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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Mr A. Elsbury	Mr D. R. J. O'Brien
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Research Assistant: Ms S. Hyslop

Witnesses

Professor C. Kirkpatrick, director, Centre for Medicine Use and Safety, and

Mr J. Jackson, director, Project Pharmacist, Monash University faculty of pharmacy and pharmaceutical sciences.

Necessary corrections to be notified to secretary of committee

The CHAIR — Good morning. I welcome Professor Carl Kirkpatrick, director of the Centre for Medicine Use and Safety, and Mr John Jackson, director of Project Pharmacist, from the Monash University faculty of pharmacy and pharmaceutical sciences. Thank you both for being here and for providing your submission to the committee. 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 a proof version of the transcript within the next week, and transcripts will ultimately be made public and posted on the committee's website. I now invite you to proceed with a brief 5 to 10-minute presentation to the committee which will then be followed by questions. Thank you again for appearing before us this morning.

Mr JACKSON — Thank you, Chair. I would like to thank the committee for the opportunity to present to this public hearing into community pharmacy in Victoria. On behalf of the Centre for Medicine Use and Safety at the faculty of pharmacy and pharmaceutical sciences at Monash University I would like to express our appreciation to the minister for initiating, to the Parliament for supporting and to this committee in particular for conducting this timely review.

The Monash University faculty of pharmacy and pharmaceutical sciences is intrinsically linked to community pharmacy in Victoria. The majority of our pharmacy graduates work in community pharmacy in Victoria, and of all the pharmacists working in the sector, the majority come from our faculty. Naturally we at the faculty have a strong interest in sustaining and developing the community pharmacy model and in the standards of practice of community pharmacists.

Our written submission has addressed the issues raised in the guide that was made available to submitters on the committee's website. Amongst other matters, we stated that we supported the role of pharmacists in post-acute care, an expanded role in aged-care, personalised medication management, vaccination and the role of pharmacists in making referrals to other health-care professionals. We have provided recommendations in support of the majority of those matters. In appearing here today we have been asked specifically to discuss whether there would be implications for the curriculum if the role of community pharmacists in Victoria were to be expanded. Professor Kirkpatrick will address these issues shortly. However, we would like to make some opening remarks in relation to the state of community pharmacy practice that may be of interest to the committee.

Victoria has a world-class community pharmacy system, and this inquiry can contribute to making that even better able to deliver the pharmacy services that the community in Victoria requires. Leading practice community pharmacies are recognised as health-care facilities, as a source of prescription and other medicines, and a broad range of other health-related products. Leading practice community pharmacists are skilled and knowledgeable, competent, considerate professionals. They work as part of a local network of health-care delivery. They are a primary source of health information not only to patients but to other people in the health system. They help people stay healthy. They routinely promote self-care and are associated with key public health messages that are generated from the health services in the country. They provide services to help people with both acute and long-term medical conditions, and in fact they are leaders in their local community in health matters.

In supporting fully the concept of expanded practice being considered by this inquiry, we believe it is appropriate to consider the existing practice and particularly the framework that surrounds current practice to ensure that it is sound and can support the new programs which this committee is considering. With that in mind, we would like to present to the committee some of the broader contextual issues that are faced by community pharmacies and pharmacists. There are three aspects that I would like to draw to your attention.

Firstly, the legislative regulation of the practice of pharmacists is, to some extent, subverted by the funding of pharmaceuticals. The Victorian Parliament is responsible for the legislation that governs the practice of pharmacists, the ownership of pharmacies and the handling of medicines, but it has no involvement with the funding of community pharmacy services. On the other hand, the federal government funds pharmaceuticals through the Pharmaceutical Benefits Scheme. This is the majority source of revenue for most community pharmacies, and because he who pays the piper calls the tune commonwealth policy is able to dominate a profession for which the commonwealth does not have the legislative responsibility, and any desire by the Victorian Parliament to foster expanded practice will need to recognise and address this issue.

The second point I would like to make is that pharmacists are identified as suppliers of medicines but their knowledge base and their training is much more than about dispensing. Pharmacists have received extensive education in relation to medicines — the indications for their use; their compounding, dispensing and distribution; the desired and possible inadvertent effects arising from their use; counselling patients and other health workers on how to achieve the best outcomes from medicines; and monitoring for the impacts, including assessing pathology tests. They are trained to apply the philosophy of pharmaceutical care, thereby focusing on the outcomes of use of medication, not solely on the supply of medication.

In addition to this education that underpins their primary clinical practice aimed at achieving best outcomes from the use of medicines, pharmacists are trained in pathophysiology and therapeutics, the recognition and treatment of minor ailments, screening, public health services and the structures and functions of the health system. Their ready access, their education and the training that they receive means pharmacists serve as an access point for the whole system for patients. They provide a wide range of primary care services, and they are in fact providing triage to other parts of the health system. Based on their knowledge and training, pharmaceutical care, primary health care and triage are provided in community pharmacies throughout Victoria every day, but these services are not quantified, they are not well recognised by other parts of the health system nor are they remunerated in an equivalent way to the patient care services of other health professionals.

The third and final point I would like to make at this stage is that the emerging constraints in the funding for PBS prescriptions will potentially compromise the capacity of pharmacists to deliver these existing and any potential new primary care services. As stated, PBS funding is the major source of revenue in community pharmacy. A significant portion of the income received for dispensing PBS prescriptions is linked to the wholesale price of the medication, and with the introduction of generics and the commonwealth government's pricing policy the revenue base of the community pharmacy is likely to fall. As these revenues have historically funded that broad range of primary care services provided to patients and enabled pharmacists to be there and serve as a triage point, the sustainability of these extended services, and obviously any new services that might be considered, may become an issue in coming years.

In view of these points, we urge that the state government to develop a vision statement and an implementation strategy for community pharmacy and community pharmacists as part of an integrated, profession-wide pharmaceutical service addressing the needs of the Victorian community and the sustainability of the community pharmacy.

Professor Kirkpatrick will now address the specific issue of the curriculum.

The CHAIR — Thank you. If you could, Professor Kirkpatrick.

Prof. KIRKPATRICK — John has outlined potential roles for pharmacy in the community in Victoria and further afield. The bachelor of pharmacy program offered by Monash is developed specifically to implement professional services, as well as its core and community roles, in a multidisciplinary manner. It is a four-year honours degree, which progresses from basic pharmaceutical sciences through to full integrated therapeutics covering all major and minor disease states. Our students are trained in medicines management. As such, as John has pointed out, they are medicines experts. This includes medicines reconciliation, patient counselling, motivational interviewing, pharmacotherapeutics and dose optimisation.

They are provided with the skills and knowledge, and furthermore have competencies assessed, to deliver key professional services to our communities. This includes asthma, smoking cessation, diabetes care, weight management and hypertension, as well as the chronic disease management of our ageing population, which is a large concern.

Following the degree, our students complete a one-year internship or training period of supervised practice. This is either in hospital or community practice. Following this they register as a pharmacist. Having undergone this degree and the one-year period of supervised practice, they are well trained to assess and implement professional programs that would allow pharmacy to play a much larger role in the health system of Victoria.

There are, however, some professional services that cannot be accredited by these pathways; for instance, the home medicines review must be credentialed elsewhere, and that is not through university. Indeed

immunisation, as it is currently being reviewed, is likely to be accredited or credentialed through the Australian Pharmacy Council.

As far as my opinion goes, there are no implications for a change in pharmacy curriculum to extend the role of pharmacy in Victoria. Our students are eminently qualified to provide many of the services I am sure you desire your patients to receive. We are there and ready and trained to go.

The CHAIR — Thank you, Professor Kirkpatrick. I think you have just answered my question because I was going to refer to that training program, and in your submission you state that not only is it a four-year bachelor of pharmacy program but a year's internship and that there is integrated therapeutics, major disease states, their epidemiology, pathophysiology, diagnosis of chemistry and pharmacology of the medicine used to treat these conditions and the clinical and practice aspects of treating patients. I wanted to know because the AMA states in its submission:

> Pharmacists do not have the appropriate clinical training or knowledge required to administer clinical service such as vaccinations.

You are effectively saying that you believe that you do have sufficient training to undertake vaccinations. Is that correct?

Prof. KIRKPATRICK — We give our students the basic information about immunisation. At this stage we cannot train or assess our students in terms of competency towards immunisation. There is a discussion document which is currently out under review by the Australian Pharmacy Council. That document as it stands does not include the credentialing of pharmacists in the undergraduate program or the intern training program. It is pharmacists that are practising and registered in Australia, as it currently stands.

Mr JACKSON — The pharmacy board has stated that immunisation is within the competence of a pharmacist. The education necessary for a pharmacist to be able to enter a training program to immunise is well established and already provided in the undergraduate programs. All that is required is a certification of the pharmacist to be able to administer the needle.

The CHAIR — Does that include the immunisation of infants?

Mr JACKSON — The Pharmaceutical Society, the Pharmacy Guild and the entire pharmacy profession has excluded the immunisation of infants in the proposed influenza immunisation programs.

The CHAIR — But does it include children?

Mr JACKSON — What pharmacists would receive in their education is a heightened awareness of the need for caution and the risks associated with the immunisation of infants. It would be well established that pharmacists would not be involved in the immunisation of infants.

Ms HARTLAND — I have a couple of questions from your submission. One of the things I have heard from a lot of doctors and pharmacists is about the discharge process, and you talked about this quite extensively. Besides having people up to date on their e-records, what are the other things that we should be looking at to make sure that that is a quick and easy process?

Mr JACKSON — I am concerned when people think that an e-record is the solution to the issues of discharge. I think it is better to think of it not just as a discharge issue; it is the transition of care. Whether the person is being admitted to a hospital or discharged from a hospital and admitted to an aged-care facility, similar issues arise. It is making the patient aware of the issues that will arise and the information they will need to make that journey safer for them. It is communicating to the carers in the next care setting, as far as the pharmacist is concerned, the information about the patient's medication. A lot of that cannot be done by just making it a better electronic record; it is actually a personal communication.

In our submission you will see we have proposed one thing that could be considered is that some of the information gathered about a patient's medication at the preadmission clinic — which is currently conducted on-site at the hospital and requires the person to go to the hospital on an occasion prior to their admission — could be done in a pharmacy. That would be the beginning of the churn. Of course when the person is discharged there is the possibility of doing it in reverse order, or communicating back, with the agreement of the

patient, to their community pharmacy. The pharmacy and the pharmacist there is well qualified to assist the patient to settle back into the community or into their aged-care facility.

Ms HARTLAND — You talk about a different process in the United Kingdom for the prescribing roles of pharmacists. Would it be possible to supply the committee with the range of drugs that pharmacists are allowed to prescribe? You do not need to answer it today.

The CHAIR — Could you take that on notice?

Mr JACKSON — I will make one comment. When people talk about prescribing it needs to be recognised that our scheduling structure in Australia creates a number of schedules for medication, one of which is a prescription schedule, and we specify who can prescribe those. Then there is a schedule — what is called schedule 3 or Pharmacist Only Medicines — which pharmacists are authorised to supply. A prescription is not written but it is the same principle of making a diagnosis and providing the medication. Going beyond that pharmacists are now obviously globally gaining the rights to prescribe some of the prescription medicines. We can provide information on that.

The CHAIR — Thank you.

Ms HARTLAND — Friends of mine who live in the outer west have three chronically ill children. They have to go to the Royal Children's twice a week to collect pharmacy items because they cannot be dispensed from a chemist. Is there any way of changing that? I know for this family it is the immense amount of travel they have to do every week, but obviously a local chemist cannot dispense them. Is there any way around that issue?

Mr JACKSON — There are likely to be two reasons why somebody might need to go to a hospital to obtain their medication. One is the nature of the medication and the other is likely to be the funding of the medication. If the medicine is not on the PBS, the cost would fall to the person unless they obtain it from a public hospital, in which case the cost is met by the state health system.

Mr ELASMAR — On that issue, would there be a possibility that the pharmacies do not have enough room to accommodate patients or proper room for it?

Mr JACKSON — If it is just a dispensing activity, pharmacies are all structured in accordance with the regulatory agency, the Victorian Pharmacy Authority, to have the space to do dispensing. There are specifications for the amount of space they need to store the medication to use as a dispensary. If you are talking about additional space for a private consultation, there is an expectation, now that pharmacists are hoping to move into these new consulting services, that private consulting space is required.

Mrs MILLAR — I am certainly very well aware of Monash University's faculty of pharmacy and pharmaceutical sciences and the reputation you have as no. 1 in Australia and also globally. I think this morning we should recognise that Monash University has an absolutely outstanding role in education in this area, and I would like to recognise that in starting.

Thank you for your excellent submission. I am interested particularly in the role of pharmacists in rural and regional Victoria. In your submission you touch on the ability of pharmacists to take on a larger role in their communities. As we are all aware, the communities in many towns have reduced access to GPs. I am particularly interested in the aspect you touch on, the data suggesting that up to 16 per cent of visits to GPs in rural and regional areas are for very minor ailments such as colds and hay fever, which I think are quoted here. How would you foresee that pharmacists are able to communicate with the community in more remote areas about the scope of being able to take on a wider number of services? How would you see the education and communication process being undertaken?

Mr JACKSON — A feature of pharmacies in rural settings is the strong relationship the pharmacists have with their community. They are already communicating exceptionally well with that community. If there are expanded services, obviously they have to be communicated appropriately. It would be up to the profession to work out how best to do that.

I will just make a comment about this 16 per cent. I am sure you will hear from the next group, who are the source of that research and information. Doctors and pharmacists have different skill sets. They are complementary and they overlap to a certain extent. That 16 per cent sits in that overlapping space — things that both doctors and pharmacists can do and historically have been done by doctors but where doctors are not available could easily be done by pharmacists.

Mrs MILLAR — Thank you for that. I think there is certainly currently an interface between those roles already being undertaken sometimes by GPs, sometimes by the pharmacists in those communities. I am interested also in your submission on some of the challenges facing pharmacists — some of this is perhaps from the global research being done — in terms of potentially the emergence of the new alternative channels such as online pharmacies. Do you see some of these trends as challenging in any way the role of community pharmacists to be able to take on these expanded services? Are we losing a connection with our pharmacists? You have referred to pharmacists as having good standing and great relationships with the community, particularly in rural and regional areas, but are these online pharmacies and competition from supermarkets and those types of changes a challenge to the trend to increase the role of community pharmacists?

Prof. KIRKPATRICK — I do not see that as a challenge for community pharmacy. We are all intelligent people and we will shop, no matter what the item, where it is often cheaper, but we will also go to a place which is more expensive when we do not know what is wrong. While there may be discounting groups and there may be online pharmacies, you will find that when patients do not know what is wrong with them they will go to a pharmacy that is not offering discounts or they will not try to buy medicines over the internet. So I do not see that as a burden. We do have an intelligent patient population. They use pharmacies that offer professional services when they do not know what is wrong with them. When they do know, they will go and buy medicines somewhere where they potentially might get them cheaper. When they know that there is something wrong they will go to somewhere where they know they will get professional services, as per patients also shopping around GPs. They will go to a bulk bill when they know what is wrong; when they do not know, they will go to a GP who does not bulk bill.

Mr LEANE — John, at the end of your verbal submission you urged something on the state government. Can you unpack that and expand on it? You lost me a little bit.

Mr JACKSON — We are fortunate in this country to have not only a strong community pharmacy network but also a fantastic Pharmaceutical Benefits Scheme. That Pharmaceutical Benefits Scheme is largely administered through a community pharmacy agreement which has delivered some benefits, but it is the commonwealth's pharmaceutical benefits scheme and it is the commonwealth's agreement with the profession. This Parliament is responsible for pharmacy in this state. I think there has been a lack of attention to what could be achieved from pharmacy through the legislative responsibility, largely because the commonwealth is sitting there with the Pharmaceutical Benefits Scheme and the source of funding.

If you were to look what has happened in the United Kingdom or Scotland, for example, there has been a substantial number of major policy statements released by the governments there on what they expect of the profession, how they are going to set a legislative framework that will enable the profession to advance its services and how they will support the profession stepping well beyond the dispensing role not only through those primary care services that have today been delivered in pharmacy and that could be expanded but into public health programs.

The education base of pharmacists and the respect for pharmacists is such that they can deliver a lot more. We have got the workforce numbers. We are fortunate we do not have a shortage of pharmacists as is the case with a number of other professions. We do not use the workforce numbers as much as we could in this state or this country. In terms of education, they are exceptionally well educated and we do not utilise that as much as we could. When I look to see why we are not doing so, I think it is because the legislative agency that is responsible for pharmacies — setting the registration of the practitioner, the approval of the premises, the regulation and the distribution of medicines — which is the state parliament, does not have active involvement with the funding, and it is that separation that needs to be thought through.

Mr ELSBURY — Just in relation to the training of pharmacists, can you see an increase in the exposure that pharmacists would have in risk for delivering additional services?

Mr JACKSON — There is a very simple example I use to try to illustrate the risk associated with being a pharmacist. On Monday morning you are in your pharmacy, the door is open and anybody can walk in. The person who walks in has their hand on their head and they say, 'I've got a terrible headache', and in that setting you ask some questions and you make some professional judgements based upon your education and training. You are likely to be differentiating between a hangover from a nasty bottle of red wine the night before and a knock on the head from the sporting injury on the Saturday morning or you might actually notice that there is a slight droop in the face and when you shook hands with them that morning their hand is a bit floppy and you appreciate that they may well in fact have suffered a slight stroke.

As pharmacists we already take that responsibility in making those judgements, and there is risk associated with that. If we are talking about whether they are prepared to take the risk in these advanced services, such as immunisation and the like, I think the profession has made it very clear that it is prepared to. I think the board has stated that it is within pharmacists' competency and their responsibility. I think the risk is recognised.

Mr ELSBURY — Also in the ongoing care of a patient for, say, someone who has a heart condition or something along those lines, there is some suggestion that possibly scripts to continue the supply of medications that people are going to be on for life could be given out by pharmacists — of course with the patient seeing their doctor whenever they need a review. When someone comes in to refill their script, if a pharmacist feels that something has changed in that person, would the pharmacist have the ability to recommend to the doctor a change in the medication?

Mr JACKSON — Absolutely. Pharmacists are medication experts. They are educated and trained in not only the nature of medication but its appropriate prescription and the outcomes of that use. In dispensing a repeat prescription you may well argue that it would be appropriate in certain patients to actually do some form of assessment before the repeat is dispensed — a blood pressure check, for example, and if the blood pressure is outside of the normal range, you communicate with the doctor, get some decision about a change of dose or change of drug, and the pharmacist could definitely participate in that discussion.

The CHAIR — Thank you. Mr Elsbury, I need to move on to Mr O'Brien for the final question. I am sorry; we are running short of time, but I appreciate that line of questioning.

Mr O'BRIEN — Thank you. Just a question following Ms Hartland's example, in a sense, and your answer to that. Are you saying that the current structure of the pharmaceutical benefits scheme has people unnecessarily going to hospital for, effectively, funding reasons, in that they will get the pharmaceuticals covered there that they would not get delivered directly at a pharmacist? You have touched on this sort of general issue in your submission under the 'Role of pharmacists and chronic disease management' and also on page 18.

Mr JACKSON — The Pharmaceutical Benefits Scheme is a very broad scheme. It covers a very wide number of medicines, but there are definitely medicines that are used in the community that are not covered by the PBS and so not subsidised. If a prescriber intends a patient to use that medicine, either the cost is going to fall to the patient if they obtain it in a private prescription process through a community pharmacy or the alternative is for the patient to have that dispensed from a public hospital where the majority of the costs would fall to the state government.

Mr O'BRIEN — If you could have a think about that on notice perhaps because we are a bit short on time. Certainly if there are categories of disease or categories where the present rules are putting a perverse incentive on patients who could otherwise receive prescriptions administered through community pharmacies that are presently being channelled back into public hospitals because for some reason or another you get the medication free in a hospital but you have to pay for it in a pharmacy, that would be something we would like to be aware of.

The CHAIR — Unfortunately we are out of time, but on behalf the committee could I thank you both very much for both your submission and your presentation. The evidence you have provided has been most helpful. Thank you very much.

Witnesses withdrew.