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

Ms G. Crozier	Ms M. Lewis
Mr N. Elasmar	Mrs A. Millar
Mr A. Elsbury	Mr D. R. J. O'Brien
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Participating members

Mrs I. Peulich	Mr S. Ramsay

Chair: Ms G. Crozier
Deputy Chair: Mr M. Viney

Staff

Secretary: Mr K. Delaney
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Witnesses

Mr S. Marty, chair, Pharmacy Board of Australia, and registrar, Victorian Pharmacy Authority; and

Mr J. Brizzi, executive officer, Pharmacy Board of Australia.

Necessary corrections to be notified to secretary of committee

The CHAIR — I welcome Joe Brizzi, executive officer, Pharmacy Board of Australia, and Stephen Marty, chair, Pharmacy Board of Australia, and registrar, Victorian Pharmacy Authority. Thank you both very much for your time this afternoon.

All evidence taken today is protected by parliamentary privilege and therefore you are protected in relation to 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. Transcripts will ultimately be made public and posted on the committee's website.

Thank you very much for your submission and for the additional information you have just provided to the committee members; we appreciate that. I now invite you to proceed with a brief presentation to the committee, and then I will ask committee members to ask questions of you.

Overheads shown.

Mr MARTY — Thank you, Chair. Looking through the first couple of submissions I noted in the transcripts that there might have been some confusion about organisations, legislation and who does what, and so I thought I would try to make quite clear the various pieces of legislation that impinge on pharmacists' practice.

First of all, there is the national law, which is in fact not national but one common piece of legislation that has been adopted in each state and territory of Australia; the Pharmacy Regulation Act, which is a Victorian piece of legislation that covers the licensing of owners and the registration of premises. There is the Drugs, Poisons and Controlled Substances Act and regulations, a Victorian piece of legislation. If I think back to the AHPRA inquiry, where you asked me a specific question.

The CHAIR — I seem to recall.

Mr MARTY — I will not visit that again today. There is also National Health Act which covers the supply of pharmaceutical benefits right around Australia.

AHPRA, just to pick up the name, the Australian Health Practitioner Regulation Agency, supports the 14 national health registration boards through registration, notifications, investigations and administration; and some of you have already been on a previous inquiry about that.

If I look at what the Pharmacy Board of Australia does, it is about monitoring the professional standards; producing some itself; registration of pharmacists; notifications, or 'complaints' is another term for it, but under the act it is called notifications; compliance with standards; and accreditation of courses leading to registration — so that is quite different, it is about accreditation of courses leading to registration as a pharmacist.

If I look at committees of the board, of course they match the board's functions. There is a Notifications Committee — in the case of pharmacy, it is one national committee — that considers notifications from all around Australia. Similarly, there is a Registration and Examinations Committee that considers matters relating to registration. There is a Finance and Governance Committee; a Policy, Codes and Guidelines Committee that writes, in consultation with the profession, the codes and guidelines; a Compounding Working Party, which is producing a set of guidelines for an increasing area of practice in compounding, if you like, the old part IV that used to be more common in pharmacies but has been rarer in this day and age; an Immediate Action Committee, which gives us the ability to impose sanctions fairly quickly where a practitioner represents an immediate risk to public safety and health, and that might be through impairment or their practice; and shortly to start, there will be a prescribing committee, which will look at — it has this in common with the Health Workforce Principal Committee — what will happen with prescribing around Australia.

The codes and guidelines, as you have here, clarify the board's views and expectations. In fact, they do require consultation, and the guidelines are approved by the board and distributed to the profession in a wide-ranging format to get feedback, and then we come up with a consensus view that guides pharmacists in practice.

The guidelines have been published to date. I have just given you each a copy of these because it would get quite boring if I talked about each one of them, but it might help to give you an understanding of where that

comes from. People often say, 'They are only guidelines', but in fact under the national law they can be used as evidence of unprofessional conduct in a series of breaches of them, for instance.

Ownership, and this is a Victorian perspective I am putting on this, so in fact all eight jurisdictions of Australia have ownership provisions for pharmacies. My counterparts are meeting at this very moment at my office. We get together two or three times a year to try to discuss things and come up with a consistent framework for dealing with things, because whilst under national law or registered practice anywhere, in any of the cross-border situations life is very difficult because of differences in other legislation, so we are at least trying to address this.

The Victorian Pharmacy Authority is the successor in law to the previous Pharmacy Board of Victoria, and as I have said this licenses persons to carry out pharmacy businesses and registers pharmacy premises, hospital pharmacy departments and pharmacy depots. I did provide you with some definitions in the initial submission, but one that seems to have caused a little bit of concern around terminology in various states is pecuniary interest or proprietary interest, perhaps expressed differently in Victoria. This means a legal or beneficial interest and includes sole proprietorship, individual pharmacists in a partnership, or as a director, member or shareholder of a company. So a corporate structure can only have directors or shareholders who are pharmacists other than friendly societies, which have a different structure, and as the trustee or beneficiary of a trust. I have provided that to you because I found the only way students can understand it is if I put it in a table to try to demonstrate what it all means. This is the relevant section of the act as to who can own a pharmacy business or a department and the maximum numbers that apply.

If we look at community pharmacy in the future, I have tried to concentrate on things that have not been in the other submissions that are on the website. Pharmacists are often called upon to act as a filter mechanism, frequently deciding between referring somebody to their general practitioner or another health practitioner, recommending a non-prescription treatment or indeed — as Mr Newton said many times — no treatment at all because it does not warrant it or the patient may in fact already be using something and they need some confidence to continue on with the treatment.

RUM — not in the drink sense but the return of unwanted medicines — is an excellent program where bins are supplied to pharmacies so that they can have returned medicines or medicines that go out of date go back for secure disposal survey; they go through high temperature incineration. Up until last week the future of this was in grave doubt. The commonwealth has just agreed to $780 000. That will not be enough; it will not last all of this financial year. It is a serious issue because that campaign gets rid of unwanted medicines from homes; you have grandkids otherwise picking up bright-looking tablets and bottles and interesting things, particularly their own if they are in the fridge or something — this is a way of getting rid of these things. Or you might have people mistakenly think, 'I was taking that last year; I think that was for pain' when in fact it was not. It is a very worthwhile program for those sorts of things. Once again pharmacists undertake this as an unpaid activity but it is a really important community resource for health.

There is a need to improve the efficiency of health IT. I am sorry, Ms Crozier, but one of my pet topics is about real-time monitoring of coroners' recommendations. For at least the past 12 years now, in consultation with coroners, I have made requests for a real-time monitoring program. I have looked at the number of deaths last year in Victoria and then gone back to 2004, when a former nurse managed to get 177 prescriptions written by 24 different doctors and dispensed at 17 different pharmacists until she finally expired from inappropriate prescribing of a sustained-release morphine analogue. This is inexcusable in this day and age. Health practitioners are working with one arm tied behind their back in that they are not aware of what others are doing because pharmacy computer systems are not linked. You might get something through PBS online, but they are interested in payment not in saving people's lives — —

The CHAIR — Mr Marty, I am sorry to interrupt you, but I am just conscious of the time. There are some very important points that I want you to go through but I am just alerting you to the time factor.

Mr MARTY — I have two more things. There is an immunisation trial in Queensland; this is not about being in competition with doctors. What pharmacy is trying to do is to lift the rates of immunisation for influenza in Australia. It is appalling compared to the rest of the world. We have rates that are well below other countries. We should be lifting this rate and trying to get people immunised. If people are immunised, you reduce the overall infection rates. For instance, if you look at successes in the United States, New Zealand, the

UK and Ireland, where pharmacists have been adding this into programs, it has had very good outcomes. In fact the Queensland trial has just been extended by two months to include whooping cough and measles. These are all really positive initiatives to get under way.

Mr Newton has just spoken about pharmacotherapy, and I agree with everything he said. I would just like to add to that pharmacists do this and yet they cop a significant amount of abuse from other customers. They sometimes have to put up with aberrant behaviour from their clients. There is a need. There are about 460 pharmacies providing pharmacotherapy services. There need to be more. There needs to be appropriate training, particularly in coping mechanisms and how to communicate with the clients you are dealing with. It is certainly an under-recognised resource. I will stop there.

The CHAIR — I am sorry to cut you off because I know that you have plenty more to say, but hopefully some of that will come out in the questions. I have a very quick and brief question. Is it fair to conclude that you are supportive of community pharmacies undertaking vaccinations or immunisation programs?

Mr MARTY — Yes.

The CHAIR — In relation to that, do you think pharmacies need to have a designated area to provide a service privately? Is that your view as well?

Mr MARTY — Yes. In fact that is the first topic of our meeting today.

The CHAIR — Thank you.

Ms HARTLAND — I want to go to something that came up in another submission from Women's Health Victoria — and I have raised this before — in terms of emergency contraception and contraception where pharmacists, especially in rural settings, refuse to supply those medications. In a country setting there is no point in saying, 'Go to the next chemist', because the next chemist could be an hour and a half away. Is this an issue you have dealt with?

Mr MARTY — Yes, it is. It keeps changing. The pharmaceutical society has produced some guidelines and policies around this. We have looked at this and made statements. Basically we believe that pharmacists should supply in the patient's interests or refer someone to the next available pharmacy. In the instance you are alluding to that might not be appropriate because of the circumstances. I guess it might take a test case when that has happened and somebody is perhaps providing maintenance for a child for the next 25 years, which might happen as a result of the outcome of a court case that follows on from that. It is a complex area which needs to be looked at. Lawyers have spoken to me about this, as have others. At the moment the board certainly believes that it should be supplied in all circumstances unless there is an alternative available within a timely manner.

Ms HARTLAND — Does that mean that you can compel pharmacists who refuse to supply contraception or emergency contraception to supply those items?

Mr MARTY — I do not think we have crossed that line, to be honest.

Ms HARTLAND — So it is now at a stage of, I suppose, it is a test case.

Mr MARTY — Yes.

Mrs MILLAR — I was interested in the last point, which I do not think you had the opportunity to address, about combating antibiotic resistance, which is a key issue for us globally as well as here in Victoria. What do you see as the key role of pharmacists to be able to impact on this very real issue?

Mr MARTY — It is a very complex issue because GPs are under a lot of pressure. Their patients think they are quacks if they do not write them a script for an antibiotic and send them home with something, and yet a lot of the time they are viral infections and so they certainly do not need antibiotics. If they are told to take a couple of paracetamol and go to bed for 24 hours or two days, their patients think that they are next to useless and they go somewhere else and yet it would have been the appropriate treatment.

Fairly soon we will end up not being able to undertake a lot of diagnostic procedures — prostate checks, biopsies and other sorts of things — because of the amount of infection that will result that will not be covered

by antibiotics. So we need to be using antibiotics for the purpose for which they were intended in the first place, serious infections, and not be handing them out willy-nilly because the patient asks for them. It represents a serious risk and pharmacists can monitor it, particularly in the aged-care sector, where they are prescribed all too often because people are worried. There are unique situations in an aged-care setting because you want to cope with pneumonia because the patients are not mobile and so they will get fluid retention et cetera, but there needs to be much better education for all practitioners about the judicious use of antibiotics. If you speak to Australia's chief medical officer, Chris will tell you exactly the same thing — that he is worried about our future.

Mrs MILLAR — Clearly it has some big implications for the way that pharmacists are remunerated, both on the prescription side — —

Mr MARTY — Indeed. The question was put to Mr Newton that in fact pharmacists perhaps should be reimbursed for advice that prescription or treatment is not necessary because sometimes that is inappropriate. If you look at quite a lot of classes of drugs in consultation with the prescriber, the better outcome might be non-drug treatment.

Mr LEANE — Touching on your frustration around doctor shopping — I am sure this is a question you cannot answer briefly but if you could have a crack at it — why is there not a real-time electronic prescribing system at least in the state? I know it has to be a national one because it would not work, but why is there not one?

Mr MARTY — The first reason I would expect is dollars. It has to be paid for. This has been looked at nationally, and there has been some agreement to use the Tasmanian scheme, but it does not go far enough because that starts at the pharmacy level. It needs to start at the prescriber level so that you know what has been prescribed. There are privacy restrictions around who this goes to and when. But when you find that people are able to get three or four prescriptions for the same thing, particularly for opiates et cetera, it is little wonder that they end up with the huge doses they are taking.

As well as that, there are people who go and doctor shop. The term — I wrote it down — is fossil farming, which describes younger people using elderly people to go and get prescriptions. They are then paid for doing that and they then onsell. Wherever there is a will, there is a way, whether it is pseudoephedrine conversion to methamphetamine, opiates or codeine over the counter. There is not a home bake heroin problem in the state; codeine is the problem. They use all those things.

It would be good if we had some checks at least on prescriptions. It is good to see that the RACGP has just issued a consultation paper on analgesic use and also benzodiazepines, because sometimes GPs prescribe sustained-release narcotics for acute pain. All you are going to do is kill a patient because what happens is that when it does not solve their acute pain in the first half hour they take another one and of course 6 hours later there is a peak and they will die because their respiration is depressed to that extent. It is about education for all health practitioners to look at these sorts of things and in the end getting some understanding of how to monitor and appropriately counsel patients at each level of practitioner.

A program of real-time monitoring that alerts practitioners to a problem can be put in place. Obviously you can then start to look at other measures to address these sorts of problems. It will not solve every one overnight, that is for sure, but as I said it is a start, a step in the right direction.

Mr O'BRIEN — Thank you for your submission. One point similar to the discussion that I wanted to follow up is that in your submission you suggest that in a sense pharmacists should or could be reimbursed through private health insurance for effectively triaging. How would this work?

Mr MARTY — I look at non-payment for, for instance, pharmacotherapy, wound care management and other sorts of things that pharmacists supply at the moment. It is only for non-PBS drugs that you might get some reimbursement, if you have extras on your private health insurance. If we were looking at some way of funding this, it might be a mechanism to start this. There are all sorts of alternative health practitioner services which you claim through your private health insurance. Some of those represent pseudoscience, in my opinion — I am trying to be nice, but it amazes me — yet registered health professionals, who can be held to

account, are providing health care for which their clients cannot get reimbursement through their private health insurance. It does not seem to me to be a cost-effective way of providing health-care services in Australia.

Mr O'BRIEN — Does this cover this aspect that we perhaps in our medical system generally across the state are disincentivising — the earlier topic — advice that there is no treatment required or there should not be the treatment that you are on?

Mr MARTY — Yes, indeed. If you had available a more comprehensive medication database — not of the medical conditions, but a medication database that would allow pharmacists to look at what the treatments are so they would be able to say, 'Well, hang on a second. You're already taking drug A and now your doctor's prescribed drug B'. Sometimes it does not matter how often you ask, people either do not want to volunteer the information or they do not understand the significance, and that includes complementary medicine. There were quite a few famous cases of things like ginkgo and St John's wort et cetera which had fatal interactions. It would be one way that this could be monitored through a system.

Mr O'BRIEN — That is presently an aspect of what pharmacists do. Many of these nutritional supplements are positive things that you could say is a holistic vitamin supplement et cetera. I think with some of them you cannot even overdose; I do not know. They are not regulated at all in the formal medical sense but they are offered for sale in pharmacies, and they are a form of alternative medicine in a sense. Is there a community health or a dietician or a wellness model that we need to be adopting so that we end up trusting someone, be it the doctor or the pharmacist who also has a financial incentive in perhaps not selling us the most extensive stuff — I am not accusing you specifically of doing that — but at least prescribing in a way that is the best for our health?

Mr MARTY — Yes. I mean pharmacists act as a gatekeeper between prescribers in the widest sense and patients — they are often in the middle — to assess whether this is safe and effective for this client to take, be it prescribed medicines or non-prescription medicines.

Mr O'BRIEN — Just on that, there would be a whole category of people who are not taking the right supplements. They might be iron deficient or there is something that they ought to be getting, and essentially that is a way to make some sales in the commercial sense, but they are not getting into the medical system because they are not going to the doctors or whatever. So do we need to actually change our wellness centres — I know they call them wellness centres; it is a bit of a funny term — the community health centre approach?

Mr MARTY — You would probably end up with a couple of years more consideration by the complementary medicines committee if we went down that track, but somehow there should be perhaps an encouragement for people to discuss more widely the medicines that include complementary medicines that they are currently taking and have somebody who is trained and has all the skills and the resources to check whether that is safe for them to be taking.

Mr ELSBURY — Just so that we can get this on the record: with your experience in your position, you are confident that the pharmacist can provide all of these services without any detriment to the base service that they provide, which is the allocation of pharmaceuticals.

Mr MARTY — If I look at some of those services such as immunisation, it is not to say that they could go straightaway and do that. It requires some additional training, particularly in first aid techniques around anaphylaxis et cetera, in an appropriate setting. In terms of prescribing, we are only just at the very start of looking at this, but in many ways pharmacists already prescribe through what is known as schedule 3 whereby they have to determine every time that there is a therapeutic need — if you like that is, in my language, a pharmacist's prescribing schedule right now to ensure that that happens appropriately.

When we move on, do we want to perhaps reduce health-care costs and unnecessary visits — or it might be through an extension where a prescription has been supplied with repeats that the patient now needs to continue. They are stable on their medication. A pharmacist is in a good position to be able to work out whether they have been concordant with their treatment and then perhaps should be able to be reimbursed for another supply because they cannot get an appointment to see their doctor because it will be two or three weeks and if they go without their medication in that time, it represents risk to their health, particularly if it is something like asthma or high blood pressure or diabetes et cetera, and yet the current law says that pharmacists can give three days'

supply. That is a nonsense, with all respect, because then they have got to go back to another pharmacy to get another three days. That just does not work. It would be much better if the pharmacist is able to give at least a month's supply to a patient who is stable on their medications and be reimbursed on the pharmaceutical benefits scheme for doing so.

Mr ELSBURY — Just one last thing. I do not know whether or not this is your area. Certainly there has been some feedback that pharmacists would not sacrifice retail space to provide adequate space for consultations to occur. What would your opinion be on that?

Mr MARTY — I disagree with that strongly because I think that if many pharmacists undertook an appropriate analysis of their business, they would find that still the majority of their profit is coming through their traditional pharmaceutical lines. If I talk about rubber ducks and shampoos, you will know where I am coming from, although I am told I am out of date because they're plastic.

Mr ELSBURY — So the L'Oréal counter would not go to come into this?

Mr MARTY — I am not going to speak of any specific brand, but it just does not provide a return. Everybody else is in that marketplace, so why on earth would you want to devote floor space and be paying quite substantial rents, as I noticed from some of the submissions. It will come to the stage where pharmacies will not be able to afford to be in regional shopping centres. I was there for 15 years, back in the old days. I am still a dinosaur of pharmacy, I suppose, but it will become unprofitable to be there. I think there is a greater future in looking at being co-located with other health services, and that is happening right now. I have medical practitioners ring and say, 'I am wanting to start a new multidisciplinary clinic. I'd like a pharmacy in there. I'd like a pharmacist to be managing our records and providing advice to the practitioners about what drugs are appropriate, et cetera'. That is an ideal world. It will not happen everywhere, but it would be a start.

The CHAIR — Thank you. Ms Hartland, do you have a question on notice?

Ms HARTLAND — I have a question on notice regarding the actual cost of pharmacotherapy. Has any work been done on it, or could you look at that and supply the information?

Mr MARTY — Cost is not something that we get involved in. As a regulator we are involved in looking at patient safety. With the department we monitor pharmacies' compliance with the guidelines for pharmacotherapy services — the records, the storage et cetera. I am frequently asked to give evidence at inquests into methadone deaths. I do not look at the costs; I am purely looking at public safety.

The CHAIR — On behalf of the committee I thank you both very much for your presentation and the submissions you have provided to us. Your evidence has been most helpful.

Committee adjourned.