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

Members

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Mr N. Elasmar	Mrs A. Millar
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Mrs I. Peulich	Mr S. Ramsay

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Staff

Secretary: Mr K. Delaney
Research Assistant: Ms S. Hyslop

Witnesses

Ms C. Hutchings, professional officer, and

Ms T. O'Hara, professional officer, Australian Nursing and Midwifery Federation.

Necessary corrections to be notified to secretary of committee

The CHAIR — I welcome Ms Trish O'Hara, professional officer, and Ms Catherine Hutchings, professional officer, from the Australian Nursing and Midwifery Federation. Thank you both for being with us this morning; we 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. 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 to proceed with your presentation for 5 or 10 minutes, and then I will open up the hearing for questions from members of the committee. Again, thank you for your submission and for being before us this morning.

Ms HUTCHINGS — Thank you for allowing us to present to the committee. Just to give you a little bit of background about the ANMF, we have a membership nationally of 225 000 nurses, midwives and assistants in nursing. The members practise in a wide range of settings across urban, rural and remote locations in public, private and aged-care sectors. We take a leadership role in nursing and midwifery by participating in the development of policy relating to nursing and midwifery practice, professionalism, regulation, education, training, workforce and socioeconomic welfare, health and aged care, community services, veterans affairs, workplace health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform. In Victoria we represent more than 70 000 members of the nursing and midwifery professions, so we believe that we are well placed to comment on these proposals.

In this presentation we are looking at nurse immunisers, medication review and rural and remote nurse practitioners. For over 10 years there have been qualified nurse immunisers who have undertaken a recognised course on immunisation, which was developed and tendered out by the Department of Health. The course was deemed necessary despite the fact that as part of their basic core education they were provided with the ability to administer medications. In the main, the change was to enable nurses who had done this particular course to possess and administer specific vaccines without a doctor's prescription. These nurses were employed in local government, and the change negated the need for a medical officer to be present for immunisations. The relevant drugs and poisons legislation was amended to reflect this practice, and it denoted the circumstances in which this could occur. At the time the department maintained or was able to obtain the list of those nurses who had completed the course.

In about 2008 we were successful in achieving the ability for this qualification to be recognised on the public register. After registration in 2010 a decision was made by AHPRA and the NMBA that additional qualifications did not need to be identified on the register. This included maternal and child health nurses and mental health nurses as well as immunisation nurses. Midwives also had their qualification recognised, but they were then given a separate register. Due to the fact that these practitioners are no longer specifically identified on the public register, figures that we have of the numbers completing the course are recent up to only a couple of years ago. We understand that at that time in excess of a couple of thousand nurses had undertaken that accredited course. The number of courses recognised by the chief health officer has increased from one to five, two of which are held here in Victoria and the others interstate. That is to allow the transfer of professionals into Victoria.

We understand that our colleagues in the pharmacy profession believe that they are well placed to provide immunisation services and have cited increasing numbers in that profession, the public value of the profession and accessibility to the community, to name but a few reasons. Currently we have a large, highly qualified group of nurses and midwives able to adequately deliver immunisations to the community via council immunisation programs, which are delivered to schools, and all immunisations on the national immunisation program to infants, adolescents and adults. So they cover the full gamut of immunisations. They can do that also through GP clinics, maternity units and specialist immunisation clinics — for example, the Monash immunisation clinic, SAEFVIC, the Murdoch immunisation clinic, the Royal Children's Hospital, refugee outreach programs, hospitals et cetera.

We are aware of pharmacies that have employed immunisation nurses to provide vaccines, and we believe that this system, along with others mentioned, provides sufficient and varied access utilising the current workforce that is work ready and at the same time is providing employment for nurses. In addition, many employer groups

provide immunisations on site, utilising immunisation agencies. They provide particularly the influenza vaccine to their staff, which was mentioned previously. During the immunisation process, nurses use their skills to identify any other possible underlying issues and refer appropriately.

Even with these last options, these services can also utilise nursing skills and expertise to provide ongoing health assessments, but only if the existing physical resources will allow it — for example, with private spaces. It is embarrassing enough as it is when you go to a pharmacy and often a member of the community is asking questions about their particular condition or ailments. You feel like you are an eavesdropper, basically. As a bystander, you are really stuck; you are overhearing their conversation, which often should be quite private.

Post-immunisation observation also needs to be conducted. This requires sufficient qualified staff as well as an area appropriate for this to occur. If pharmacies were to provide these services, even utilising nurse immunisers, it is concerning that the requirement to remain for observation for a period of 15 minutes has a secondary benefit to pharmacies in potential sales in the non-medication business that seems to have overtaken pharmacies.

We have a special interest group which is specifically for immunisation nurses. One of the concerns they raised was whether pharmacists have the time available to them to undertake and provide complex immunisation catch-ups for schools and overseas individuals; schools statements; uploading onto the Australian Childhood Immunisation Register, which goes to the age of seven; and the HPV register, which is not limited by age.

It is not just simply a process of providing the immunisation. These immunisation schedules change regularly, and I have an example of it just to show that it is quite a complex process that changes very regularly.

Overhead shown.

Ms HUTCHINGS — In the current school programs you have year 7 students having three doses of the HPV vaccination with three time frames for boys and girls; year 9 students — —

The CHAIR — Excuse me, Ms Hutchings. Some of the committee members may not be aware of HPV. Could you just — —

Ms HUTCHINGS — HPV — sorry, human papilloma virus vaccine. Boys in year 9 are having the three timed ones. In year 10 you have your diphtheria, tetanus and whooping cough vaccination for boys and girls. That changes in 2015 so that year 7 students get the diphtheria, tetanus and whooping cough vaccination for boys and girls and the HPV vaccination; for year 8 students, it is back to the diphtheria, tetanus and whooping cough vaccination; year 9 students get the diphtheria, tetanus and whooping cough vaccination and year 10 students get the diphtheria, tetanus and whooping cough vaccination. Then in 2016 it goes back to year 7 students receiving the diphtheria, tetanus and whooping cough vaccination and the HPV vaccination for boys and girls.

It is actually quite a complicated process — it is not simply just turning up — and you have to have it reported appropriately. We believe that that provides for potential errors. Given it is so complex, there is potential for the duplication of services.

In terms of medication reviews, we do know that community pharmacies in particular play a really important role, and we see this as an opportunity for pharmacists to further embrace the potential hotspots in health, and the really important aspect of that is the medication review. Other submissions have quoted the number of medication-related admissions to hospital at 230 000 Australia-wide, and the quoted figure of an average cost of $5200 per patient is quite staggering. We agree that pharmacists should be part of that solution.

The reference to the ageing population and the need for a medication review is an important one, particularly in light of the recent changes to the Aged Care Act which will see more elderly people being cared for in their homes rather than in residential aged-care facilities. Again, the services provided via a home medicines review should be increased. We believe there are a number of avenues for community pharmacies to further enhance their roles without extending their role and potentially creating a more complex, duplicated system.

Trish is now going to address the rural and remote issues.

The CHAIR — If you could briefly, thank you.

Ms O'HARA — Thank you very much. I am going to speak to rural and remote areas. The ANMF is not quite clear why the role of community pharmacies in rural and remote areas would require special attention, if you consider that Omeo really is the only designated remote area in Victoria, which is different to other states and territories. It is also clear that community pharmacies do not tend to be sited in towns where there is not a GP service provided but the number of nurses are spread densely across all the state and we have seen the development of nursing and midwifery scope of practice, particularly in relation to medications.

The first one was when the state government implemented the introduction of rural and isolated practice nurses, and they have extended education. They are situated in rural and remote areas, they have obtained their basic three-year bachelor degree and in addition to that they have an extended practice where under the Drugs, Poisons and Controlled Substances Act they are able to prescribe and dispense medicines in a particular formulary in that rural and remote hospital. Therefore they are able to provide a very efficient and effective service that addresses the needs of rural consumers — for example, a patient comes in with a urinary tract infection, the nurse does the assessment and she diagnoses within that competency that she has obtained. She is able to prescribe the antibiotic, dispense it and supply it within the hospital setting.

In addition, nurse practitioners have been endorsed in Australia for over 10 years under the Health Practitioner Regulation National Law. There are an increasing number of nurse practitioners. They are independent in their practice, they work in a collaborative arrangement with the GP but they practice independently. They are able to provide a full extended, advanced practice at a masters level and are able to diagnose, prescribe and actually treat patients within their specialty of nurse practitioner practice. They exist in not only acute public hospitals; they are in rural and remote areas, they are in primary health care centres and they are in aged-care centres and community health centres.

The role of nurse practitioner, together with the RIPN nurses with their advanced nursing skill and diagnosis and treatment, we feel has added to the growing importance of providing an equitable service for the consumer in the community.

Ms HUTCHINGS — Just finally, we know that there are 91 000 nurses and midwives registered in Victoria. They are the most geographically well dispersed of the health professions and consistently top surveys of the most respected professions. From a workforce perspective we are currently struggling in Victoria to place our new graduates, and while we cannot claim to have the youngest average age — one of the submissions did make that point — we can claim to have one of the most experienced and definitely the most cost-effective workforces, which raises the issue of where the pharmacist is going to take on these additional duties and where the costings are going to come from. Immunisation nurses just do immunisations. If they can be employed in the pharmacy, why would that not be a sensible way to utilise the current workforce that you have around the state. Thank you.

The CHAIR — Thank you very much to both of you for your presentation. I will just remind committee members that we are a bit short of time, so if they could keep their questions brief. I think you have been sitting in on the evidence all morning and you have heard various witnesses give their evidence, and you rightly highlight the school program, which is a very important vaccination program. In your submission you also suggest that the training offered to pharmacists in the Queensland vaccination trial is at a lesser quantum than that required of nurses. In that Queensland trial, are they undertaking school program vaccinations?

Ms HUTCHINGS — I do not know. I believe that trial only commenced in April and is going until December — —

The CHAIR — That is correct.

Ms HUTCHINGS — I spoke to the department but it was not aware of any of the parameters of that particular trial either, so I was not able to get that information.

Ms HARTLAND — I will go to vaccinations as well. Is an immunisation nurse able to vaccinate all age groups?

Ms HUTCHINGS — Yes.

Ms HARTLAND — So they would be regularly employed by the local government within a GP practice or — we get our flu vaccinations here.

Ms HUTCHINGS — Yes.

Ms HARTLAND — So it is that kind of work. How many nurse vaccinators are there in Victoria?

Ms HUTCHINGS — The only data we could use was the data from a couple of years ago, which was that there had been over 2000 — and I got that from the department as well — who had gone through the courses at that time. Once they stopped collecting that information, it was impossible to get.

Mrs MILLAR — I am particularly interested in the comments in relation to rural and remote Victoria. There seem to be some significant internal inconsistencies in some of the statements you have included on this point in your written submission. You did say, both in the submission and verbally today, that it is not clear why the role of community pharmacy in rural and remote areas would require special attention, but in the very next paragraph you also note that it is clear that there is some difficulty in recruiting and retaining pharmacists to live and work in rural and regional Victoria. I am aware that you have mainly pitched your submission to the issue of vaccinations and, in addressing that, that you see some potential turf conflict between what nurses are doing and what pharmacist may do, but I am sure you also accept that community pharmacists provide a much broader role and range of services than just the potential around immunisation. I am interested in your views on why you think community pharmacy does not require any special attention in rural and regional Victoria.

Ms O'HARA — We will share parts of the question. Do you want to speak to immunisation?

Ms HUTCHINGS — One of the issues is that, if there is already difficulty in recruiting pharmacists to country areas, why is there a suggestion being made that to expand the practice will somehow solve that problem? That is one of the points that was being drawn out, but clearly we did not do that very well.

Ms O'HARA — In relation to rural and remote nursing and community pharmacy, they are two different roles. Rural and remote nurses certainly provide continuity of care. It is not only about the actual diagnosis of the signs and symptoms the patient is presenting with; you also have to have that linked to the medical records so that the GP also has an understanding of what has been diagnosed and what is being treated. It is also about continuity of care, evaluation and outcomes. Did the antibiotic work? Did the patient have to go back to the hospital because they had complications or their symptoms were exacerbated? It is that continuity of care that rural and remote nurses provide, with patients having access not only to the GP but to the rural and remote nurse.

Ms HUTCHINGS — From a rural point of view, it is not a turf war by any stretch. We get it drummed into us so often about the need for cost-effectiveness everywhere. When you listen to the submissions, I think everyone agrees that if you had a GP, a dietician, a nurse — whether it be a practice nurse or a diabetes nurse educator — and a pharmacist all in the one area, particularly in rural settings, you would have the ideal situation. Then I thought that actually what we are talking about is community health. If you had a community health centre that had those services, that would be the ideal situation because you would have everyone in the one spot. That fixes up the issues of communication between health providers. You get collaboration and coordination of care. That would be the ideal. It is more about needing to have the infrastructure in place rather than just developing a role.

Mrs MILLAR — Absolutely, and I suppose that is where my question is going — that your organisation acknowledges that there is a significant role for community pharmacists to play in rural and regional Victoria and that in fact it is a question of having two groups of exceptional health practitioners providing services to a community.

Mr ELASMAR — In your submission you suggest that community pharmacies should employ nurses. Where will the funding come from, and would nurses do different jobs to pharmacists?

Ms HUTCHINGS — Completely different jobs. A nurse is not a pharmacist, nor do they set out to be. We know that last year a number of the big chains of pharmacies employed nurse immunisers to do influenza immunisations. We know it is a model that does occur. I think it was through an immunisation agency. It was not that pharmacies had to employ a nurse ongoing; it was bringing them in to do sessions of immunisations

during the peak immunisation period. I am assuming, and I do not know for sure, that the fact that people could go to the pharmacy to have their immunisation meant there was a potential benefit to the pharmacy in potential sales. I do not know how else they fund that. The vaccine is obviously purchased from the chemist, but I am not clear about the service itself.

Mr O'BRIEN — As a variation in the rural setting of the discussion you just had with Mrs Millar, looking at the RIPN scheme and the nurse's role with the pharmacy, as I understand it from your answer to Mrs Millar you support the coordinated type of community health centre, wherever they can be facilitated. Would it also be the case that you support more limited roles of nursing within a pharmacy if, say, there is no doctor around? Nurses could effectively extend into the pharmacy role for vaccinations et cetera.

Ms HUTCHINGS — I do not believe it is extending into the pharmacy; it is just providing a service they are qualified to provide in a different setting.

Mr O'BRIEN — It is both of them doing their roles in a co-located setting, without necessarily having a full medical clinic.

Ms HUTCHINGS — If you are a nurse immuniser, you do not need to have a doctor present. You do have to have access, and that can be by phone. That immunisation can then go ahead, and that can cover the full range of ages from children up.

Mr O'BRIEN — But a specific limitation, as I understand from your submission — I may be wrong — is that, to the extent to which under the RIPN scheme there is the ability for nurses to prescribe, it is through hospitals. Could there be an extension of a collaboration between nurses and pharmacies? You have that broader pharmacist role, but you also have — —

Ms HUTCHINGS — I would see no reason why. I have not actually considered it, but I understand there would not be too many obstacles. But that would be for DHS — for the department — obviously to — —

Mr O'BRIEN — It would be helpful, if possible, for you to identify whether that would be something that we could look at trialling to improve services in certain remote or rural areas where that might be possible.

Mr LEANE — Thank you for your submission. In line with Mr Elasmar, I was going to touch on that area as well. How prevalent is the engagement of immunisation agencies with pharmacies, and do you see an opportunity for that to occur more?

Ms HUTCHINGS — My understanding is that it was the two largest pharmacy chains that actually did it. I will get their names wrong, but one of the discounting pharmacies was one of them. Anyway there were two large ones, because I actually spoke to the immunisation nurses in our group and asked them about it. They said that they understood that the two groups had employed immunisation nurses to provide immunisation services this year, during that February, March, April time period, for influenza.

Mr LEANE — I find it interesting, and it is probably a good thing, that some of the things that we were looking at to expand the role of community pharmacists are already happening through that process.

Ms HUTCHINGS — Yes. And the other thing is that when you are using a nurse to come in to do an immunisation, that is all they are doing. It is not about the pharmacist having to make time to do it. They can come in for their hour, two hours or whatever and that is all they do, so their scope, their knowledge and their skill keeps abreast of all the required changes and they can focus solely on that. There is no going backwards and forwards to dispense medication for other clients who have come in and are waiting.

Mr LEANE — Sounds good. Thanks.

Mr ELSBURY — In your submission you raise some concerns about the training that is provided to pharmacists in Queensland for immunisations as compared to the training that is provided for nurses who carry out immunisations. Can you flesh that out a little bit and explain the differences in that training regime, and do we face a similar issue in Victoria?

Ms HUTCHINGS — I would really like to, but I pinched that from another submission — I think it was from the pharmaceutical society. When I looked it up, it was clear what they were identifying was that they were using a modified course, not the full course. But in the Northern Territory they are using the full course that nurses undertake. Having said that, I have spoken to the department recently in light of this and have become aware of the additional courses — —

The CHAIR — Sorry to interrupt you, but was that the Victorian department or the Queensland department?

Ms HUTCHINGS — It was the Victorian department. I asked its staff to look at our course, because our course was quite an extensive course which had a clinical placement component as well. It was not just theory, and it was not just online; it was quite a rigorous process. I have been made aware that there are a couple of other courses that have been accredited that do not have the same quantum of theory and some are online. I think the New South Wales college, which has had their course accredited by our department, does not have the same quantum of theory as the original one; it is online and there is no clinical placement. I think there is also an issue that if you are going to do a course, then a standard should be set and adapted from. They are all accredited by the department so they obviously believe they are reasonable, but there are inconsistencies in the depth of the courses.

The CHAIR — As there are no further questions, on behalf of the committee I thank you both very much for your time today. Your submission and the evidence you have provided have been most helpful.

Witnesses withdrew.