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 — 25 June 2014

Members

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Mr A. Elsbury	Mr D. R. J. O'Brien
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Chair: Ms G. Crozier
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Witnesses

Mr B. Suen, branch director,

Ms M. Lynch, Victorian branch president, and

Dr A. Roberts, director, policy and practice, Pharmaceutical Society of Australia.

Necessary corrections to be notified to secretary of committee

The CHAIR — I welcome from the Pharmaceutical Society of Australia Mr Bill Suen, Victorian branch director; Ms Michelle Lynch, Victorian branch president; and Dr Alison Roberts, director of policy and practice. I thank you for being before us this evening. We appreciate your time. All evidence taken at this hearing is protected by parliamentary privilege; therefore, you are protected against any action for what you say here this evening, but if you go outside and repeat the same things, those comments may not be protected by this privilege. Tonight's evidence is being recorded. You will be provided with proof versions of the transcript within the next week. Transcripts will ultimately be made public and will be posted on the committee's website. I invite you to proceed with a brief presentation to the committee of 10 minutes or so, which will be followed by questions by the committee until the conclusion at 9.30 p.m. I thank you again for being before us.

Ms LYNCH — Thank you for the opportunity to present tonight to the committee and to go through how the Pharmaceutical Society of Australia views how pharmacists can be better utilised to deliver better patient care. We would like to congratulate the Honourable David Davis and the Parliament for their foresight thus far in extending and testing extended roles in many of the public health services such as nurse endoscopy, physiotherapy and emergency and also for their recognition of the significant contribution that pharmacists can make.

The Grattan Institute report which was released earlier this year recognised the expertise of pharmacists, their roles and where they are located in Australia. But the role of pharmacists is far more limited in Australia at the moment compared to other countries. The opportunity exists to expand this expertise and to enhance the role of the pharmacist.

Overheads shown.

Ms LYNCH — This is a really useful diagram because it highlights what pharmacists can do. I apologise if the red pointer reflects off the TV screen. Peter Fitzgerald from the Royal Pharmaceutical Society in London used his 'Now or never — shaping pharmacy for the future' presentation in June this year to highlight the accessibility of pharmacists. In that middle component it talks about the opening hours of community pharmacy, the expertise and trusted professionalism that pharmacists display and how we are integrated as part of a broader health-care team.

We take care of people who are healthy. We look at care for people with preventive components of their health. We treat people with minor ailments. They use the term 'LTC', which means long-term conditions. We use the term 'chronic conditions' more commonly in Australia. We look after patients who have one or more conditions, along with their carers. Peter Fitzgerald discussed the future model of service provision for community pharmacists in care in the top part of the diagram, discussing healthy lifestyle options and taking care of chronic conditions and vaccinations. For the most part these things are already happening, but not in a structured and systemised way which integrates all the health-care networks and not in a remunerated model that is actually sustainable for the future.

This is a model that the pharmaceutical society has developed. It is about pharmacists in the community. I suppose we take a bit of a broader view of pharmacists in the community. Community pharmacy is an absolutely integral part of the network in Australia, and we have community pharmacists that are accessed by the public. In the centre of the diagram we have the consumer. It is really about the patient-centred medical home. We have the consumer in the middle, and they can access the pharmacies within the community. But there are also a whole range of other areas where pharmacists can deliver their services and do so at the moment, working outside of community pharmacies. These include Aboriginal health-care centres, Medicare locals, residential aged-care facilities, in patients' actual homes and at GP clinics. There is a huge opportunity for accessing the expertise of the pharmacist not only within the community pharmacy but also in these other broad-spectrum settings and delivering the care to the patient where they need it.

This is quite a compelling slide. It really does highlight the sense of looking to pharmacists as part of the solution in delivering better patient care, because the scale and cost of medication-related problems is huge. These are Australian figures for all of Australia. Almost 53 000 hospitalised transport injury cases per year are admitted versus 230 000 medication-related admissions. It is quite compelling. The cost of those medication-related admissions annually is $1.2 billion. We have done some work to make that real for Victoria. It is a cost of about $320 million. That is based on some 2.46 million separations in public hospitals with an average cost of $5200 per patient. The cost of medication-related admissions for Victoria alone is huge. Further,

it would make sense to have pharmacists as part of the solution, because they are the medication management experts and have the expertise to be so.

This also demonstrates the medication-related hospital admissions. Within Australia they comprise 2 to 3 per cent of all hospital admissions. As we then go to the older cohort of our population, people 65 years plus, that increases to 20 to 30 per cent, highlighting again why it is important to have pharmacists appropriately funded in a structured and systemised way in the equation so they are part of the team that helps manage the care of a patient in the community in a coordinated and systematic way.

The accessibility of the pharmacists in a community pharmacy setting makes that setting ideal for a self-care triage and assistance with minor ailments. Our colleagues at the guild talked about that before, and you asked some questions about it. This is the Pharmacy First minor ailment scheme and is a great example from the UK. It was run by the Nottingham NHS, and it reduced emergency department pressure by redirecting people to pharmacies for treatment of minor self-limiting conditions. They were defined. This service was accessed by more than 250 000 consumers over 10 years, thereby reducing the burden on the hospital system and allowing the redirection of those patients to where they could get appropriately treated within the community pharmacy and cared for in that way. It is using the community pharmacy and the pharmacist within that community pharmacy to help identify the right avenues of treatment for those patients and identify where they need to be treated.

This is a slide that they developed as part of an advertising campaign to highlight the role and contribution of pharmacists, and it has been recognised at a policy level by the NHS. Again, it is a means of managing costs and ensuring that those people who need high-level care can access it. This slide is also compelling. It shows people lined up and indicates where they should have been accessing services instead of all rushing to the emergency department. This slide is about utilising the health-care network and the expertise of the professionals who are available in a systemised and standardised way.

This week the COAG Reform Council released a report which highlights the fact that the time to act is now. Across the broader health picture we are seeing increases in potentially preventable hospital admissions, vaccine-preventable admissions as well as overweight and obesity rates elevating. Again, we know they have a linkage to potentially long-term chronic illnesses. The pharmacist absolutely has a role in primary care. We can be utilised in minor ailment schemes. We talked about redirecting the flow of traffic away from general practice and redirecting the burden from emergency departments to pharmacies where pharmacists can treat those conditions.

We have seen development and work done where pharmacists have incorporated their after-hours solution in Medicare Local initiatives. One has been developed in the ACT, but there is a whole lot more that we can do around that. We can explore opportunities for pharmacies in the primary health-care network.

PSA is the peak professional body representing over 18 000 pharmacists in Australia, and 4000 of them are in Victoria. Our proposal builds on the Victorian government's active program, testing and expanded scopes of practice in primary and public health-care settings. We think there is a great alignment between the Victorian government's goal to deliver better patient care through the better utilisation of a skilled health workforce. PSA shares that goal. Our vision is to improve our nation's health through excellence in the practice of pharmacy. Two of our core missions are building capability through practice support and professional development, and positioning pharmacy for the future through innovative and sustainable models of practice. Sustainable models of practice are the key for all involved.

In summary, we think pharmacists in the community can provide some key things. They can improve public health — for example, by providing immunisation services. We can improve medication adherence and reduce hospital readmissions by performing medication reviews and discharge follow-up. We can reduce unnecessary emergency department presentation by the provision of minor ailment and appropriate triage and referral services by the pharmacist. We can support and reduce the pressure on GPs by extending the list of medicines for continued dispensing and provision in chronic disease management. We think we can also fill the rural health service gap by the better utilisation of pharmacists who have appropriate prescribing rights, training and certification. We thank you again for your time today.

The CHAIR — Thank you very much, Ms Lynch, for that very thorough presentation. Before we go to questions, would Dr Roberts or Mr Suen like to make any comments to the committee?

Mr SUEN — No. We will support the question time.

The CHAIR — I thank you again. I would like to go to the question of whether the PSA has a view on fee for service, and whether private insurance should also be considered in the role that pharmacies can play in the delivery of health care?

Ms LYNCH — A whole range of possible funding models need to come in. Obviously we recognise that there are federal government funding models at the moment. I think we need to work in a systemised way with the government to be able to identify those appropriate funding models available in Victoria. Private health insurers absolutely are another source of funding. We need to explore those options and work together to find the best way to utilise the moneys to get best health outcomes for the patients.

The CHAIR — Is the PSA having discussions with private insurance agencies and organisations in relation to fee for service?

Ms LYNCH — I refer that to Dr Roberts.

Dr ROBERTS — My understanding is that that is the case, particularly in the area of prevention, so perhaps less in some of these areas related to acute episodes or minor ailment presentations in pharmacies. As you know, private health funds have a big interest in prevention.

The other thing that will be interesting is in terms of engagement with the new primary health-care networks once the Medicare Locals wrap up. Obviously we have had quite a big involvement with the Medicare Locals and looking at what could be locally coordinated in this area. That would be another place that we will look to. We are keen to further those discussions at both a state and primary health-care work level.

The CHAIR — Thank you.

Mr LEANE — I have two questions. Community pharmacies, As I know them, are busy places. You go into one — at Doncaster Shoppingtown or wherever it is — and people are selling perfumes and sunglasses. I do not begrudge the owners making money, because they have got to make money, but what happens when you go in with a prescription and they ask, 'Can you come back in 20 minutes?'. To me, pharmacies are very busy places at the moment, so are your 4000 members in Victoria looking to broaden their responsibilities and their activities?

Ms LYNCH — Absolutely. With the model in Australia at the moment we are seeing increased pressure of funding from the PBS; therefore the pressure to be able to deliver that service is increasing and we have reduced remuneration. Our members absolutely want to deliver sustainable models of clinical and professional services to the public. The problem is we do not have a systemised funding model at the moment to do that. This is the opportunity to seek those models and see what they look like so that we are able to appropriately develop the framework within which pharmacists will have to operate in community pharmacies to deliver those services — that is, we need to have the time to be able to sit down and deliver those services to patients within the right framework, in the right setting, in a private consultation room et cetera, but there needs to be the sustainable funding model to able to allow them to offer that service.

Dr ROBERTS — The other thing to consider about pharmacy is that as a profession we have a relatively young and large workforce — young compared to many of the other health professions. There are a lot of pharmacists around, and most of the community pharmacists you would see would put on another pharmacist if the services were in place for them to deliver so that a customer would not have to wait 20 minutes for a script. They could be delivering something else at the same time.

Mr LEANE — I have another question that is not related to what I just asked, but it is related to a question I asked members of the guild when they gave their evidence around concerns about diagnosis. The slide from the UK shows people in a queue. The middle person has the words above her 'Painful cough. Should be at the pharmacy'. I am not an expert, but an alarm bell goes off in my head, because a painful cough could be something that potentially you should be going straight to the hospital with.

The CHAIR — Or your GP.

Dr ROBERTS — Yes.

Mr LEANE — Or your GP. There is a grey area where we are talking about minor ailments. Where do you draw the line?

Mr LYNCH — It is about defining what those minor ailments are and developing the training for pharmacists. Pharmacists have a skill set and expertise which we currently use each day. When someone comes in, we make an assessment of the type of care that that patient needs. It is about developing and further developing and scoping out what those minor ailments are, what training is needed, and providing the framework that pharmacists operate within, and defining limitations on their ability to refer. It is probably no different to GPs, for example. I draw the analogy of GPs referring to specialists. They have some set groundwork and limitations, and it would be no different for pharmacists to know what their limitations are.

Ms HARTLAND — I have one question, and you may not be able to answer it. I am interested in pharmacists who refuse to sell condoms, contraception or morning-after pills. Is there any sanction in terms of regulation that they are required to carry those items, or does your organisation play a role in trying to convince them? A lot of what you are talking about is prevention.

Ms LYNCH — Sure.

Ms HARTLAND — Clearly condoms, contraception and morning-after pills are preventive measures?

Ms LYNCH — PSA has a code of ethics. We recognise that sometimes there are going to be moral and ethical situations, and we respect the right of the pharmacist and the health practitioner to be able to exercise that. With what we do, patient care is our priority first and foremost. If someone chooses not to supply or not to stock a certain item, they need to declare that. We recommend that they should be declaring that so a consumer has a choice in whether or not to attend that pharmacy.

The challenge obviously comes in regional and remote areas, where there may not be a choice of pharmacies, so they need to ensure that the patient's care and service is not compromised. If it means referring to another pharmacy close by or a GP, having some other means to ensure that their care is not compromised is first and foremost for us.

Ms HARTLAND — If we do have a situation where it is a rural area and there is not a choice unless someone travels 50 kilometres, is there anything that your organisation can do? Are there any sanctions? Does it go with their licence to be a pharmacist?

Ms LYNCH — No, that would be outside our realm. There would be with AHPRA, which is the registry authority for pharmacists, if they chose to take action if there was a complaint. From our perspective we have our code of ethics, and if they were a member, they would certainly have to follow our code of ethics.

Ms HARTLAND — So a complaint would have to be made to AHPRA for action to be taken?

Ms LYNCH — Yes; correct.

Mr O'BRIEN — I just wanted to look at what checks and balances might need to be in place if there were an extension of the pharmacist's role, particularly into some form of GP-related ailment care. There is a potential conflict that we need to be attuned to in relation to the retailing role of pharmacists in medications. There is a bit of concern that there is overprescription in any event, and there have been concerns about GPs and kickbacks or relationships with pharmaceutical companies. The last figure you gave us was 230 000 medication-related problems.

Ms LYNCH — Admissions, yes.

Mr O'BRIEN — Particularly if you have the fee-for-service type consultation, and in a sense you are doing that already. Have you thought this through, and what have other countries done in relation to checks for rogue pharmacists or to make sure that the system is not abused?

Ms LYNCH — I will refer that to Dr Roberts.

Dr ROBERTS — I will deal with the rogue pharmacist bit in a minute, but firstly I will just go through some of the models that exist internationally. There is a range of different models that have been put in place. There can be a range of conditions that are allowed to be treated under the model, so usually short conditions from which not a great amount of harm would come if the person received treatment for a couple of days but then needed to go on to further care, like urinary tract infections, skin conditions, minor wounds and that sort of thing. So sometimes they are defined in terms of the condition. In other cases they are defined by a limited formulary of items that the pharmacist has rights to prescribe. Sometimes that will be things like antibiotics for a short period, for a urinary tract infection, for example, or for a skin rash. They are some of the models that it would be interesting to look at piloting here.

Obviously some of the models that exist in places like the UK and Scotland under an NHS system are slightly different, because the patients do not pay even for the drugs that they get under the minor ailment scheme. They do not pay anything for the prescription; there is no co-payment. They are quite different, so in piloting something like this in Australia we would need to look at those.

But I guess, to address the potential rogue element, key to that is a good documentation system, a good auditing system that goes with it and some measures of quality control. We have some good systems in place in pharmacies already to be able to both capture that data and then look back at that and see what is going on. That would need to be part of the pilot, though.

Mr O'BRIEN — To clarify that answer, just on the UK model, whilst the patient might not pay under whatever scheme is in place, the pharmacists themselves would be remunerated on the dispensation?

Dr ROBERTS — Yes, because it becomes like a prescription, essentially. If the person is seen under the minor ailment scheme and they provide something for that, they would receive a payment.

Mr O'BRIEN — Would that not in a sense create a greater concern, if there is a concern of overprescription, because the patient is not paying anything at that point?

Dr ROBERTS — Yes, and there is some concern around that. There was some concern in one of the provinces in Canada. For example, they included on the formulary a higher strength hydrocortisone cream, whereas the lower strength was available over the counter but did not get the service fee element, and they were having a lot of discussions about that being the wrong sort of payment model. They are absolutely the sorts of concerns that we would want to see looked at in piloting this sort of model so that we could work out what is the best way of actually paying for this kind of service, if you are able to save costs elsewhere in the system.

Mr SUEN — I just want to add something about that question, about the checks and balances. Australia already has a built-in system for checks and balances. The Pharmacy Board of Australia has a registration standard, a mandatory standard required. If any pharmacist individually goes beyond their current practice — so, for example, if there is an expansion of roles — that pharmacist must demonstrate appropriate training, and that training must map through the standard established and match up with the competencies before the pharmacist is allowed to practice. So we already have built in, through AHPRA, those internal checks and balances.

Mr O'BRIEN — You sit much higher on the trust scale than politicians.

Mr LEANE — There is only one below us: door-to-door salespeople.

Ms LEWIS — I was just wondering about the range of immunisations that you would see as being appropriate. We have just heard tonight about influenza and measles, but I am fairly interested in seeing the full range of early childhood and preschool immunisations considered. Would that be appropriate to be administered?

Ms LYNCH — At this time we do not think we would like to touch the national schedule of immunisation. We think the framework for the provision of that is adequate. What we would absolutely do is adult vaccines, and those people who fall outside the regular vaccine schedule will absolutely have the vaccine. We do not think children should be part of that. I think the statistics that have come from Queensland have demonstrated

the accessibility of that service, where people who would not normally have been vaccined have now accessed this service. If you look at it as a public health initiative, if a pandemic was to break out, then you would have a network of pharmacists who would be ready and able to then deliver that health care and deliver the best health outcome, minimising the effects of that.

Ms MILLAR — I am particularly interested in the preventive medicine aspects, and your presentation touched upon in particular overweight and obesity rates, which are on the increase and are linked to a number of serious diseases. I am interested in whether there is any data around what percentage of the public go to a pharmacy first in relation to these types of more preventive medicine, as compared with going to a GP or other health services.

Dr ROBERTS — I do not think we have the discrimination. We do know that over 95 per cent of people visit pharmacies in a year, so we know that between pharmacies and GPs we are the most commonly accessed health professionals in the system, but in terms of discriminating whether they come first to a pharmacy for that kind of thing or go to their GP, I do not know, unfortunately.

Ms LYNCH — We can take it on notice and see if there is some data, and certainly if there is, we will avail you of that.

Mrs MILLAR — I am particularly interested in the breakdown of the preventive medicine aspects and perhaps distinguishing that from the people who are actually ill in some way and go to a GP or to emergency departments.

Ms LYNCH — Certainly. Thank you.

Mr RAMSAY — My question is part of that also. I am from a region that has high diabetes and high obesity rates in low socioeconomic communities. I was wondering about what role you could possibly play in that and the referrals you might make in relation to putting them on a plan to help. I am reminded of the fact that pharmacies I am aware of in my region have basically one pharmacist at the back who does the prescription filling and a lot of little staff running all over the place who I assume have specific skills but are not trained to the point of the pharmacist. Is the training to allow you to broaden your preventive care service required also for staff as well as for pharmacists? What happens when you get to the referral stage, where you might well be compromised by a whole range of factors? You cannot actually provide the ongoing service, or I assume you cannot. Someone who is facing significant diabetes or obesity issues — —

The CHAIR — So the role of a referral to a proper medical practitioner — is that your question?

Mr RAMSAY — The first question was what the training component was between the staff and the pharmacist, but also, yes, what sort of framework is around the referral process that you might make to someone.

Ms LYNCH — The training absolutely would be not just for the pharmacist but also the support team that you see — so, pharmacy assistants or the dispensary technicians. It really is, I suppose, about looking at the way pharmacies practice and making the pharmacist foremost and at the front of care so that they are the accessible health professionals. It is about, I suppose, supporting the network to be able to change the way we practice, and that is a long journey sometimes to encourage them to do that, but again it is about having those sustainable, fundable models that will allow them to change their practice to have the right resources available to deliver the services.

Pharmacists can absolutely be involved in a referral process: the identification of potential links to chronic illness and referring them to the right individuals, be they a GP or a dietician and so forth. We have those systems, I suppose, established somewhat already. We refer medication reviews between GPs and their pharmacists, and there is an established network, a structure and a systemised way that that occurs at the moment. We would look at, ideally, mimicking or using that as a template to develop future services as well.

Dr ROBERTS — Can I add too that in the area of diabetes there is already a service that is funded through the fifth community pharmacy agreement called Diabetes MedsCheck. A pharmacist can deliver that in the case where a consumer cannot access a diabetes educator within a reasonable time frame. That is in place currently. Pharmacists do not have to have any particular extra training other than their general training in order to be able to do that. However, we encourage them to do additional training.

The other thing that has not been tapped into is that GPs can put patients' chronic diseases, like diabetes, on a chronic disease plan, and they are able to refer to a range of other allied health practitioners, from exercise physiologists, diabetes educators and physios to podiatrists. Pharmacists are not currently included on that list of allied health practitioners, but they could potentially, like they do in New Zealand, play a really significant role. You talked about the ongoing care of people with chronic diseases — actually coming in and having their blood glucose monitored, talking about their medications and checking how everything is going. That is a role that pharmacists in New Zealand have taken on and is actually part of the community pharmacy agreement over there for long-term conditions. There are some gaps where pharmacists are not being utilised when they could be, and there is certainly scope for them to be better used.

The CHAIR — So you would encourage that pharmacists be included in the chronic disease care plan?

Dr ROBERTS — We certainly would.

Ms LYNCH — Yes, most definitely.

Mr LEANE — Could you just go back over for us what actually is a medicine-related admission and give some examples?

Dr ROBERTS — It usually relates to where someone has come in to emergency but in this case has actually been admitted to hospital as a result of what is called 'misadventure' medication. That can be taking too much — so, an overdose situation, often unintentional, not intentional. It can be two medications used that interact, so you end up with an adverse effect as a result of an interaction. It can be a medication that is taken and that is contraindicated with another condition — so, they have a condition, but the medication they are taking does not work with that condition. In practice we see a whole range of issues: people on two different types of the same medicine because they have different names and they have been to different places, and because we currently do not have a shared record it is really difficult sometimes to unpack those, or there are different prescribers. There are a breadth of reasons, and in practice we see a whole range.

Ms LYNCH — Absolutely.

Dr ROBERTS — I am happy to give you other examples, but they are just a couple.

The CHAIR — Are you clear with that, Mr Leane?

Mr LEANE — Absolutely. It is just interesting that there are that many.

Ms LYNCH — Yes, absolutely. It is huge.

Dr ROBERTS — It is concerning.

Ms LYNCH — It is very concerning.

Mr O'BRIEN — Can I just ask: do you have recommendations as to that breakdown and how those medication injuries could be reduced?

Dr ROBERTS — There are a number of recommendations made in the latest report that deals with that data, and I would have to come back to you on that. It is referenced on one of the slides.

Ms LYNCH — We can take that on notice, and we will give that to you.

The CHAIR — Thank you. That would be most helpful. On behalf of the committee I thank the three of you very much for your presentation and the evidence you have provided to the committee. It has been most helpful. Thank you again for appearing before us.

Ms LYNCH — Thank you so much.

Dr ROBERTS — Thanks for having us.

Committee adjourned.