The Pharmacy Guild of Australia

SUBMISSION

Review of the Retail Grocery Industry (Unit Pricing) Code of Conduct

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1. INTRODUCTION

The Pharmacy Guild of Australia (the Guild) is the national peak organisation representing community pharmacy. It supports community pharmacy in its role delivering quality health outcomes for all Australians. It strives to promote, maintain and support community pharmacies as the most appropriate primary providers of health care to the community through optimum therapeutic use of medicines, medicines management and related services.

The Guild welcomes the opportunity to provide comment on the Review of the Unit Pricing Code.

We note that the objective of the Code was to support Australian households to save time and money and increase price competition in the grocery market. We note that the pharmacy market is very different to that of the grocery market and to impose a mandatory Unit Pricing Code will cost much more than it will benefit consumers.

2. EXECUTIVE SUMMARY

We note that the Code is scheduled to sunset on 1 October 2019. We do not believe that there is an economic case for the community pharmacy market to be included in the Code. We would even recommend that medicines and other health care products sold in grocery should be exempted in the Code. Unit Pricing has the potential to send the wrong message to consumers and they may purchase medicines inappropriately or in larger quantities than is clinically required leading to misadventure and harm.

Unit Pricing is inconsistent with Quality Use of Medicines principles and all medicinal and health care products should be included in the Code's exemption list.

The Pharmacy Guild of Australia do not believe that Unit Pricing Code of Conduct should include community pharmacy for the following reasons:

- Community Pharmacies are not grocery shops. The goods and services provided are not ordinary items of commerce.
- By definition grocery items are typically non-durable, purchased frequently and not consumed at a retail site. This definition is not applicable to community pharmacy.
- Pharmacy is predominately a health care provider not a grocery retailer.
- Consumers that base purchasing decisions on unit price for medicines and health care products may make poor purchasing decisions that may have undesirable health and safety outcomes.
- Due to the inherent danger of medicines when used inappropriately, unit pricing is inappropriate for community pharmacy and would be misleading for the majority of pharmacy products.
- The average pharmacy is 236 square metres compared to the minimum limit at which the Code applies for grocery (ie 1000 square metres).

- The average weekly grocery bill for a family is $176 but data from the Household Expenditure Survey for 2015-16 indicates households spend on average only $16.92 per week on medicines, pharmaceutical products and therapeutic appliances.[1]

- Pharmacies do not sell the minimum range of food-based grocery items.

- Pharmacy business on average is split between dispensary (i.e. dispensing prescriptions of S3, S4 and S8 medicines) and "front shop" (i.e. a range of first aid, medicines, vitamins, complementary medicines and beauty items). The split between the two is on average 63% for prescription and 21% for front shop.

- The cost of implementation would be greater than the benefits.

- The objective of Unit Pricing was to increase price competition in the grocery market. Community pharmacy is not grocery. There are 4 main grocery retailers by market share in Australia: Coles, Woolworths, IGA and Aldi. There are 5,723 PBS registered pharmacies in Australia and there are restrictions on how many pharmacies a pharmacist can own under state legislation so there is already competition in the pharmacy market.

- Non-supermarket food retailers such as butchers, fruit shops and convenience stores do not typically meet the Code's criteria and neither do pharmacies.

- We believe that any medicine or device registered by the TGA on the ARTG (Australian Register of Therapeutic Goods) should be exempt from the Code irrespective of where it is sold to avoid inappropriate consumer choices.

The Discussion Paper states that:

> *Drawing upon the conclusions of the Post-Implementation Review in addition to the relatively low levels of complaints received by the ACCC, there is reasonable evidence to suggest that the Code is assisting consumers in informing their purchasing choices.*

We do not accept that the relatively low levels of complaints received by the ACCC is reasonable evidence to suggest that the Code is assisting consumers. As is commonly argued in medicines evaluation *"Absence of evidence is not evidence of absence".*

Just because consumers are not complaining about something does not give any indication of their opinions. Consumers may be:

- reading the Unit Price and have nothing to complain about; or
- ignoring the Unit Price and have nothing to complain about; or
- reading the Unit Price, noticing that its incorrect but cannot be bothered to complain; or
- looking for the Unit Price, noticing that its missing but cannot be bothered to complain.

We would be interested to know of any research that the Treasury has done to show the percentage of consumers that take notice of their everyday grocery prices. For example: if a 3 litre carton of milk that they buy regularly for their family is $3.00 and has always been $3.00 for as long as they remember do they really notice? Often consumers will purchase milk and other grocery products not based on the cheapest price per unit but maybe, based on the brand that they believe gives dairy farmers a fair farm-gate price or a brand that is grown and processed in Australia.

[1] Source: Australian Bureau of Statistics, 6530.0 - Household Expenditure Survey, Australia: Summary of Results, 2015-16

In addition we would be interested to know if the price on the shelf label is really what is scanned at the checkout and the number of complaints received by the ACCC on this issue. Has Treasury or ACCC done any surveys of this kind to evaluate the accuracy of shelf labels vs scanned prices? Have they done any surveys to evaluate the accuracy of the Unit Price to ensure that calculation and units are correct?

Anecdotal evidence would suggest that many consumers do not request/take the receipt when purchasing groceries so one has to question if they are really monitoring prices when buying their weekly groceries.

We note that the Treasury has a Consumer Survey on its website for the Unit Price Consultation[2]. We would suggest that the results of this survey should be interpreted with caution as they will be subject to selection bias. Many consumers would not even know the existence of this survey. The only consumers that do know of the existence of this survey would be those that have a particular interest in Unit Prices and this will no doubt skew the results. Consumers that do not care about or notice Unit Prices are unlikely to take part in the survey to indicate their lack of interest.

We would suggest that the Treasury could obtain a less biased view of consumer attitudes if they were to conduct the survey by interviewing a sufficient number of consumers from a sufficient percentage of the four major grocery chains as they exit a grocery store. Treasury could also do a survey on the number of consumers who kept their receipt and could recall the shelf prices was the price scanned at the checkout.

We would highlight the research done by Mortimer and Weeks[3] that suggest a large proportion of shoppers simply do not understand it, use it or even see it. Their research suggest that shoppers have simply forgotten about the Unit Price printed on shelf labels.

Furthermore, research by Bogomolova and Louviere[4] found that consumers largely ignored the unit pricing, instead using the main selling price to guide their choices. The main finding from their simulated choice experiment was no difference between the group who saw the unit price information and the group who did not see it with the brand choices they made. This finding suggests that the group who saw the unit pricing information may have still largely relied on the main selling prices to guide their choices, not the unit prices. Bogomolova and Louviere suggest that there is a disparity between what consumers actually do and what they think they do. 31% of the sample who were shown the unit pricing could not recall even seeing it. Perhaps more interesting is that 45% of participants who were not shown the unit pricing reported seeing it, and of those, 63% claimed that they used (the non-existent) unit price information in their choices.

We would also suggest that some consumers are very brand loyal when it comes to certain products and they will purchase their favourite toothpaste, washing powder or coffee brand irrespective of the price or the Unit Price[5]. This loyalty to brand names is well known in the pharmacy sector where some consumers will never elect to have a generic brand of a medicine dispensed even when the Brand Price Premium is quite large. The placebo effect is very real and it has been shown that Brand Names increase the placebo effect of active drugs[6].

[2] https://consult.treasury.gov.au/market-and-competition-policy-division/grocery-unit-pricing-consumer-survey/
[3] https://theconversation.com/unit-pricing-saves-money-but-is-the-forgotten-shopping-tool-61379
[4] https://theconversation.com/unit-pricing-is-smart-shopping-practice-but-do-consumers-care-8414
[5] https://www.inc.com/geoff-smith/millennials-becoming-more-loyal-in-era-of-consumer-choice.html
[6] https://www.psychologytoday.com/au/blog/minding-the-body/201510/generic-drugs-live-down-expectations

The Deloitte Mobile Consumer Survey 2018[7] states that *"since 2016, the rate of increase in smartphone penetration has tapered - 89% of surveyed Australians now own a smartphone, up from 88% in 2017 and 84% in 2016. In last year's edition of the Mobile Consumer Survey, we suggested the maximum penetration rate for smartphones would lie between 90% and 95%; we are still just shy of that range".*

Given that the majority of consumers have a smart phone we would suggest that if Unit Prices were not displayed the consumer could easily calculate the Unit Price on their smart phone. In fact consumers could even compare the price on a competitor's website using their smart phone.

3. PHARMACY LANDSCAPE

We note with interest that one of the reasons for the introduction of Unit Prices into the grocery market was to increase competition. However, the discussion paper states that Coles and Woolworths in 2012 had a fairly substantial share of the market with approximately 31 and 40 per cent of the grocery market. We also note that Table 1 in the discussion paper shows that the structure of the grocery market in 2018 has remained similar to that in 2012. So it could be argued that the introduction of Unit Pricing did not change the grocery market in Australia.

It is also noted that some retailers had already implemented a unit pricing scheme or had planned to implement one. So one has to wonder if it was really necessary for the Unit Pricing Code to be implemented when competitive forces in the market would have led to its implementation without the Code.

The discussion paper states that *"Non-supermarket food retailers such as butchers, fruit shops, and convenience stores do not typically meet the Code's criteria for having to display unit prices".* Likewise we would strongly argue that pharmacies do not meet the Code's criteria for having to display unit prices.

We note that the total costs of implementation reported by major retailers amounted to no more than $27 million. This cost would be a huge impost on small businesses such as community pharmacies in the current fiscal climate and would be very difficult to justify. The average community pharmacy is a small business that does not have the resources nor space to completely redesign and re-fit its shelf labelling systems to include a Unit Price. There is also the ongoing costs to maintain the database for Unit Pricing which is considerable for the pharmacy sector as it cannot all be done from "head office".

The discussion paper states that:

> *"households that actively use unit prices would only need to benefit by 32 cents per week, on an average weekly grocery bill of $176, for the benefits to outweigh its costs. The 2012 review did note, however, that benefits are difficult to quantify and different households are likely to benefit differently and in ways that cannot be easily monetised."*

We would highlight that data from the Household Expenditure Survey for 2015-16[8] indicates households spend on average only $16.92 per week on medicines, pharmaceutical products and therapeutic appliances. It is clear that the cost of implementation would outweigh the benefits.

[7] https://www2.deloitte.com/au/mobile-consumer-survey
[8] http://abs.gov.au/household-expenditure

Online Sales

We agree that if a grocery store also sells its products online then it should be subject to the code. However, we would repeat that wherever medicines or health products that are registered on the ARTG are sold they should not be subject to the Code.

As part of the Fifth Community Pharmacy Agreement the Research and Development Program[9] undertook the Consumer Needs Project. A Community Survey was designed and administered to a sample of 3000 consumers' representative of the Australian population aged 18 years and over. Key findings of the survey include:

- 49% of participants reported their last visit to a pharmacy had been in the last week and 82% of participants reported going to the same pharmacy for most of their pharmacy needs (i.e. more than 75% of the time).
- 35% of participants reported that they seek health advice on the treatment and management of health conditions at their community pharmacy. When participants were asked where they would go in the first instance for future advice/information on minor ailments or chronic conditions, 51% chose their pharmacist.
- 16% of participants reported going to their pharmacy in the first instance 'always' or 'most of the time' for information on prescription medicines. When participants were asked where they would go in the first instance for future advice/information on prescription medicines, 65% chose their GP.
- The four leading factors impacting participants' choice of pharmacy were: convenience (59%); knowing and trusting the pharmacist/staff (18%); cost (14%); and good service (6%). Convenience was the leading factor across all age groups. For participants below the age of 50, the second most important factor was cost, while for participants 50 or older, the second most important factor was the interaction or relationship they had with the pharmacist.
- 90% of participants reported being satisfied with the interaction they had with their pharmacist (based on the last three visits to the pharmacy), with satisfaction shown to increase with age, and higher among females and those taking one or more medicines. The main reason for satisfaction was that the pharmacist is knowledgeable and provides good advice (51%).

The results of this survey show that whilst pricing is one factor impacting participants' choice of pharmacy the more important aspects were convenience and pharmacy staff. Pharmacies are providers of health care services and should not be compared to supermarkets.

As part of the Pharmacy Guilds Community Pharmacy 2025[10] project Orima Research did a survey of 2,500 patients.

Of interest from this research it was shown that:

- 36% said cost was the most important factor when choosing a pharmacy, followed by convenience (proximity) at 33% - (expertise 13% and personalised service 13%). Three-quarters of patients said they are primarily cost or convenience driven
- 50% of patients surveyed said they used a single pharmacy for dispensed medicines, OTC and front of shop products and services
- For dispensed medicines specifically, 62% of patients reported using one pharmacy in the last 12 months

[9] http://6cpa.com.au/resources/fifth-agreement-rd/consumer-needs-project/
[10] https://www.guild.org.au/about-us/community-pharmacy-2025

- Over 53% described themselves as entirely satisfied with pharmacies overall in the last 12 months
- Patients don't feel safe buying prescription medicines online – they still value the face-to-face experience. It is about a perception of safety.

Pharmacy vs Supermarkets

The discussion paper states the following for the supermarket

Major Company	2012 Estimated Market share	2018 Estimated Market Share
Coles	31 per cent	30 per cent
Woolworths	40 per cent	38 per cent
Independent Grocers of Australia (Metcash Trading Limited)	7 per cent	7 per cent
Aldi	4 per cent	10 per cent
Total	82 per cent	85 per cent

Pharmacy ownership numbers by banner groups or independent [11]

	TWC*	CWH **	Priceline	Amcal	Chemsave	DDS ***	Other Banner	Not Identified	Total
ACT	3	4	7	1	6	2	37	20	80
NSW	70	93	121	48	70	39	496	993	1930
NT	3	5	1	8			9	14	40
QLD	101	77	73	28	33	52	391	377	1132
SA	103	24	26	15	3		103	153	427
TAS	13	13	8	13		3	54	52	156
VIC	57	152	73	73	33	16	411	540	1355
WA	53	23	24	20		19	234	283	656
Total	**403**	**391**	**333**	**206**	**145**	**131**	**1735**	**2432**	**5776**

*TWH – Terry While Chemart
**CWH – Chemist Warehouse
***DDS - Discount Drug Store

[11] The Pharmacy Guild of Australia

4. PHARMACY WHOLESALERS (CSO)

Pharmacies source most of their stock from CSO wholesalers. A “CSO distributor’ is a pharmaceutical wholesaler that is eligible under the CSO Funding Pool. The aim of the CSO Funding Pool is to ensure there are arrangements in place for all Australians to have access to the full range of PBS medicines, via their community pharmacy, regardless of where they live and usually within 24 hours.

The CSO Funding Pool financially supports pharmaceutical wholesalers to supply the full range of PBS medicines to pharmacies across Australia, regardless of pharmacy location and the relative cost of supply.

Under these arrangements, payments are provided directly to eligible wholesalers (known as CSO Distributors) who supply the full range of PBS medicines to any pharmacy, usually within 24 hours, and that meet compliance requirements and service standards. These payments are over and above those made directly to pharmacists to cover the costs of supply from the wholesaler.

The CSO Distributors currently eligible under the CSO Funding Pool are:

- Australian Pharmaceutical Industries Ltd (National Distributor);
- Clifford Hallam Healthcare Pty Ltd (National Distributor);
- Sigma Pharmaceuticals Limited (National Distributor);
- Symbion Pharmacy Services Pty Ltd (National Distributor); and
- Friendly Society Medical Association Limited, also known as National Pharmacies (State Distributor).

5. SCHEDULING SYSTEM

Scheduling is a national classification system that controls how medicines and poisons are made available to the public. Medicines and poisons are classified into Schedules according to the level of regulatory control over the availability of the medicine or poison required to protect public health and safety.

Schedule 1.	This Schedule is intentionally blank.
Schedule 2.	**Pharmacy Medicine** – Substances, the safe use of which may require advice from a pharmacist and which should be available from a pharmacy or, where a pharmacy service is not available, from a licensed person.
Schedule 3.	**Pharmacist Only Medicine** – Substances, the safe use of which requires professional advice but which should be available to the public from a pharmacist without a prescription.
Schedule 4.	**Prescription Only Medicine**, or **Prescription Animal Remedy** – Substances, the use or supply of which should be by or on the order of persons permitted by State or Territory legislation to prescribe and should be available from a pharmacist on prescription.
Schedule 5.	**Caution** – Substances with a low potential for causing harm, the extent of which can be reduced through the use of appropriate packaging with simple warnings and safety directions on the label.

Schedule 6.	**Poison** – Substances with a moderate potential for causing harm, the extent of which can be reduced through the use of distinctive packaging with strong warnings and safety directions on the label.
Schedule 7.	**Dangerous Poison** – Substances with a high potential for causing harm at low exposure and which require special precautions during manufacture, handling or use. These poisons should be available only to specialised or authorised users who have the skills necessary to handle them safely. Special regulations restricting their availability, possession, storage or use may apply.
Schedule 8.	**Controlled Drug** – Substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.
Schedule 9.	**Prohibited Substance** – Substances which may be abused or misused, the manufacture, possession, sale or use of which should be prohibited by law except when required for medical or scientific research, or for analytical, teaching or training purposes with approval of Commonwealth and/or State or Territory Health Authorities.
Schedule 10 (previously Appendix C).	**Substances of such danger to health as to warrant prohibition of sale, supply and use** - Substances which are prohibited for the purpose or purposes listed for each poison.

Whilst only Schedule 2, 3, 4 and 8 medicines can be supplied through pharmacies there are many health related products that are not sold in supermarkets and only provided through pharmacies. These are such things as particular brands of complementary medicines, first aid devices and bandages. Any non-scheduled medicine sold in either a supermarket or a pharmacy should be exempt from unit pricing.

6. AUSTRALIAN REGISTER OF THERAPEUTIC GOODS

The Therapeutic Goods Administration (TGA) is responsible for regulating therapeutic goods including prescription medicines, vaccines, sunscreens, vitamins and minerals, medical devices, blood and blood products. The TGA carry out a range of assessment and monitoring activities to ensure therapeutic goods available in Australia are of an acceptable standard with the aim of ensuring that the Australian community has access, within a reasonable time, to therapeutic advances. Almost any product for which therapeutic claims are made must be entered in the Australian Register of Therapeutic Goods (ARTG) before it can be supplied in Australia.

In relation to the evaluation, assessment and monitoring done by the TGA, therapeutic goods are broadly defined as products for use in humans in connection with:

- preventing, diagnosing, curing or alleviating a disease, ailment, defect or injury
- influencing inhibiting or modifying a physiological process
- testing the susceptibility of persons to a disease or ailment
- influencing, controlling or preventing conception
- testing for pregnancy

So whilst a medicine may be Schedule 2 and can only be sold in a pharmacy (eg ibuprofen), smaller pack sizes of ibuprofen are exempt from scheduling and can be sold in any retail outlet such as a supermarket.

We note that the Code has a list of grocery categories that are exempt from unit pricing and these are outlined in Part 3 of the Code. Part 3 (10) (t) lists “cigarettes and other tobacco products, including nicotine replacement products”. We assume that cigarettes are included as an exemption to the Code as they are addictive and to sell such products on a Unit Price would encourage consumers to purchase large amounts.

Likewise we would argue that if cigarettes and other tobacco products are exempt from the Code of Conduct then all medicinal and health devices registered on the ARTG should also be exempt from the Code of Conduct. No ARTG listed product should have the Unit Price displayed irrespective of where it is sold.

Consumers should never be presented with ARTG listed products that have unit prices such as those above. Consumers may be influenced to purchase one paracetamol product over another when in fact the Panadol Extra contains caffeine and is not equivalent to Panadol Rapid, which is not equivalent to Panadol Optisorb.

7. QUALITY USE OF MEDICINES

Quality Use of Medicines (QUM) [12] is one of the central objectives of Australia's National Medicines Policy.

QUM means:

- Selecting management options wisely;
- Choosing suitable medicines if a medicine is considered necessary; and
- Using medicines safely and effectively.

The definition of QUM applies equally to decisions about medicine use by individuals and decisions that affect the health of the population.

The term 'medicine' includes prescription, non-prescription and complementary medicines.

The following is an example of how QUM can be applied:

At an individual consumer level, the application of QUM to the management of medical conditions assists in the identification and implementation of:

- Methods to select and communicate the most appropriate medicine or non medicine option from all available prevention and treatment options, so that the individual gains optimal, cost effective health outcomes; and
- Methods to monitor the outcome of the selected treatment option, to allow rapid modification according to response, so that optimal health outcomes are maintained over time.

At a community level, the National Strategy for QUM provides a guide to the development of these methods by outlining evidence-based steps that:

- Facilitate the development of processes and resources that allow the identification, selection and effective implementation of both non-medicine or medicine prevention or treatment options, which best meet the individual needs and management objectives of the consumer, health care professional and community;
- Can be used to develop educational and information materials to support health care professionals and consumers in the selection and use of medicines according to appropriate individual needs and management goals; and
- Can be used to construct an evaluation framework, which allows the continued monitoring of the selected treatment option against health goals, and processes to reassess choice according to these outcomes."

We believe that Unit Pricing of any good registered on the ARTG will send the wrong message to consumers who may be unduly influence by the Unit Price and could purchase products that are not appropriate for their condition or they may be tempted to purchase products in excess of what is clinically appropriate leading to waste or misadventure should they be taken accidently by children or taken in overdose.

[12] http://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-quality.htm

Pharmacy

The *Report of the Australian Competition and Consumer Commission (ACCC) inquiry into the competitiveness of retail prices for standard groceries 2008* recommended the introduction of a mandatory, nationally consistent unit pricing scheme. We note that original impetus to introduce a Unit Price Code was for grocery and not pharmacy.

The Price Code is mandatory for store-based grocery retailers who sell the minimum range of food-based grocery items and have a floor space greater than 1000 square metres. We would point out that the average size of a community pharmacy in Australia is 239 square metres and therefore even if the Code was extended to pharmacies there would be very few pharmacies greater than 1000 square metres.[13]

The Code is mandatory for online retailers who sell a minimum range food-based grocery items online. Again, whilst there are pharmacies that operate online they do not sell a minimum range of food-based grocery items.

The Unit Price for a grocery item must also be prominent. This would be difficult for pharmacies to implement as the size of shelf labels used in the pharmacy sector do not allow for inclusion of a Unit Price unless all the shelf stripping and price labels were re-fitted. This would be an enormous cost impost for the small businesses such as community pharmacies for little consumer benefit.

An example of price labels used in pharmacy:

[13] https://www.guild.org.au/resources/guild-digest

8. POST IMPLEMENTATION REVIEW 2012

We note that a Post-Implementation Review of the Code was completed in October 2012[14].

We highlight the following in this review:

- *Unit pricing is likely to be particularly relevant where the nature of a product means that consumers are more focussed on the quantity price of a grocery item rather than other attributes (page 15)*

  Guild comment: This is of particular concern with health products as this could lead to consumers being more focussed on the Unit Price of a health product rather than Quality Use of Medicines principles. The cheapest Unit Price product is often not the most appropriate for a consumers health condition.

- *Broad definitions of products as well as varying interpretations of the Code have led to the inconsistent application of unit prices on some items to the confusion of consumers. (page 17)*

  Guild comment: Due to the nature of many of the unscheduled health products sold in pharmacies, inconsistent application of unit prices could lead to confusion for consumers.

- *For many grocery items, unit prices decline with package size—which in part represents the economics of packaging or forms of second degree price discrimination—but this relationship does not hold universally. (page 7)*

  Guild comment: Where unit prices decline with package size for healthcare products this could encourage consumers to buy inappropriate amounts of these products that are unnecessary or even dangerous. Health items should be purchased with Quality Use of Medicines principles in mind rather than unit price. If consumers purchase large quantities of items such as paracetamol that are in excess of therapeutic need it could lead to misadventure, misuse or abuse.

- *A submission by academics from the Ehrenberg-Bass Institute (University of South Australia) and CenSoC (University of Technology Sydney) outlined the results of a simulated choice experiment conducted in Australia. (page 11)*

  Guild comment: We note that the simulated choice experiment did not find a difference in the choices made by the respondents exposed to unit prices and those made by the respondents who did not have unit prices.

14 https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=2ahUKEwjCkpWN84LgAhUbU30KHWCnAfEQFjAAegQIARAC&url=https%3A%2F%2Fwww.choice.com.au%2F-%2Fmedia%2Fdac0c5172feb4857914b08cabeade490.ashx&usg=AOvVaw3TCxRD6Oyl5N_iBYMhMkbj

- *Unit pricing is likely to be particularly relevant where the nature of a product means that consumers are more focussed on the quantity price of a grocery item rather than other attributes. This may be particularly relevant for homogeneous grocery items where consumers do not differentiate between grocery items based on brand or perceived quality. (page 15)*

  Guild comment: We believe that unit pricing may be suitable for homogeneous grocery items but pharmacy is not grocery and Quality Use of Medicines principles should be the primary consideration. Healthcare products are not "homogeneous grocery items" and should be exempt from the Unit Pricing Code irrespective of where they are sold.

- *The submission by Oppewal, Yao and He of the Department of Marketing at Monash University explores under what circumstances consumers were most likely to be influenced by unit prices. It is suggested that unit prices were more likely to be influential where consumers are under time pressure, where consumers are less likely rely on other information presented on the packaging and where consumers have an existing understanding of what unit prices represent. (page 15)*

  Guild comment: We believe that a consumer should not make purchasing decisions on health care products if they are under time pressure or less likely to rely on important information on the packaging. When purchasing a health care product the consumer SHOULD be relying on the information presented on the packaging to ensure that the product is appropriate and if they have any doubts they should ask pharmacy staff for assistance or healthcare advice.

- *The Queensland Consumers Association (QCA) raised the possibility that some consumers may have incurred additional costs due to the wastage associated with relying on unit prices without consideration of the quantity needed. (page 15)*

  Guild comment: We believe that health care products should be purchased in quantities relevant to the condition being treated taking into account Quality Use of Medicines principles and not based on price per unit. If consumers were to see a price per unit they may be adversely influenced to purchase inappropriate quantities.

  For example: paracetamol is Schedule 2 (Pharmacy Medicine) but there is a scheduling exemption (ie can be sold outside a pharmacy) when:

  a. in tablets or capsules enclosed in a primary pack containing not more than 100 tablets or capsules except in tablets or capsules each containing 500 mg or less of paracetamol as the only therapeutically active constituent (other than phenylephrine and/or guaiphenesin or when combined with effervescent agents) when:
     i. packed in blister or strip packaging or in a container with a child-resistant closure;
     ii. in a primary pack containing not more than 20 tablets or capsules;
     iii. compliant with RASML requirements;
     iv. not labelled for the treatment of children 6 years of age or less; and
     iv. not labelled for the treatment of children under 12 years of age when combined with phenylephrine and/or guaiphenesin

When the ACMS discussed a change to the paracetamol scheduling at its meeting in March 2016[15] they noted that:

- The risks of paracetamol are well known. Paracetamol is involved in deliberate self-poisoning and is the single most commonly used drug in overdoses leading to hospital presentations. Risks from overdose – either deliberate or accidental – can include severe and life threatening hepatotoxicity. The benefits include when used according to label instructions, and for short duration, paracetamol has analgesic properties and provides relief of mild to moderate pain.

Well known concerns with toxicity when involved in deliberate or accidental poisoning (The Daly, et al., MJA paper referred to in the submission states that paracetamol is the single most commonly taken drug in overdoses that lead to hospital admissions.)

- Common (>1%): Hepatotoxicity (including increased aminotransferases). Rare (<0.1%): hypersensitivity reactions, neutropenia, thrombocytopenia, pancytopenia, acute hepatitis.

- Paracetamol is currently available to patients in packs of 100 tablets/capsules and 50 sachets of granules. Available in packs larger than 100 tablets/capsules. There is an upper limit to dosage of paracetamol, generally 4 g per day. For 500 mg tablets this represents a maximum 8 tablets/day in divided doses. Doses are generally on an "as required" basis. Other formulations of paracetamol include liquids, suppositories (S2) and injections (S4). There are also some products containing paracetamol in combination with other agents, (e.g. codeine, cough & cold substances) and pack size of these is controlled.

Given the known dangers of paracetamol we strongly recommended that all medicines should be exempt from the Unit Pricing Code as this could encourage the purchase of large quantities of medicines eg such as paracetamol that are dangerous in overdose.

- *The QCA further commented that the ACCC should be more actively monitoring compliance with the Code, rather than relying on consumer complaints. (page 17)*

  Guild comment: As mentioned earlier we do not believe that relying on consumer complaints is a valid metric to gauge the acceptance, appreciation or the benefits of unit pricing.

- *The benefits of unit pricing for consumers are difficult to quantify. It should be noted that the benefit of unit pricing to an individual consumer is not necessarily equivalent to the savings made by purchasing cheaper groceries. Consumers may benefit from lower expenditure on grocery items, however they may also benefit by receiving a greater amount of a grocery item for the same price. (page 20)*

  Guild comment: If the benefits of unit pricing for consumers are difficult to quantify for groceries, we would question why it should be extended to pharmacy. We would also question the premise that receiving a greater amount of a medicine or health care product is necessarily beneficial or indeed safe. We would strongly argue that medicines are not normal items of commerce and should not be considered as grocery items.

[15] https://www.tga.gov.au/book-page/36-paracetamol

The independent Review of Pharmacy Remuneration and Regulation noted: "PBS medicines are not normal items of commerce".

Pharmacists should be able to focus their time on providing professional care and advice to patients about their medicines, competing as health professionals based on the quality of service and care rather than per unit prices.[16]

- *Given the difficulties in quantifying the consumer benefits, it may be useful to examine the costs relative to each household or shopping trip. There are a total of 9,117,033 households in Australia with an average of 2.6 persons per household. Based on estimates of annual grocery industry revenue of $83.7bn, each household spends approximately $9180 per year, or $176 per week on groceries. By way of comparison, for a unit pricing scheme with an annual ongoing cost of $15 million dollars, the average household would need to benefit by the equivalent of approximately 3.2 cents per week for the annual cost to equal the total annual consumer benefit. For an ongoing annual compliance cost of $1 million dollars, the average household would only need to benefit from the equivalent of 11 cents per year. (page 24)*

  Guild comment: The above analysis also does not fully account for the opportunity costs faced by pharmacists and their staff in complying with the code – that is, the opportunity cost of the time foregone as a result of having to spend time administering the code (changing labels on shelves) instead of dispensing medicines to patients, conducting health checks and providing advice. This is an opportunity cost not only to the pharmacist but to the overall community as well because those valuable activities and services that promote health outcomes are crowded out.

  We note that data from the Household Expenditure Survey for 2015-16[17] indicates households spend on average only $16.92 per week on medicines, pharmaceutical products and therapeutic appliances. We do not believe that the average household would benefit enough to cover the costs of implementation in the pharmacy sector.

- *Because this is a worst case scenario based on conservative estimates of both the number of households benefiting from unit pricing as well as the annual costs of the Code, it is therefore difficult to conclude that the costs of the Code have outweighed its benefits over the Postimplementation Period, or are likely to do so over the life of the Code. Without an objective measure of the benefits received by consumers it is only possible to conclude that there is a reasonable probability that the benefits of the Code have outweighed the costs. As many of the costs associated with the implementation of the Code are sunk costs, it is more probable that the benefits of the Code are likely to outweigh the costs into the future. (page 29)*

  Guild comment: We note that as Post Implementation Review considered that it was difficult to conclude that the costs of implementing the Code in supermarkets have outweighed its benefits over the Postimplementation Period so we would question why Unit Pricing would be extended to pharmacy or any other sector given such equivocal cost benefit analysis.

[16] Review of Pharmacy Remuneration and Regulation Final Report, September 2017, available at: http://www.health.gov.au/internet/main/publishing.nsf/content/review-pharmacy-remuneration-regulation

[17] http://abs.gov.au/household-expenditure

9. CLINICAL APPROPRIATENESS OF PHARMACY PRODUCTS

The goods and services provided in pharmacy are not the same as weekly groceries purchased by families. Many of the health products sold in community pharmacy are for minor ailments, health conditions, health & wellbeing and it would not be appropriate for the unit price to be displayed.

Some products whilst they may appear to be similar will have different ingredients and may not be appropriate for the medical condition that a particular patient has. It would be unfortunate if consumers were influenced by unit pricing to purchase an inappropriate product simply because it was cheaper per mL or mg. Most of the products in pharmacy are not 'alternative products' as those is grocery where a bag of jasmine rice is a bag of jasmine rice but in pharmacy a non-adherent island dressing does not necessarily have alternatives and dressings are purchased on variables such as the type and size of wound.

Safety concerns

One of the primary concerns the Guild has with regards to unit pricing is the manner in which unit pricing may influence the choice of medicine purchased by consumers, at the expense of clinical appropriateness and/or safety.

To explain this concern, some examples are discussed below:

Example 1: eye drops

A patient suffers from a long-term eye allergy, and has been recommended Zaditen Eye Drops by their pharmacist. The patient uses these eye drops for several months at a time for a seasonal eye condition.

ZADITEN EYE DROPS 5mL
$15.49
$3.10 per mL

If the patient were to compare this item with other over the counter eye drops for allergies, they may feel that Zaditen from a unit pricing perspective is not cost effective.

VISINE ALLERGY EYE DROPS 15mL
$7.99
$0.53 per mL

ALBALON A ALLERGY EYE DROPS 15mL
$9.49
$0.63 per mL

NAPHCON-A EYE DROPS 15mL
$8.99
$0.60 per mL

However the unit price alone does not tell the whole story.

Firstly, Zaditen has a dosage regimen of 1 drop twice a day. The other three examples require patients to use 1-2 drops 3-4 times a day. This could equate to using four times as much of these drops than Zaditen in order to achieve the same effect. Unit pricing in this case does not give an accurate representation of the actual cost of treatment.

More importantly, there are significant clinical differences between the different eye drops for allergies. Zaditen is safe to use as a long-term treatment for allergic conjunctivitis. The other three examples, however, should not be used for more than 5 days at a time. Exceeding 5 days use results in rebound hyperaemia, a condition where the eyes become red. The risk is that consumers will be swayed by the large difference in unit price between Zaditen – which may have been recommended to them as the best and safest medicine for their condition – in comparison for other, seemingly more cost effective eye drops. The result is that patients will experience unnecessary adverse effects for this choice.

Example 2: analgesics

Paracetamol and ibuprofen are commonly purchased over the counter pain relievers. They are also available in tablets that contain the two medicines in combination. There are several brands that contain this combination.

Consider the following examples:

NUROMOL 12 TABLETS **$5.39** $0.45 per tablet	**MAXIGESIC 12 TABLETS** **$4.99** $0.42 per tablet

While the two products have the same active ingredients and appear to be similar in unit cost, this is not the case.

- Nuromol has a dosage regimen of one tablet three times a day. 12 tablets would provide up to three days of analgesia.
- Maxigesic has a dosage regimen of 1-2 tablets four times a day. 12 tablets would provide a maximum of one and a half days of analgesia.

While the price label suggests that Maxigesic is more cost effective, in reality, consumers may consider that they get better value from purchasing Nuromol. In this example, unit pricing does not provide a practical price point of reference for consumers.

More concerning is that consumers may assume that since the products have a similar unit price, they therefore have the same dosage regimen. This may result in patient harm if consumers are not careful with the differences between the two products.

Example 3: anticoagulant vs analgesic

Consumers may be tempted to purchase the aspirin based on the price per tablet but may not realise that the dose of 150 mg is used as an anticoagulant and the higher dose as an analgesic/antipyretic.

Conclusion – safety concerns

We argue that consumers who base purchasing decisions on unit price may make poor purchasing decisions that may lead to poorer treatment of their condition, or in some cases, unsafe practices.

Defining unit price for medicines

For grocery lines, unit pricing can easily be determined for most products:

- Price per weight – applicable to most products (e.g. cereal, tinned vegetables, toothpaste)
- Price per volume – applicable to liquid products (e.g. milk, soft drink, washing detergent)
- Price per unit – for items used singularly (e.g. bin liners, toilet paper)

Categorisation of the majority of pharmaceutical lines is not nearly as straightforward.

Consider the following examples.

Example: children's fever medicine

Consider the example of paracetamol for children, one of the most common products sold in community pharmacy. There are many different brands, sizes, and concentrations available to purchase, all with different age recommendations. This example focuses on three formulations from the most well-known brand, Panadol:

Panadol Children 1 Month - 2 Years Baby Drops 20mL **$6.99**	Panadol Children 1-5 Years Suspension 200mL **$15.49**	Panadol Children 5-12 Years Suspension 200mL **$18.49**

Price per volume

If we were to use a price per volume unit pricing as is common with liquid form grocery lines, the pricing would appear as this:

Panadol Children 1 Month - 2 Years Baby Drops 20mL **$6.99** $0.35 per mL	Panadol Children 1-5 Years Suspension 200mL **$15.49** $0.08 per mL	Panadol Children 5-12 Years Suspension 200mL **$18.49** $0.09 per mL

This unit pricing indicates that Panadol Baby Drops are more than three times the price of the other two formulations. However, this is not the case. Panadol Baby Drops are the most concentrated form of the three options, so the amount of medicine given per dose is lower. This is therefore not an accurate representation of value for consumers.

There is also a risk that consumers may purchase a seemingly more cost effective product (i.e. the 1 - 5 year formulation for a child less than 1, in order to save money. This creates issues around patient safety.

Price per weight (active ingredient)

If we were to instead present the price as price per amount of active ingredient, we see a very different perspective:

Panadol Children 1 Month - 2 Years Baby Drops 20mL **$6.99** $0.0035 per mg paracetamol	Panadol Children 1-5 Years Suspension 200mL **$15.49** $0.0032 per mg paracetamol	Panadol Children 5-12 Years Suspension 200mL **$18.49** $0.0021 per mg paracetamol

In this case, we can see that Baby Panadol is similar in price to the Panadol 1-5 Years, not three times price as seen in the unit per mL presentation.

However, this measurement would be confusing for customers, who would require a knowledge of pharmaceutical concentrations and potency to be able to understand the meaning of this unit pricing.

Price per unit

Another option would be to convert this to a price per unit (dose) presentation. However, given that the dosage of these medicines is dependent on the age and weight of the child, we would end up with vague comparisons.

Panadol Children 1 Month - 2 Years Baby Drops 20mL **$6.99**	Panadol Children 1-5 Years Suspension 200mL **$15.49**	Panadol Children 5-12 Years Suspension 200mL **$18.49**
$0.60 - $1.80 per dose	$0.46 - $0.85 per dose	$0.55 - $1.20 per dose

This presentation is confusing for consumers, as the price per unit will differ for everyone.

Unit pricing for medicine

The Guild strongly argues that unit pricing for the pharmacy lines is impractical and misleading for consumers. There is no logical way to present the pricing for medicines that clearly allows consumers to determine the value of a product relative to others. It will not achieve the objective of unit pricing, which is to save consumers time and money and instead may lead to confusion and harm not in line with QUM principles.

The Guild argues that the Unit Pricing Code should exempt all medicinal products and devices registered on the ARTG sold in grocery stores as this can lead to inappropriate consumer choices.

For example the following picture of a box containing an ibuprofen product could encourage inappropriate purchase and use of this product.

We would highlight that ibuprofen has a long scheduling history and for many years it was Schedule 4 (Prescription Only) medicine. A Scheduling history is available at the ACMS website.[18]

It is worth noting that whenever ibuprofen has been considered there has always been a mention of pack size restrictions as the TGA expert committee has felt that only small quantities should be sold outside of a pharmacy.

The following extract from the most recent consideration of ibuprofen highlights the issue:

> *In November 1987 the NHMRC considered a request to move ibuprofen from Schedule 4 to Schedule 2 with pack size restrictions. The committee was of the opinion that there was a place for ibuprofen outside Schedule 4. Recommendation for a new Schedule 3 entry with pack size restrictions of less than 50 tablets or capsules (200 mg).*
>
> *In May 1995, the NDPSC considered proposal for a new Schedule 2 entry for ibuprofen and agreed to a new entry. Schedule 4 entry amended. New Schedule 2 for ibuprofen in divided preparations for oral use containing 200mg or less with a recommended dose of 1200mg or less.*
>
> *In November 1998, the NDPSC considered an application for ibuprofen liquid suspension 100 mg/5 mL to be rescheduled from Schedule 4 to Schedule 2. Overall, the committee considered that a Schedule 3 classification was more appropriate for this formulation, and agreed that the Poisons Standard be amended accordingly. The committee agreed that a maximum daily dose should be stipulated, but because the proposed pack size was 200 mL (maximum of 4 g ibuprofen) a restriction on total content was not required for this classification. A new entry for Schedule 3 was agreed in undivided preparations for oral use when labelled with a recommended daily dose of not more than 1200 mg of ibuprofen.*
>
> *In May 2000, the NDPSC considered a proposal to amend the Schedule 2 entry for ibuprofen to include oral liquid preparations containing more than 20 mg/1 mL. The committee considered the safety profile of ibuprofen and that Schedule 2 is appropriate when used in analgesic dose for minor and temporary ailments for short periods. The committee was seeking consistency with divided dose formulations.*
>
> *In June 2003, the NDPSC considered a proposal to exempt ibuprofen from scheduling in divided preparations containing 200 mg or less of ibuprofen per dosage unit in packs containing 24 or less dosage units when labelled with a maximum recommended daily dose of 1200 mg of ibuprofen. The NDPSC decided to exempt ibuprofen from scheduling as requested, but with an amended maximum pack size (25 dosage units) and additional restrictions as follows: ibuprofen as the only therapeutically active constituent other than an effervescent agent; and requirements for label warnings (consistent with Appendix F warnings for Schedule 2 ibuprofen). The minutes note that the NDPSC had agreed that the schedule wording should be comparable with that of the current aspirin and paracetamol entries.*
>
> *In October 2003, following consideration of further public submissions, the NDPSC made some amendments to the label warning statements required for ibuprofen when exempted from scheduling, in particular, by adding warnings not to use the product unless advised by a doctor in children ages 6 years or less, or by people aged 65 years or over.*

[18] https://www.tga.gov.au/book-page/16-ibuprofen

In August 2010 the NDPSC considered the scheduling of paracetamol in combination with ibuprofen in June 2010. At that time, divided dose combinations containing up to 200 mg ibuprofen + 500 mg paracetamol were included in Schedule 2 (when labelled with a maximum daily dose of 1200 mg ibuprofen, and in packs of up to 100 dosage units). The NDPSC recommended, and the delegate confirmed, that the scheduling of ibuprofen and paracetamol that was current at that time remained appropriate.

In June 2011 the ACMS considered a proposal from the Advisory Committee on Non-prescription Medicines (ACNM) that the delegate/ACMS consider up-scheduling paracetamol/ibuprofen combinations (containing up to 500 mg paracetamol/200 mg ibuprofen) from Schedule 2 to Schedule 3. The ACNM had also recommended consideration of a maximum pack size for Schedule 3 paracetamol/ibuprofen combinations. The ACNM, in an assessment of an application to register a combination paracetamol/ibuprofen product, had raised concerns that the sponsor had not satisfactorily established the safety of the product, and considered that pharmacist intervention was needed to assist consumers with safe use of the combination.

The ACMS recommended that the combination paracetamol/ibuprofen products that were in Schedule 2 should be rescheduled to Schedule 3, when in packs containing 30 dosage units or less, with larger packs to be included in Schedule 4. The delegate agreed with the ACMS advice.

In February 2013 the ACMS considered proposals to reschedule paracetamol 500 mg when combined with ibuprofen 200 mg from Schedule 3 to Schedule 2 in packs containing 12 dosage units or less, and to also include Schedule 3 paracetamol when combined with ibuprofen in Appendix H. The ACMS recommended that the current scheduling of paracetamol in combination with ibuprofen remained appropriate, and that paracetamol in combination with ibuprofen should not be included in Appendix H. The reasons for opposing rescheduling to Schedule 2 included insufficient data to disprove the safety concerns with the combination, lack of evidence to support rescheduling, lack of long-term evidence of safety of the combination, potential for additive gastrointestinal side effects, potential for inadvertent misuse and no experience with use of paracetamol/ibuprofen combination products in Australia. The ACMS also considered that there were no public health benefits with inclusion of the combination in Appendix H, and that advertising could lead to inappropriate use. The delegate agreed with the ACMS advice.

In June 2012, the ACMS considered a submission to reschedule ibuprofen from Schedule 2 to unscheduled when in divided preparations containing 200 mg or less of ibuprofen in fixed dose combination with 5 mg or less of phenylephrine, in packs containing not more than 25 tablets. ACMS recommended to the delegate that ibuprofen in combination with phenylephrine should be exempt from scheduling, as requested. The delegate decided to also restrict the scheduling exemption to use for the treatment of adults and children aged 12 years of age and over.

In November 2015, the ACMS considered a submission to amend the Schedule 2 entry for paracetamol to include paracetamol when combined with ibuprofen in pack sizes of 12 dosage units or less. The ACMS recommended that paracetamol should be included in Schedule 2 when combined with ibuprofen in preparations for oral use when labelled with a recommended daily dose of 1200 mg or less of ibuprofen in divided doses in a pack of not more than 3 day supply. The delegate agreed with the ACMS and made an interim decision based on the ACMS advice. After deferring their final decision to give consideration to a late submission received during the interim decision consultation period, the delegate decided to vary their decision. In view of the dosage levels of paracetamol and ibuprofen the delegate considers it is more appropriate to limit the Schedule 2 part a) entry to 12 dosage units per pack rather than 3 days' supply packs as this would ensure the total paracetamol available in the pack would not be excessive.

In March 2017, the ACMS considered a proposal to amend the Schedule 3 entry for ibuprofen to include a modified release dosage form of 600 mg of ibuprofen per dosage unit in packs of 32 or less dosage units. ACMS recommended that the Schedule 3 entry should be amended as suggested, allowing consumers greater access to a product for pain relief that is longer-lasting than other products currently available. The delegate's final decision was to amend the Schedule 3 entry for ibuprofen to include the modified release dosage form, with an implementation date of 1 October 2017.

The above history of ibuprofen scheduling highlights the importance of pack size restrictions to support appropriate analgesic use for minor and temporary ailments for short periods. Therefore we believe that to have medicines such as ibuprofen sold in supermarkets with unit prices will undermine the Quality Use of Medicines principles that are pivotal to the scheduling policy framework.

DISPLAY REQUIREMENTS

Community pharmacy shelf labels are generally printed by the pharmacy POS software or provided by the wholesaler. There are approximately 14 software vendors in the pharmacy market and they all have varying sizes of labels.

ALTERNATE UNITS OF MEASUREMENT

We note that the Code currently also provides a list of alternative units of measurement which must be used for certain grocery items.

As explained above in “Defining unit price for medicines” section we believe that many of the health products sold in pharmacy are not appropriate for unit pricing and that the list of alternatives would be very onerous to manage in any Code.

Examples of items that would not be appropriate for unit pricing:

- Blood Glucose monitoring
- Blood pressure machines
- Shower Chairs
- Ring Cushions
- Walking sticks,
- Inner soles
- Syringes and medicine measures
- Pill boxes
- Bandages and support stockings
- Asthma spacers
- Ear plugs – silicon putty vs foam – one is for sound , one is for swimming

Blood glucose monitoring and the associated strips which are not interchangeable with different testing machines do not lend themselves to unit pricing.

Blood pressure monitors are sold as one unit but are sold on the features such as memory rather than unit prices.

Bandages are sold on their inherent properties to treat particular wounds rather than on square centimetres or number of plasters contained in a box. These are not scheduled items and do not lend themselves to Unit Prices. To include Unit Prices on bandages would not provide consumers with any useful information and may indeed provide information that may confuse consumers or encourage the purchase of inappropriate products for the particular wound that they have.

A consumer faced with a selection of non-scheduled medicines used for ear ache should purchase the product based on their particular condition rather than the price per mL. Not all products are interchangeable and if in doubt the consumer should ask the pharmacy staff what is most appropriate for their particular condition. Ear wax impaction and swimmer's ear are different conditions and require different treatments.

3.3 EXEMPTIONS TO THE CODE

We note that Part 3 “Exempt grocery categories and alternative units of measurements” lists the categories of items that are exempt from unit pricing.

We note that cigarettes and other tobacco products including nicotine replacement products are exempt from the Code.

We would therefore recommend that all medicines and devices listed on the ARTG should be exempt from the Code.

10. CONCLUSION

Community pharmacies are healthcare providers, not retail grocery outlets. They are also small businesses. Unit pricing in pharmacy is uncecessary and inapprorpriate.

As outlined in this submission the Guild does not believe that imposing Unit Pricing in pharmacy is cost effective as it will cost considerably more to implement and maintain in community pharmacies, compared to the benefit it will achieve.

We highlight that products supplied in pharmacy are very different from those sold in grocery outlets. Medicines are not general merchandise and there is complexity in applying unit pricing to medicines. The proposal to apply unit pricing to pharmacy is based on a misconstrued premise that pharmacies are grocery outlets when they clearly are not. Community pharmacies are primary health care providers, owned and operated by pharmacists who are registered health practitioners.

In addition, there are potential risks in encouraging consumers to be making their product comparison decisions in pharmacies based on unit prices (both in terms of individual products which may have subtle differences that can impact their health and also encouraging purchases of larger than necessary quantities with the potential health impacts entailed). Therefore, health care products should not be sold with a unit price as this is likely to mislead consumers to make incorrect purchasing decisions.

In conclusion, the Guild recommends that unit pricing should not be applied in pharmacies and that any product that is registered on the ARTG should be exempt from the Unit Pricing Code irrespective of where it is sold.