration was standardised a decade ago, the time has come for nationally-consistent regulation of retail pharmacies and businesses and professional pharmacy practice.

Finally, we recommend a fresh detailed review of regulation and competitiveness in the pharmacy and pharmaceutical sectors be undertaken, ideally under the auspices of a respected neutral umpire like the Productivity Commission. We believe that this would complement the work already done in this much wider-ranging Harper Review.

About Ramsay Health Care and Pharmacy Services

Established in 1964, Ramsay Health Care has become a global hospital group and takes great pride in operating facilities in Australia, the United Kingdom, France, Indonesia and Malaysia.

In 2007, Ramsay Health Care commenced creation of a network of in-house hospital dispensaries and pharmacy departments in Ramsay Health Care facilities where previously these services were provided by external third party pharmacy service providers. The vision was to create a network of like-minded pharmacists, technicians and support staff providing services to patients in line with the Ramsay Health Care message of "People Caring for People".

This initiative is improving the quality of clinical and medication management in Ramsay facilities and ensures the consistency of service provision across Ramsay Health Care's 69 Australian private hospitals. Ramsay's in-house pharmacy operations now total 39 along the Eastern seaboard, and this number is expected to increase with new sites expected to come into operation soon.

Ramsay Pharmacy Services (RPS), as the internal business unit of Ramsay Health Care, is responsible for the provision of specialised medication management services and the full suite of pharmacy services to inpatients and day patients at 39 Ramsay facilities offering progressive and contemporary pharmacy services to patients, whilst being a very important component of the multi-disciplinary heath care team within the facilities. In addition, RPS also provides leadership and advice on all medication-related matters to non-deployed Ramsay Health Care sites.

RPS employs in excess of one hundred pharmacists, in addition to sixty support technician and administrative staff who are trained to service the full range of patient needs across the Ramsay facilities where RPS operates.

RPS services and standards compliance include:

- Dispensed and ward imprest patient supplies
- Ward clinical pharmacy services, including medication reconciliation
- Finance and procurement functions
- Contributions to hospital services as members of a multidisciplinary healthcare team
- Coordination of sterile drug manufacture via a third party TGA Registered facility
- Cost containment strategies

- Adherence to Australian Pharmaceutical Advisory Council guidelines and recommendations.
- Training and development of intern pharmacists
- Provision of drug information and decision support though the RPS network; and
- Adherence to best practice contemporary pharmacy

RPS operates in strict accordance with established corporate policies and professional procedural practice. A robust Continuous Quality Improvement programme tailors audits and procedures to meet the specific needs of facilities, which ensures consistent high professional standards across our network. A defined audit calendar provides a framework for Ramsay Pharmacy Services to provide valuable input and recommendations relating to the Quality Use of Medicines; safe handling and custody of drugs; and compliance with all State and Federal legislative requirements needing to be met by Ramsay Health Care facilities as part of the International Standards Organisation and the Australian Council on Healthcare Standards accreditation.

Ramsay takes its pharmacy business and pharmacy operations seriously. It is in our business's best interests to ensure that pharmacy services provided on our campuses are of the highest professional standard. While we advocate commercial deregulation in the retail pharmacy industry, we do not support a lessening of professional pharmacy qualifications and standards.

We also strongly believe that any dispensary or pharmacy must always be under the professional control of an experienced professional pharmacist, and that no third party has the right to direct a pharmacist-in-charge in relation to professional duties. The comments made in this submission must be read with these statements in mind.

Ramsay and pharmacy regulation

Ramsay and RPS understand and accept that pharmacy services are necessarily regulated in the public interest. We have worked, and will continue to work, with whatever Commonwealth and State legislation and regulations apply to our businesses, including our private hospitals and pharmacies operating on our campuses.

This submission, however, is intended to highlight for the Review aspects of the regulatory regimes that could be improved, reduced or removed without harming the public interest in the safe and competent dispensing of medicines and the provision of pharmacy services.

We also hope that our views may be taken on board by governments and by other parties in the pharmacy space as a basis for consultation and discussion that may lead to policy innovation.

Pharmacy ownership

Ramsay welcomes the Review's Draft Report conclusion that restricting, with grandfathered exceptions, pharmacy ownership to registered pharmacists is anti-competitive, and fully supports Draft Recommendation 52's position that these legislative restrictions should be abolished.

A community pharmacy is a healthcare business. Its purpose is to provide quality pharmaceutical dispensing and advisory services to the Australian public, and to hold out to consumers a level of professional skill and competence in providing these services.

Retail Pharmacies are also service points for medical and other health-related goods and services, including complementary medicines, wound care, babycare, condition management, distribution points for publicly-funded programmes including the Commonwealth' s National Diabetic Supplies Scheme and state-administered addition management schemes including safe methadone dispensing.

These significant professional responsibilities make it imperative that dispensing and other professional services provided in a community pharmacy are under the continuous supervision of qualified professional pharmacists to ensure that they are conducted safely and competently. That this is not only desirable but essential is not disputed.

In Australia, however, regulations effectively restrict the ownership of community pharmacies to registered pharmacists. This pharmacy ownership regulatory monopoly has now prevailed for almost eighty years.

It now has been 15 years since the 1999 National Competition Policy Review of Pharmacy (the Wilkinson Review) made a narrow on-balance judgment that the ongoing regulation of pharmacy ownership is legitimately regulated to the public's benefit[1]. Therefore this present Review is a timely opportunity to revisit ownership restrictions and to consider whether they should be opened up for more comprehensive re-evaluation and potential deregulation.

It is therefore very encouraging that this current Review challenged the pharmacy ownership monopoly in its Draft Report, reflected in Draft Recommendation 52, that these restrictions should be abolished.

Should pharmacy ownership be opened up?

Ramsay believes that the regulatory tradition of community pharmacy owned by pharmacists generally has served Australia well over many decades. But we have come to the view that, in future, ensuring the safe and competent practice of pharmacy and related services does not require a registered pharmacist to own a pharmacy.

There is no compelling evidence to retain such a rigid regulatory status quo for the retail pharmacy sector. Ensuring safe and competent professional practice really comes down to three key factors:

- A community pharmacy is in the operational charge of a registered pharmacist, and that he or she is accountable for the professional conduct of their pharmacy;
- The pharmacy proprietor is ultimately accountable for the professional operation of their pharmacies; and
- If not a pharmacist, the pharmacy proprietor does not control, or interfere with, the professional responsibilities of registered pharmacists and employees under their professional supervision.

[1] That this was an on-balance and "at this point in time" judgment was not highlighted by the Pharmacy Guild's submission to the Harper Review when in endorsing Wilkinson's conclusion.

The ownership of medical centres, pathology services and diagnostic imaging facilities is not confined to doctors. Indeed, pharmacists lawfully can have controlling interests in those businesses. To give pharmacists monopoly control of pharmacy businesses is counter-intuitive, discriminatory and blatantly unfair – not only to non-pharmacist third parties, but to non-owning pharmacists who are shut out from owning their own businesses.

This should change, and the Review's Draft Recommendation 52 is a big step in the right direction.

Ramsay recommends that State and Territory restrictions on who may own a pharmacy be removed in the foreseeable future, and in any case should not operate beyond the end of the Sixth Community Pharmacy Agreement in June 2020.

Restrictions on number of pharmacies owned

State and Territory *Pharmacy Acts* limit how many pharmacies a registered proprietor or corporation controlled entirely by pharmacists may own. In Victoria, for example, the ceiling is five[2]. The ownership ceilings have long been of such low numbers in recognition of the personal supervision principle: the expectation that the proprietor can keep a close professional eye on his or her holdings.

The current reality, however, is different. Since the introduction of national registration of pharmacists and other professionals a decade ago, with *de facto* mutual recognition of registration, it is easy for entrepreneurial pharmacists to amass holdings across State and Territory borders, up to the maximum allowed in each jurisdiction.

Moreover, for many years enterprising pharmacists, families of pharmacists (i.e. spouses and children), and pharmacist business partners have formed operating alliances that combine their personal holdings under State laws, creating loose conglomerates in which each member exercises nominal supervision over their personal pharmacy holdings (and therefore everyone remains within the legislative boundaries).

In effect, supposedly professional practices are operating as commercial businesses, using the rules to maximise returns and profits rather than give consumers the best possible professional service.

In our view, if these restrictions are so easily got around by entrepreneurial pharmacists acting more like business tycoons they are pointless, make a mockery of ownership rules excluding non-pharmacists, and should be removed.

It should be noted that if pharmacy ownership restrictions are eventually lifted, restrictions on the number of pharmacies per proprietor may become redundant.

Co-proprietorship with non-pharmacists

Beyond friendly societies and other grandfathered exemptions, there is no provision for non-pharmacists to have a shared proprietorial interest in retail pharmacies.

[2] *Pharmacy Regulation Act* 2010 (Vic) section 5(2)

Ramsay believes that co-proprietorship between pharmacist and non-pharmacist partners should be allowed. How this can be done is considered, with other pecuniary interest issues, in the next section of this submission.

Pecuniary interests in a pharmacy business and who may own a pharmacy

State and Territory *Pharmacy Acts* prescribe, to differing degrees, the conditions under which parties can hold a pecuniary interest in pharmacy businesses.

A common thread generally runs, however, through the various regulatory conditions:

- Only pharmacists, or bodies corporate entirely controlled by pharmacists, can hold a pecuniary interest in a retail pharmacy; and
- No non-pharmacist party can exercise control, direction or influence of a pharmacy business. This includes co-proprietorship.

Such restrictions effectively mean that third parties may invest in pharmacy businesses but they cannot tell the proprietors how to conduct those businesses. The biggest instances are the "banner groups" of pharmacies – brands such as Chemmart, Chemists World and Amcal, established by the major pharmaceutical wholesalers and distributors, Sigma and Australian Pharmaceutical Industries.

These banner groups are not proprietorial or even franchises: they are brands owned by the wholesaler but adopted by a pharmacy business. In return for access to common branding and signage, banner group sponsors also commonly invest in fit-out and equipping of a pharmacy taking their brand, and provide back office support and assistance to banner group members. Even more significantly, banner sponsors and other third parties can loan or advance funds to pharmacists establishing a new pharmacy business or purchasing a pharmacy or PBS dispensing approval.

In a truly commercial arrangement, a banner group sponsor could expect to contract some quid pro quo from this investment, such as a requirement to use the wholesaler's distribution service exclusively, or give the sponsor a share of the pharmacy's profits or turnover, or agree to other conditions binding the business in return for a loan or start-up assistance. However, the working of pecuniary interest restrictions effectively prohibit these perfectly reasonable commercial arrangements as infringing on the absolute control of a pharmacy by the pharmacist proprietor.

As a result, pharmacist proprietors can have their cake and eat it too. They can accept significant investment from third parties, yet repudiate commercial or moral obligations to those investors at their whim. Having this ability discourages investment, innovation and involvement by third parties in the community pharmacy market, even if they have established track records in providing safe and competent healthcare services.

For Ramsay as a healthcare provider, this is a matter of ongoing frustration. As indicated earlier, we see great synergies in the wide-scale integrating of community pharmacies into our campuses, providing in-hospital dispensary services as well as serving the walk-in community pharmacy market. We want to deepen our relationship with community pharmacy, and work with pharmacists in supporting Australians who need quality pharmacy

services. We believe that pharmacies that work in partnership with us will be better, more effective and more viable and profitable.

Further, we see the inability of non-pharmacist corporations and individuals to have fair and reasonable commercial arrangements with pharmacy proprietors as a major disincentive to investing in those businesses and/or forming working partnerships with them. Not only do those businesses lose but, more importantly, so do potential customers and consumers.

Essentially, legislation and regulation implying that non-pharmacist third parties cannot be trusted to safeguard the professional integrity of pharmacists, and pharmacies, is absurd. There is no point in investing in a pharmacy business, and in the iconic reputation of retail pharmacy, if the intention is to downgrade or undermine them – to "trash the brand".

Competition thrives on innovation and investment: the current heavy restrictions on third-party pecuniary interests in pharmacy businesses suffocate both.

Getting the balance right on pecuniary interest is a more important competition and market reform priority than pharmacy ownership and proprietorship. This is because wider competitive reform, with the potential to transform pharmacy businesses for the better, should go well beyond who owns pharmacies.

Liberalising pecuniary interests

While it did not touch pharmacy ownership restrictions, the 1999 Wilkinson Report made a number of recommendations relating to the more liberal treatment of pecuniary interests in pharmacies.

Unfortunately, these recommendations were shelved by Commonwealth, State and Territory governments. Like most aspects of Wilkinson, once the politically-sensitive ownership question was resolved, governments preferred to let sleeping dogs lie.

Wilkinson recommended[3] removing provisions in State and Territory *Pharmacy Acts* that:

- Prevent parties other than a registered pharmacists to have a lawfully-permitted association with a pharmacy business;
- Insert specific items in commercial documents relating to pharmacy businesses;
- Prevent considerations for third parties based on a pharmacy's turnover or profit;
- Prevent pharmacies having preferred wholesaler suppliers of medicines;
- Otherwise prevent pharmacy proprietors from developing lawful business associations with other (i.e., non-pharmacist) parties; and
- Allow regulatory authorities to intervene inappropriately in matters of this nature.

Ramsay believes this recommendation is as appropriate now as it was 15 years ago, and hopes that this Review endorses it as part of any recommendations it makes to improve competition in the community pharmacy market.

Ramsay also believes that, with Wilkinson's checks and balances, co-proprietorship with a pharmacist proprietor (if the pharmacist-ownership principle is retained); genuine franchise

[3] Wilkinson Report, Recommendation 6(c)

agreements between pharmacy businesses and banner group sponsors; and joint ventures by third parties, such as Ramsay, with pharmacy businesses, should be permitted.

In regard to co-proprietorship, as a transitional issue it could be provided that pharmacist co-providers must have a controlling interest in the operating entity for a limited period of years.

Safeguarding the public interest in safe and competent pharmacy services

It is essential to reassure the Australian public that the dispensing of medicines, and the provision of other professional pharmacy services, are provided first and foremost by community pharmacies in the best healthcare interests of Australians. They are entitled to expect that commercial imperatives never override clinical and professional judgments of pharmacists and trained pharmacy staff.

Clearly, assuring the Australian public about this is even more important if pharmacy ownership is opened up to non-pharmacists.

Therefore, Ramsay supports revisiting Wilkinson's complementary recommendation[4] to safeguard the public interest. This recommendation proposed *a statutory offence, with appropriate and substantial penalties for individuals and corporations, of improper and inappropriate interference by a pharmacist in the course of his or her practice*.

Our view is that such a provision is fair and reasonable; is in the public interest; sends a message to pharmacists, business partners and consumers about appropriate professional and commercial conduct; and reflects the ethics and values that the community requires of everyone holding a professional or commercial interest in retail pharmacy.

Who may own a pharmacy: fit and proper person tests and negative licensing

A quid pro quo of liberalising the commercial side of pharmacy businesses is to apply appropriate criteria that should be satisfied by no-pharmacist parties establishing commercial relations with pharmacy businesses, or ownership if that is eventually permitted.

Being a fit and proper person is part of the test for registering professional pharmacists and other health professionals. In the public interest, fit and proper person tests could be applied by pharmacy authorities to third parties, either on a case-by-case basis or by a negative licensing approach – specifying specific attributes or factors that an individual or body corporate must not have if they are to have a commercial relationship to a pharmacy business.

This could include whether the principal line of business of the intending proprietor or co-proprietor is consistent with the safe and competent provision of pharmacy services, and should include safeguards to ensure that ownership or other pecuniary interest compromises such provision.

Relevant criteria could include the compatibility their personal or corporate business philosophies and marketing practices; whether there are risks of the professional judgments of pharmacists and staff being conflicted or compromised; and risks to the safe and

[4] Wilkinson Report, Recommendation 6(d)

competent practice of pharmacy in a premise or commercial arrangement associated with the third party.

Ramsay recommends that regulations on non-pharmacists having pecuniary interests in pharmacy businesses, including ownership partnerships between pharmacists and non-pharmacists; exclusive or preferential supply agreements; and agreements between pharmacist owners and third parties on sharing profits and/or turnover, are phased out provided that the safe and competent professional services in a pharmacy are under the direct control of a pharmacist and are not interfered with.

Pharmacy location rules

Ramsay welcomes the Review's Draft Report's conclusion that the PBS's pharmacy location rules are anti-competitive, and fully supports Draft Recommendation 52's position that they should be abolished.

The location rules impose an unreasonably heavy control of pharmacy location in terms being approved to dispense prescription medicines under the Pharmaceutical Benefits Scheme. While they have been modified over time, location rules have been a consistent feature of successive Australian Community Pharmacy Agreements between the Commonwealth and the Pharmacy Guild. So entrenched are they that it will take a supreme act of political courage to abolish them – but that is no reason not to do it.

The key rules are well-known, indeed notorious, in the pharmacy and pharmaceutical industries. Set out formally in a statutory instrument[5], their operation needs careful explaining in a 50 page handbook issued by the Australian Community Pharmacy Authority, the government body that administers PBS dispending approvals and processes pharmacy location applications[6].

Submissions made to the Review by the Guild and other pharmacy interests commented on the location rules. In terms of their policy and social benefits, the Guild cited approvingly[7] the Wilkinson Review's conclusion that the Rules:

- Operate to keep pressures on growth in government expenditure on the PBS to a minimum;
- Help to maintain a stable and sustainable local pharmacy market and minimum market saturation;
- Support a stable distribution network for the PBS; and
- Facilitated the placement of new and relocated pharmacies in localities where there is genuine need for pharmacy services, particularly regional, rural and remote areas, and for areas of new population growth in metropolitan areas.

As the only other significant retail pharmacy grouping, the Australian Friendly Society Pharmacies Association echoed the Guild in its submission, subject to some adjustments around shopping centre locations[8]. In Ramsay's case, we have specific concerns about

[5] National Health (Australian Community Pharmacy Rules) Determination 2011
[6] Australian Community Pharmacy Authority, Pharmacy Location Rules: Applicant's Handbook, March 2014
[7] Pharmacy guild submission to the Harper review, page 14
[8] Australian Friendly Society Pharmacies Association submission to the Harper review, page 4

Rule 125, which does not allow a PBS-dispensing pharmacy to be located in a private hospital of less than 150 beds.

Beyond that, however, we have serious concerns that the PBS location rules are a serious brake on retail pharmacy competiveness, innovation and efficiency. As former senior Howard government policy adviser and now commentator Terry Barnes has written, the location rules "protect the position of the relatively few retail pharmacists who have provider approvals in commercially desirable locations against the many who don't".[9]

Furthermore, and given that PBS dispensing is essential to a retail pharmacy's viability, the rules have the effect of keeping more efficient and better quality professional competition off the doorsteps of less efficient and competent professionals and businesses.

In short, the PBS Location Rules are anti-competitive, capricious and arbitrary in their eligibility criteria; protect poor performers from stronger competition; and unfairly limit freedom of commercial judgment. Given that there is to be another Australian Community Pharmacy Agreement between the Commonwealth and the Pharmacy Guild from July 2015, Ramsay questions whether there should be a continuation of the Location Rules as part of the agreed arrangements.

Certainly, if pharmacy ownership is too hard politically, deregulating pharmacy location for PBS purposes would in itself be a huge step forward for taxpayers and consumers.

If the Commonwealth Government believes that some intervention in the retail pharmacy market is needed to ensure that no part of the Australian community is under-serviced by community pharmacies, it has the option of enticing pharmacies to operate in marginally-viable outer suburban, rural and remote localities by offering targeted operating subsidies or other incentives. Any such intervention ideally should be contestable and conducted on a competitive tender basis.

Indeed, if current ownership rules do not change, and pharmacist-owned entities do not respond adequately to such tenders, non-pharmacist entities could be invited to participate in contestable processes on the grounds of a failure in the de facto pharmacy market causing unmet need. Commonwealth legislation to allow this would prevail over State ownership provisions via section 109 of the Commonwealth Constitution.

Ramsay recommends that pharmacy location rules are abolished, either to coincide with the start of the Sixth Community Pharmacy Agreement in July 2015, or otherwise phased out progressively over the period of the Sixth Agreement to be removed by 2020.

Pharmacies in or co-located with private hospitals

By staying largely constant over many years, the Location Rules are not keeping pace with rapidly-evolving healthcare trends and consumer demands. This very much applies to pharmacy services in private hospitals.

For instance, a private hospital smaller than 150 beds in a developing suburban area actually could be an ideal site for a retail pharmacy that not only serves the facility, but also

[9] Terry Barnes, A prescription for pharmacy reform, *Policy*, Summer 2011-12, page 25

an evolving surrounding suburban or regional community. The 150-bed floor criterion is just one example of the overall arbitrariness of the Location Rules, and clearly it is a restriction that affects Ramsay Health Care's ability to host a retail pharmacy on many of its campuses – a factor that is related solely to the quantitative criterion of number of beds, not the nature and quality clinical services and specialities provided on site.

Private hospitals are ideal hosts for a retail pharmacy, offering economies of scale and scope to serve hospital dispensary needs as well as walk-in dispensing. Indeed, some of the most successful pharmacy sites in Australia are in profitable private hospital co-locations. Another factor is that most private hospital sites are distinct, free-standing campuses away from the usual high street localities, in many cases not easily accessible off-the street.

Regardless of any other factors, pharmacy location criteria based on the number of impatient beds a private hospital are crude and unhelpful and fail to recognise evolution in acute and sub-acute healthcare practice. The mix of hospital activity is far more relevant to the medicine needs of a hospital. What is more, day procedure and outpatient services, and specialist consulting rooms, are now a big part of most private hospital operations.

Increasingly too, private hospitals are offering Emergency Department (ED) services which help meet demand for 24/7 accident and emergency care. Access to on-site dispensary services make private EDs more self-sufficient and therefore more capable of reducing demand pressures on public emergency facilities. Ramsay sees contiguous pharmacy facilities as essential to any future plans to expand our ED capabilities.

What should determine whether a pharmacy is co-located with a private hospital should depend on the business case for the site, not arbitrary and inflexible bureaucratic criteria based on an inappropriate and crude quantitative measure.

To address this issue, Ramsay is happy to work in association with the Pharmacy Guild, the Pharmaceutical Society of Australia, the Australian Private Hospitals Association and healthcare consumers to deregulate the provision of pharmacy services in private hospitals to make these more accessible, more clinically efficient, and both more affordable and profitable. This process can proceed notwithstanding any wider review of the anti-competitive Location Rules as a whole.

At minimum, however, the Rules needs to be made more flexible, and reflect the qualitative mix of hospital activity – as a source of dispensing volume and turnover – rather than use the current crude and arbitrary bed-based measure. This should be done sooner rather than later and, even though it is not ideal, it would be a big step in the right direction.

Ramsay recommends that pharmacy location rules relating to private hospitals are abolished from the start of the Sixth Community Pharmacy Agreement in July 2015, on the basis that sensible commercial judgments and business cases are the best indicators of pharmacy viability on private hospital campuses.

If the rules are not to be abolished, Ramsay further recommends that the inflexible 150-bed criterion is abolished forthwith, and more flexible criteria reflecting the inpatient, day procedures and outpatient activities of the hospital catchment are applied instead.

Other competition and regulatory issues

There are currently eight State and Territory *Pharmacy Acts*, each with its own requirements and idiosyncrasies. For a nationwide business like Ramsay's, the diversity of regulation makes compliance difficult; creates avoidable red tape and compliance costs; and dampens enthusiasm for investing in pharmacy services that benefit both our consumers and our facilities.

We note the great success of consolidating health professional registration into a single national framework. This has created a registration and accountability regime that is simple, transparent, consistent and by and large effective. We see no reason why the same homogenous approach cannot be applied to the regulation of pharmacy *businesses*, and call for Commonwealth, State and Territory governments to work together to achieve the aim of nationally-consistent pharmacy ownership and business regulation by the end of 2015.

Ramsay also notes that the bipartite Australian Community Pharmacy Agreement between the Commonwealth and the Pharmacy Guild is essentially anti-competitive. The Agreement does not prevent other parties (including friendly interested parties like Ramsay) from seeking to influence Commonwealth policy and funding, but it does deny them an independent voice in any discussions. How the PBS is administered is the call of the Commonwealth, however, no one stakeholder should have a *de facto* right of veto over the Government's PBS policy.

Our view is that the PBS must be administered to the benefit of all Australians needing to access affordable medicines ahead of safeguarding the interests of those who manufacture, distribute and dispense then. It is not clear that bipartite Community Pharmacy Agreements, where the parties can ignore the concerns of other relevant interests because they are not signatories, adequately reflect that principle.

Conclusion

Overall, the present Review can only scratch the surface of regulatory and competition issues in the retail pharmacy industry. We also believe that, should Draft Recommendation 52 be included in the Review's Final Report, that the vested interest resistance to abolishing ownership and location restrictions will be intense. As a healthcare provider of 50 years' standing, we would be reluctant to see sensible structural reform blocked without good reason.

Therefore, Ramsay sees value in further detailed and independent examination of the retail pharmacy industry and its regulatory system, . This should be an authoritative, economically-rational forum in which to test claims and counter-claims about the costs and benefits of the current regime.

Ramsay recommends that the Review's Final Report contains a supplementary recommendation to the Commonwealth Government that the wider pharmacy industry and supply chain is the subject of a comprehensive Productivity Commission inquiry, with Terms of Reference broad enough to test existing regulatory regimes and whether these are relevant to today's professional, clinical and commercial environments.

Such an inquiry would assure the public that they are getting, and will continue to get, convenient and affordable access to the world-class retail pharmacy services they are accustomed to, and at the best possible price.

It would also ease the transition to better competition, with an emphasis on price and service quality, in the retail pharmacy industry. Better competition in retail pharmacy would improve the lives, and healthcare choices, of all Australians.