C O R R E C T E D T R A N S C R I P T

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

LEGISLATION COMMITTEE

Inquiry into the role and opportunities for community pharmacy

Melbourne — 28 July 2014

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Witnesses

Dr S. Duckett, director, health program, and

Mr P. Breadon, health fellow, Grattan Institute.

Necessary corrections to be notified to secretary of committee

The CHAIR — I welcome Dr Stephen Duckett, director, health program, and Mr Peter Breadon, health fellow, from the Grattan Institute. Thank you both for being before us this morning. We do appreciate your time.

All evidence taken today is protected by parliamentary privilege; therefore you are protected for what you say here today, but if you go outside and repeat the same things, those comments may not be protected by this privilege. Today's evidence is being recorded, and you will be provided with proof versions of the transcript within the next week. Transcripts will ultimately be made public and posted on the committee's website.

I invite you now to proceed with a brief presentation of 5 or 10 minutes or so, and then we will open the hearing to questions from the committee. Thank you again for your submission and for being before us.

Overheads shown.

Dr DUCKETT — Thank you, Chair. Basically this submission builds on previous work done by the Grattan Institute looking at access to health care in rural and remote Australia. This first slide shows that there are areas in Victoria that are lower than the national average in terms of access to general practitioners. You can see that there are a number of parts of Victoria, including parts of Melbourne, where there is relatively poorer access to GPs than other Australians have. Once you recognise that, you can then ask what the ways are of improving that access. One obviously is to flood the market with more GPs. Another one is to look at what GPs do now and ask if there are things that other professionals could do that we could use as part of an immediate strategy to improve access to health care.

As part of that previous Grattan work we looked at the impact of poorer access to general practitioners, and we found — shown in this graph, which shows on the vertical axis the cost of care and on the horizontal axis access to care — as this graph shows that by and large as there are more GPs in an area the costs of a hospital admission go down. We think one explanation for that is that where there are fewer GPs people tend to go to GPs less, they tend to defer going to a GP until their problem is slightly worse and then when their problem is slightly worse they go to the hospital and it costs more to actually deal with it. That is borne out in this national study. This one also shows that when there is lower access to GPs then the rate of bulk billing goes down. Not only are there costs to the public hospital system as a result of worse access to GPs but there are also costs to the individuals.

As I said, we looked at what GPs do now that other health professionals might do. This is taken from a national survey of general practitioners. We interrogated the data to identify what we call less complex GP visits, where only one problem is being managed, where one or two medications are being prescribed and where there is no pathology or imaging, no procedures, no referrals and no other clinical treatments — what we call less complex. In this national survey we found that 19 per cent of GP visits — almost 20 per cent, almost one in every five — were of this less complex kind. About half of them were new problems; about half of them were old problems. We then asked what those less complex visits were. Some were prescription of the pill, ear infections, bronchitis, colds and so on. Obviously there were differential rates in rural and remote Australia. What we are showing there is that there are a substantial number of visits that GPs are seeing at the moment that we think could be shifted onto other professionals, including pharmacists.

Then you ask what GPs would do to fill up their time. Especially in areas where there are fewer GPs, they could see more complex visits. Rather than using their time for less complex visits, they would have more time for more complex visits and people would not wait as long to see a GP.

There was also another survey that asked GPs how they feel about how they spend their time. The question was: do you undertake tasks that could be done by someone less qualified than you? We found that almost 10 per cent of GPs — 9 per cent — strongly agree that they are undertaking tasks that could be done by someone less qualified, and 36 per cent agree with that statement. Between the two, almost half of all GPs are saying something along the lines of that they are doing tasks that could be done by someone less qualified.

When you look at the relationship between that and job satisfaction, you find the proportion of doctors who think they are doing work that could be done by others are actually less satisfied with their existing roles, and that makes sense because basically they are not using the skills they have been taught and not using their skills to the full extent, so they feel somewhat less satisfied. We have taken that to mean that the GP's life could be

improved, the patient's life could be improved and the hospital cost system could be improved if we look at other people doing some of the work of GPs.

With respect to pharmacists, what we said was that in many countries pharmacists play a much broader role than they do in Australia at the moment. There is a lot of research evidence about this, and we quoted some of it in our submission — that it is convenient for patients, it provides good quality care and it contains costs. What are some of the things that could be done? Vaccinations — a number of states have now introduced pharmacists providing vaccinations; what is called medication continuance or repeat prescriptions and also providing advice on chronic care. We said those latter two should be done only with the GP's agreement — that is, that the patient, the GP and the pharmacist should all agree about what should happen and the rules by which this should happen. We did not want to do anything that would undermine the role of the GP as central to primary care, and we wanted to support a health team rather than have pharmacists totally isolated and doing their own thing. In the submission we noted the countries which this happens in. As you can see, there is a significant number of places around the world where there is a broader role for pharmacists already. Thank you very much.

The CHAIR — Thank you, Dr Duckett. Mr Breadon, do you have any comments that you would like make to the committee?

Mr BREADON — No, thank you.

The CHAIR — Thank you very much for that presentation. I would like you to expand on that last slide you have shown us. In your submission you say that with additional training pharmacists could help reduce GP workloads, and one of those areas is around vaccinations, which you have just highlighted to us. In your submission you say that there is solid international evidence that patients benefit when pharmacists take on these roles, and you go on to highlight that in the box in your submission and speak of a number of international jurisdictions that are taking on immunisation programs. Can you tell the committee how long they have been conducting that role? Do you know?

Dr DUCKETT — I do not think any of the ones we cited have been in the last year. There are some that have been doing it for more than five years. I am not entirely sure when New Zealand started, but it is more recently. Canada and the US especially have been doing it for many, many years.

Ms HARTLAND — I have a number of questions around vaccinations. On page 8 of your submission, pharmacists as immunisers, you make a number of assertions about the reasons why immunisation rates have reduced. I think what you are trying to say is that if pharmacists were able to do them, then they would go up. But it seems to me that the issue about reductions in vaccinations is around education and parents either deciding for sometimes quite bizarre reasons not to do them or not knowing that they are available. It is not necessarily that the pharmacist cannot dispense them.

The second part of that question is that we have heard evidence from the two previous submitters about child vaccinations — the AMA does not feel that it is appropriate to do child vaccinations in pharmacies and also from Monash concern about the fact that it is not within their training to do child vaccinations. Could you speak to those issues?

Dr DUCKETT — On the last point, in Canada, for example, I think they restrict immunisation to people over five. Yes, I think there are different issues for vaccinations for older people and for younger people — children's vaccinations. With respect to the first point, yes, obviously there are a host of reasons why vaccination rates might have fallen. The scare campaigns about immunisation that the anti-vaccinators run are principally about younger kids rather than older people and so on. I do not have any evidence about why the vaccination rates have fallen, but I think obviously access and convenience might be part of that, so pharmacy vaccinations will go somewhat towards addressing the convenience argument.

Ms HARTLAND — I understand that especially children's vaccinations are done through maternal health services and community services, so access to those vaccinations is reasonably easy. I am just very concerned that you have made an assertion about access rather than about a number of other factors around why the rates have dropped.

Dr DUCKETT — Yes. But they also get access through GPs. Not all immunisation is done by maternal and child health.

Ms HARTLAND — I am aware of that.

Mrs MILLAR — I am particularly interested in the aspects of the submission which touch on collaborative chronic care management. I think in some instances some of this already happens where there is a very good interface between community pharmacists and GPs, but clearly it does not happen in all cases. I am interested in the Grattan Institute's view of how a model might be developed to enable community pharmacists to have a greater role in the management of chronic care conditions.

Dr DUCKETT — Our view is that the pharmacist and the GP should work together on this. We do not support the pharmacist taking an independent role in either chronic care management or repeat prescriptions. If you think about people with chronic disease, what you want to encourage is continuity of care and what you want to encourage is going back to the same people on a regular basis rather than making multiple visits. With medication, obviously you have the issue of scripts running out and you have the issue of ensuring that if a person's condition changes, they actually go back to the GP to have the medication adjusted or whatever. In that context you can have pharmacists who are able to monitor progress quite easily by questions and/or if necessary further consultation, but you also have the issue that as people age they end up with multiple medications. The people who are more expert than GPs in looking at drug interactions and multiple medications are in fact pharmacists.

They are very well trained in looking at what combinations of medications might not be working. So if a person with a chronic illness is seeing a specialist and is seeing the GP, they very often end up with multiple medications which might have interactive effects, and then one is given to counter the interactive effects of the other and so on. The pharmacist should be very good at managing that and then saying, 'Well, hang on, should they be taking all these?', and having the authority to talk to the GP about changing some of those medications. But as I said, we think it needs to be done as part of a team arrangement. Some have suggested that that team arrangement should involve the pharmacists being actually based in the general practice, but then you would have to think about what the revenue stream is for that. But you could also have it where there is a pharmacy nearby, and in many suburbs and in fact in rural Australia there is an ability to have a good relationship because of location.

Mrs MILLAR — Is it the view of the Grattan Institute that you need some tools to assist with the management of those relationships? Or should it be done by agreement between the professional bodies?

Dr DUCKETT — I know the Pharmaceutical Society of Australia and the AMA have recently reached an agreement, which is more a statement of intent rather than detail. In my view these things are best worked out locally because it is also a matter of trust — what does the GP trust the pharmacist to do and so on — and obviously if they have built up a relationship over decades, as many have, there would be more trust than if a new pharmacist has come into the town or whatever, so it is partly through local arrangements. Secondly, it would be facilitated if there were some systems, like if we had an electronic health record that the pharmacist could see what medications the patients were on at the GP and so on and so forth. Yes, tools would help, but it also requires trust.

The CHAIR — Mr Leane, do you have a question?

Mr LEANE — I have two if that is all right. I do not know if you can go back to the slide where you had a graph about less complex visits to GPs. I think there are two categories that are easily accepted in the position, but when it comes to bronchitis and colds and maybe even ear infections some individuals might feel that they are about to die when they have those sorts of conditions.

The CHAIR — Man flu.

Mr LEANE — Rightly or wrongly some people may feel that way.

Dr DUCKETT — My wife accuses me of that very thing.

Mr LEANE — Same as myself. If this committee has a recommendation or encourages some form of that category of less complex visit to doctors, if we try to have a push where we are actually going to see a chemist rather than going to a doctor, I am concerned about that small percentage who have symptoms and think they are going to die and they are going to die.

Dr DUCKETT — We are not suggesting that there be a barrier placed in front of patients about where they go. Patients are not good judges of whether something is serious or not. What we are saying is that we should facilitate other options, that pharmacists have the potential to take on a greater role. Pharmacists are also able to judge whether the person should go and see a doctor, and sometimes they do that. But in these particular cases we made three recommendations: one about immunisation, one about repeats — and so in that case they would have already seen a doctor — and the third one was in chronic care management where they would also have already seen a doctor. We are very much arguing that this should be done not as pharmacists having independent rights, but as pharmacists having rights which they can exercise in consultation with or as part of a team rather than independently.

Mr LEANE — Thanks for that, and I think it is a concern that we will have to work through. I think this comes under your submission around the chronic care management plan to discuss the potential for personally controlled health records and a new arrangement allowing the necessary communication between GPs, pharmacists and patients. It might take us into a whole different realm, and if it does, then I will accept that. But I have a concern about greater communication than we have at the moment where a patient goes to a doctor, a doctor gets a piece of paper out and scribbles something you can hardly read, and then that person takes it off to the pharmacist and the pharmacist can maybe read it. That is the actual communication we have now between pharmacists and GPs in what I think is a very important, critical role. How do you see that there could be an improved communication when this is the status quo?

Dr DUCKETT — In some circumstances, and this is an experience that I had myself, the GP has ordered something and we have taken it to the pharmacy around the corner and they have said, 'We do not have that, we have this. Go back and see if the GP will write another script for that'. There has been a 50-metre walk from one to another, and then the GP, in a sense without even seeing us, has rewritten the script and given us another script. There is informal communication that takes place via the patient already, and I am quite sure that there is also communication: they see each other at professional development meetings or locally they see each other in the shops or something like that. If they are nearby, there is all sorts of informal communication that can take place. What we are encouraging is more formal communication, that there is a formal arrangement, that with this patient you can do this or whatever, so that the GP's work can be extended to have more time to deal with the more complex things that only a GP can deal with.

Mr O'BRIEN — Thank you for your work and your evidence today. Just following on from Mr Leane, are we dealing with a situation where we are accepting that there is a risk in all medical advice, be it from pharmacists or otherwise, that sometimes it goes wrong and you do misdiagnose? Are you saying that there are opportunities to increase the work of pharmacists that do not adversely affect that risk of misdiagnosis, or are you saying that it is a risk that we just need to accept because that are other issues — say, no medical access at all?

Dr DUCKETT — Exactly, but we are also saying —

Mr O'BRIEN — You are saying that? I am sorry.

Dr DUCKETT — you minimise the risk by saying that the pharmacist has to work in partnership with the doctor.

Mr O'BRIEN — It is collaborative.

Dr DUCKETT — Yes, so in a sense you are not saying to do away with doctors altogether; what we are saying is that if the pharmacist works in partnership with the doctor, there are things the pharmacist can do that frees the GP up to do other things. So we are able to address the access for other people — providing more GP time, for example — but at a minimum risk because the GP has already seen that patient in the case of repeat prescriptions.

Mr O'BRIEN — So in the collaborative approach you see it more as better triaging across the society of — —

Dr DUCKETT — Yes, using the skills that are already out there to improve access.

Mr O'BRIEN — And to therefore enhance patient outcomes.

Dr DUCKETT — Yes.

Mr O'BRIEN — Would you be able to identify where you would consider that risks of changing the current breakup could have adverse patient outcomes and things we should be careful of treading on?

Dr DUCKETT — We started with the position that we wanted to keep GPs in the centre. I did not want to do anything — or we did not want to do anything — which undermines the role of general practice in the community. If we are trying to improve access, we do not want to do things which will alienate GPs, and then they might become less viable in rural areas or whatever. What we wanted to do was start with the position where GPs are central to primary care and then say, 'How can we actually make their job more interesting and improve access?'. That is why we said it has to be a collaborative model.

In answer to your question, if you did not go with a collaborative model — if you said, 'We want to have totally independent prescribing by pharmacists', for example — it introduces a whole other set of risks. It introduces risk of conflicts of interest, it introduces risk of there possibly not being appropriate diagnosis and so on. We said that is not a path we supported.

Mr O'BRIEN — I have noted that on page 11 you have some commentary about conflicts of interest in Canada. Could you just briefly go to the Canada provisions?

Dr DUCKETT — What we have said here is that, with respect to conflicts of interest, if we are talking about repeat prescribing, then you do not actually have the same conflict-of-interest issue because someone independently has made the decision about prescribing. In some countries they have said that pharmacists can either be prescribing pharmacists or dispensing pharmacists — you cannot be both. That is, you cannot prescribe and dispense, because that is when the conflict of interest is most acute.

Mr O'BRIEN — That is something you would recommend for Australia?

Dr DUCKETT — No. We have said that you do not need to deal with that, because if you say that the GP has to already prescribe, you do not have same conflict of interest.

Mr ELSBURY — Just in relation to the job satisfaction study you have done about undertaking tasks some doctors feel are below their qualifications, I am sure that all of us around this table have had those days where we have just gone, 'Do we really need to be doing this?', considering what we do and where we have come from and all this sort of stuff. Is that not just a little bit of, 'Build a bridge and get over it'?

Dr DUCKETT — All I can say is that I am just reporting what the GPs have said. One of the risks is that the more dissatisfied a GP is, the more they might leave the community or whatever. We are saying that there are ways of addressing that dissatisfaction by trying to increase the proportion of time they spend on things that only GPs can spend their time on.

Mr ELSBURY — Certainly also with some pharmacists, would they not look upon this as just being well below what they ever envisaged doing — that they would see this as yet another 'not what I signed up for' sort of deal?

Dr DUCKETT — I think managing chronic illness is more complex than the work they do now. Obviously every pharmacist should provide advice when they are giving out the prescriptions about how to take it and what side effects there are, so they are already providing advice; this is just expanding the nature of the advice, and it becomes more complex if they are actually much more engaged in managing multiple medications.

The CHAIR — Thank you. We are almost on 11 o'clock. I do not believe there are any further questions. Dr Duckett and Mr Breadon, could I on behalf of the committee thank you both for your appearance this morning and for your submission. The evidence you have provided to the committee has been most helpful. Thank you very much indeed.

Witnesses withdrew.