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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Witness

Dr C. Hirst.

Necessary corrections to be notified to secretary of committee

The CHAIR — I welcome Ms Christine Hirst to the committee hearing this morning. 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 the privilege. Today's evidence is being recorded. You will be provided with proof versions of the transcript within the next week, and transcripts will ultimately be made public and posted on the committee's website. I invite you now to proceed with a brief 5 to 10-minute presentation to the committee, and then the committee will have questions relating to both your submission and presentation. Thank you again for being before us.

Dr HIRST — Thank you for providing me with this opportunity to give you my views on community pharmacy. As a matter of housekeeping, I am Dr Hirst. I would like to be called that.

The CHAIR — I beg your pardon, Dr Hirst.

Dr HIRST — I was not intending to make a presentation. I have not brought an extra 10 copies of supporting evidence. I was going to use my submission and what I have prepared.

The CHAIR — That is absolutely fine.

Dr HIRST — I was not going to talk to it because I know you have all read it. I was going to leave you to ask questions of me, if that was okay. My views are well-expressed in my submission. I think I have made the recommendations clear. I would like to just take questions.

The CHAIR — Okay. Thank you very much for that. I would like to ask a question in relation to your views. You are firmly against community pharmacies expanding their role, as expressed in your submission. Could you just elaborate to the committee a little about why you have that view?

Dr HIRST — I have worked in a number of areas of health care, so I have a more global perspective on health care. I have only worked in community pharmacy for maybe two years. My experience and my observation, and it is not across every pharmacy in Victoria, is that in the very good pharmacies — that is, in the sense that the pharmacists were very well trained, very knowledgeable and knew what they were doing — pharmacists were essentially pressed for time. They did not really have enough time to do their work. They felt rushed the whole time.

I am not in favour of pharmacies expanding their role in the community. I think there are currently too many qualified pharmacists. It is very difficult for interns to get internships. When I was trying to retrain in community pharmacy I myself found it very difficult to get an internship. That might just be ageism, and that is fine, but there are many students who cannot get an internship. There are some who work for nothing, just so they can get their internship. There is an oversupply, and I think there is another institution that is going to result in more graduates coming onto the market. Personally I think there are too many pharmacists already. I think there needs to be a review of the practise of pharmacy. I think there are too many pharmacies in each suburb and that there is a lot more competition — the economics of that competition being that the pharmacists do not have enough time to actually spend with their patients.

I also feel — and these are my own personal views — that there are many complementary medicines and over-the-counter medicines that are relatively freely available in Victoria that should not be so freely available and for which there is often no clinical supporting evidence. I know that from my own experience. I can give you an example. For some reason I had to look up linseed oil. It was recommended to a patient as a source of omega 3 unsaturated acids. I never heard of linseed oil being recommended for that purpose. I only ever remember it being used for cricket bats and sealing tables. So I actually went to the manufacturer to ask for the evidence, because they are meant to hold the evidence for it, and the evidence I got was so slim; none of it was clinical evidence. Some of it was test tube evidence, and some of it was on the back of a rat. It did not really support what was being recommended. I think in our whole system there are too many medicines being consumed. I think that is borne out by data. I do not think there are enough controls on what is being recommended and also on the claims that are being made.

The CHAIR — Thank you for that. You say that you have been in community pharmacy for two years. Could you just clarify for the committee when that was?

Dr HIRST — I think it was in 2010 to 2012. I was always a registered pharmacist, but I had not worked in community pharmacy. I had worked in academia, industry and private business using my pharmacy education as very worthwhile background information. After I retired I went back to get a more general registration. I went to the pharmacy board, and I had to do the equivalent of a six-month internship in a pharmacy. I did that, and then I started to work in community pharmacy. I very clearly recognised that it was not for me.

The CHAIR — How many community pharmacies did you work in?

Dr HIRST — I worked in only two community pharmacies.

The CHAIR — Where were they located?

Dr HIRST — One was in Balwyn, and the other was in Prahran.

The CHAIR — Were they full-time positions?

Dr HIRST — No, they were not. Both of them were part-time positions.

The CHAIR — How many days a week did you work?

Dr HIRST — Two, three or four days a week. As well as doing that I am also qualified to do medication reviews in both homes and aged-care facilities, so I worked alongside a pharmacist who was similarly trained, for probably three years during this process, maybe longer. It was a part-time position again, maybe two or three days a week, going to visit aged-care facilities and assessing the medication. I took a view, having completed that, that I did not really want to do that. I found it unsatisfying. I found that it was quite difficult to get doctors to communicate with the pharmacists about the patients' needs and to get changes in their prescribing habits. You would understand that in aged-care facilities, people who are taking medication are often in their 90s and may have been on a whole range of medication for a number of years. There is a lot of evidence to suggest that that should be reduced. There is a process that has been worked out in the UK where they take them off those medications progressively to make sure that the key ones that are required are retained. It was very difficult to get GPs to communicate on that basis. Some would — one or two would — but the majority did not want to communicate about that.

Ms HARTLAND — I have one quick question and then a comment. I was interested in your views about what we call the warehouse-type chemists that are selling everything else except for medicine. What kind of controls would you think are necessary on those kinds of premises?

Dr HIRST — I am not privy to what the registration process is, but for me it does not say, 'This is a place where you go to get high-quality health care'. I know there was one in Cheltenham where I had difficulty distinguishing it from the hardware store, so I think there needs to be higher standards of inspection. I am sure there are standards of inspection on doctors' practices about what they can put out the front and how they can advertise. I think the same thing should apply to pharmacies, and I think there should be a review of advertising and promotion of the same sort of over-the-counter medicines. Every Sunday there are advertisements such as the ones in the newspaper I am holding up now, and if I go through them — which I have not had time to do — the clinical evidence to support the use of a lot of these products is highly questionable.

The CHAIR — You are saying that is your opinion?

Dr HIRST — That is my opinion, but it is also backed up by other people. I have not collected the evidence; you could collect it. The Pharmaceutical Society and the *Australian Journal of Pharmacy* regularly conduct continuing education programs. It is not every month, but some of those involve reviews of cough, cold and flu medications, and complementary medicines — "Natural" medicines. Inevitably for the "natural" medicines, it says there is little evidence to support their use – the evidence is quite "thin". It is not my view: I just go by what is written. Similarly with cough and cold medications, there is very little clinical evidence to show that they are effective or even worthwhile.

Ms HARTLAND — I also have more of a comment. On page 3 of your submission at the top you talk about 'no direct contact'. My experience with my chemist, on two occasions when my prescription was actually wrong, was that my chemist questioned it and rang my doctor. So I do not know that what you are suggesting

does happen routinely across chemists. I think there is a lot of contact between the chemist and the patient. I just wanted to make that statement.

Dr HIRST — I would support that, in that, with the pharmacy I worked at in Balwyn, when there were things wrong with the prescription — categorically wrong, such as the patient was allergic to penicillin and was being prescribed penicillin or cephalosporin — I rang up the doctor in that case, and the prescription was changed. But if you have got 50 to 150 prescriptions per day coming through, and even if they are routine prescriptions, I still think the pharmacist should be involved in giving them out, rather than the pharmacy assistant.

Mr ELASMAR — Dr Stephen Duckett, before you, spoke about repeat prescriptions provided by chemists with the GP referral. Do you believe there is a benefit for the community from this? What is your opinion?

Dr HIRST — I am not sure what the question is. Do you mean do I think it is a benefit for the pharmacist just to prescribe? Personally I think it is a good idea for the patient — —

The CHAIR — Sorry, Dr Hirst. Would you like to clarify your question, Mr Elasmar?

Mr ELASMAR — No, that is okay.

Dr HIRST — I think even if it is a repeat prescription, it is a good idea for the patient to go back to the doctor. I can quote the case of my husband, actually, who has been treated for hypertension for some time. He was overweight. He did not do anything about it for many years, but suddenly something changed in his mind, and he decided to do something about it. He spoke to his doctor, and they reviewed the medication he was taking. He lost weight, reduced his smoking and did a bit more exercise. Those are things that improve people's health enormously. As a result he is taking less medication. So I do not really believe that just because a doctor has put a patient on a prescription — on a drug — and they are getting a repeat, then they should not go back and see their doctor. I actually feel that you need to see your doctor to be counselled about that. I do not accept the other proposition. That is my view.

Mrs MILLAR — Just to pick up on Ms Hartland's point about no direct contact, questioning or advice, I would have to say that that also does tend to fly in the face of some of the other evidence we have had, where there is in fact very good interaction between the pharmacist and the GP with regard to checking.

Dr HIRST — I am telling you this is my experience. I was confined, and the pharmacist was confined, to the dispensary. Prescriptions were collected by the pharmacy assistant and handed out by the pharmacy assistant, unless it was a new medication. If there was some problem, then it definitely would be the responsibility of the pharmacist, but you would understand that there are not so many problems with prescriptions. If there were, then we would be really concerned.

Mrs MILLAR — I do appreciate that you want this to be evidence based, and that is very appropriate and significant. I am interested in your comments in respect to rural and remote Victoria, and you have written in here that you have seen in rural areas communities poorly serviced by pharmacists. Again, we have quite a bit of evidence before us to the contrary view, that in fact there is a great relationship between the rural communities and their pharmacists and that the pharmacists are held in high regard by the community and are well serviced.

Dr HIRST — Yes, absolutely.

Mrs MILLAR — So I would like to know how you have formed this particular view that the community is poorly serviced and what you are basing that on.

Dr HIRST — My view comes from when I did some reviews of health services in New South Wales, so it is not Victoria, but I do not think it is so different. In a rural area there would be a depot where the prescriptions would be left, they would be picked up by a courier and then they would be filled. The patient would think they had got a good communication with the pharmacist because the pharmacist filled the prescription, but that is not the same as the patient coming in — you see the patient and you can see that something is not quite right. I am sure they do think they have got a good relationship that exists personally, one on one.

When I was doing the reviews in New South Wales, I observed that the pharmacists were concentrated in the base, and it was very difficult to get them to move out. One of my recommendations was that pharmacists move out to the smaller hospitals and be based there regularly to see the patients. Again, those are my observations.

Mrs MILLAR — Have you worked in community pharmacy at all, in rural or regional Victoria?

Dr HIRST — No, I have not; actually I was contracted at that stage to do three reviews of provision of pharmacy services across the health service. It was a part of the contracted work, so I have not actually worked there; I have just commented on what I saw.

The CHAIR — Thank you.

Mr O'BRIEN — Just following up on that, I know some of those depot services that operate in Victoria and a friend of mine works in one. They would be said to be beneficial as opposed to having no pharmacy services in town, which is often the alternative, where people know they are going to pick up a prescription and they are going in to pick it up. You are not saying that those services should disappear in Victoria?

Dr HIRST — No.

Mr O'BRIEN — You are saying that there is limited ability to increase GP operations of those sorts of services, because I am not even sure if the employees are trained pharmacists. I know some of them, and I do not know — —

Dr HIRST — Some of them are just depot managers actually. Look, if you have got a patient who has got hypertension and you know they are smoking — you can tell it, you can probably just smell it — then it is good every time you see them to say, 'Have you thought about giving up smoking? How is your weight going? How are things going?'. It is that contact. People often do not disclose things until you engage them. I think the depot is better than nothing, but not ideal.

Mr O'BRIEN — It is not a suitable location. So talking about the co-located ones, just assuming we have got another type of premises where there is a GP, full dispensing pharmacy and also all the holistic wellness-type approaches, you have still got concerns, as I see from your comments on the ad, that there is inappropriate advice and purchasing and use of the wrong treatments et cetera in the non-medical side of pharmacies.

Dr HIRST — Yes, I was talking about over-the-counter products actually, so that was the linseed oil example I gave. This is my experience, I am just telling you what I have observed; in my experience with the over-the-counter products and the non-prescription products, when someone came in, if the pharmacy assistant could respond and provide something for that treatment, then the pharmacy assistant did, and often that information, from my experience, was based on information provided by the manufacturer and the supplier of the medication.

I go back to that point that there is often not clinical data to support many of these over-the-counter products. They are listed products, they are listed on the Register, and the requirement is that the manufacturer holds data to support the claims they make.

Mr O'BRIEN — Could I just follow up on, say, the diabetes or the preventive medicine — you said hypertension — but the concept that we have all got to be looking after our health a bit more, and assuming that you have got the centre that can dispense everything, does it become a critical question of whom you trust for advice and management of conflicts et cetera? If the pharmacists cannot provide prescription medications, they might be incentivised to send out other stuff; I do not know. Does it come down to a lot more community acceptance of the role of preventive medicine in general terms?

Dr HIRST — It probably does, and the paradigm you have described of the pharmacist being in the medical centre would be ideal, but that is very rare in Victoria. Most pharmacies are stand-alone; they might be close to a medical centre, but there is not that close interaction.

Mr O'BRIEN — Do you accept that that is the sort of place, if we are going to look at the redefinition of roles or the extension of pharmaceutical roles, that is an appropriate place to start?

Dr HIRST — Do you mean in combined medical?

Mr O'BRIEN — Yes.

Dr HIRST — Yes, I think so, but also even in the pharmacies I worked in, which I was critical of, the pharmacies provided monitoring of blood pressure and monitoring of blood sugar levels. It was really well sourced and lots of people came in asking for that to be done. People, patients, do want to manage their own health, and they are looking for some way of getting that information. It is not easy to get it from your doctor. Your doctor does a quick test or whatever, and patients tend to be a bit frightened about what the doctor is saying.

Mr O'BRIEN — Just one other thing, with your background, I see you have worked on the board of Glaxo.

Dr HIRST — Yes.

Mr O'BRIEN — Do the drug companies have a deeper role to play here that we are not identifying or that has not been identified yet in the sense of all the medical research, the competition and the patents issues?

Dr HIRST — Sorry? I do not think that is an issue; I am not sure what you are saying. I think patients do want to know more, and I think the pharmacies that provide the service of measuring blood sugar levels or measuring blood pressure often have nurses to do it. The patients would queue up before it was ready, so they would queue up in the morning.

The CHAIR — Are you saying there is a greater role for pharmacy to play in the community, for people to come in and have those services conducted because they do not necessarily want to go to the GPs?

Dr HIRST — You do not get it from the GPs, but I do not know whether it would not be better placed with the GPs if the GP had a practice nurse to do this. I am just not sure; you would need to have all the background.

The CHAIR — Certainly, but if they have not got a practice nurse, then there is a potential role, as you have witnessed, as you have said, for that pharmacy to conduct those services.

Dr HIRST — There is a need, but I did not think it was conducted as well as it should have been. Because the pharmacies are quite small, there is no area. There may be an area set aside — a very small area with just a few chairs — but it is not what I think would be the right area for taking blood samples, measuring blood pressure, communicating with the patient, giving them advice and certainly not right for vaccinations.

The CHAIR — Thank you. Mr Leane?

Dr HIRST — I have not answered the question about the drug companies, because I was not sure of what you were trying to say.

The CHAIR — Sorry, Mr Leane; 5 minutes for Mr O'Brien.

Mr O'BRIEN — Just in terms of whom we trust on the dispensation.

Dr HIRST — On dispensing?

Mr O'BRIEN — You were talking about these non-over-the-counter products that presumably are provided by someone, and then we have also got the prescribed medication provided by the Glaxos et cetera.

Dr HIRST — Are you talking about prescription products, because they are Glaxo products?

Mr O'BRIEN — Thank you, yes, prescription products versus over-the-counter, non-prescription products, and how the community ensures that it is getting the best level of care across that, and the role of the pharmacist and the role of the GP?

Dr HIRST — That is a big question.

Mr O'BRIEN — Do we need to bring the drug companies into these discussions, is what I am saying?

Dr HIRST — I actually do not think it is the drug companies. I think it is the complementary medicines, the natural medicines — —

Mr O'BRIEN — That is the problem.

Dr HIRST — I think that is the area, because for prescription products, you have to actually send data to the Therapeutic Goods Administration in Canberra, and you are monitored all the time for your claims and because of the competitiveness of the industry, people write in and complain. The prescription medicine industry is well controlled. It could be better — —

Mr O'BRIEN — Comparatively well controlled — —

The CHAIR — Thank you, Mr O'Brien. I need to move on.

Mr LEANE — I am sure there are some very good forms of communication between doctors and chemists, but I think there is one form of communication between doctors and chemists — or pharmacists — that is in the dark ages as far as scribbling out a prescription and then sending it off — —

Dr HIRST — I heard you say that, but doctors are legally meant to write prescriptions so that they are legible.

Mr LEANE — I can send you an email right now that only goes to you and that is controlled, but that is an aside. You are the only person sitting at this big table who is a professional who has worked in a community chemist. In your submission you say they are very busy and time-poor. In your experience, are the chemists you have dealt with looking for more roles? Do they want more work?

Dr HIRST — I think personally, the pharmacists dispensing do not want more work, but I think the pharmacy — the business — is looking for more work. Part of looking for more work has come about because at one stage pharmacists had to be separated by a certain distance, so there was a limit on the number of pharmacies and therefore it was not so competitive. Now it is much more competitive economically. So the pharmacies — the businesses themselves — are looking for more roles.

Mr LEANE — And the expanded roles, or the sorts of roles we are discussing now, would have to be dealt by the qualified pharmacists, not the staff?

Dr HIRST — I cannot tell you how it should be, but I know that a lot of diabetes monitoring was performed by a nurse who was contracted by the pharmacy to come in and do it. I do not think the pharmacist would do it; I am not sure. I certainly would not do it, because I have not been trained, but maybe a centre could be set up with a properly qualified nurse to do it. After you have had a vaccination you have to hang around for 15 minutes to make sure.

Mr LEANE — Thank you.

Mr ELSBURY — I am just trying to get my head around the concept that you put forward in your submission that pharmacists are putting out 50 to 150 prescriptions a day and that they are out in the backroom just doing that work and making sure all the checks and balances are done, yet you also say there are too many pharmacies. I am struggling with the concept that there is an oversupply of pharmacies and yet pharmacists are overworked. I do not get the correlation.

Dr HIRST — I am not really completely across this, but for a pharmacy to be profitable it is directly related to the number of prescriptions they do. They do other work as well, but that is a key driver. You cannot attract prescriptions, so you balance the number of pharmacists you have, according to the number of prescriptions that come in.

The CHAIR — Do you have a further question, Mr Elsbury?

Mr ELSBURY — I am just thinking about this in relation to a past experience I had in a rural setting. One township had two pharmacies, which were both owned by the same operator, who refused to bring in certain prescription medicines because he did not want to stock them. He did not see a need for it. So people were having to travel some 40 minutes down the road to the next town to be able to get their prescription.

Dr HIRST — I think that is unreasonable — —

Mr ELSBURY — A change did occur. You were right about there being a limitation on distance between pharmacies, especially within populations of certain sizes to stop there being — —

The CHAIR — What is your question, Mr Elsbury?

Mr ELSBURY — My question is: where there is an instance of pharmacists not providing all the services that people need, should there not also be the ability for a pharmacy to be established within that area, thus allowing competition to occur?

Dr HIRST — In my experience, it is not general practice for pharmacies and the pharmacist in a pharmacy not to bring in a particular medication for someone: I am really surprised by that. But profit is a big driver in pharmacy. It is almost like a conflict of interest in that the patient comes in for advice, but then the pharmacist needs to have a business transaction.

The CHAIR — Thank you. We are out of time. Dr Hirst, on behalf of the committee, thank you very much for your submission and your evidence this morning. It has been most helpful.

Witness withdrew.