# *ECONOMICS AND GOVERNANCE COMMITTEE*

**Members present:**
Mr LP Power MP—Chair
Mr RA Stevens MP
Mr MC Bailey MP
Ms AJ Camm MP
Mr MJ Crandon MP
Mr A Tantari MP

**Staff present:**
Ms L Manderson—Committee Secretary
Ms M Salisbury—Assistant Committee Secretary

## PUBLIC HEARING—INQUIRY INTO THE PHARMACY BUSINESS OWNERSHIP BILL 2023

### TRANSCRIPT OF PROCEEDINGS

**Monday, 12 February 2024**

**Brisbane**

# MONDAY, 12 FEBRUARY 2024

**The committee met at 10.18 am.**

**CHAIR:** Good morning. I declare open this public hearing for the committee's. I would like to respectfully acknowledge the traditional custodians of the land on which we meet today and pay our respects to elders past and present. We are extraordinarily fortunate to live in a country with two of the oldest continuing cultures in those of Aboriginal and Torres Strait Islander peoples, especially the Yagara-speaking peoples, whose lands, winds and waters we all share.

My name is Linus Power. I am the member for Logan and chair of the committee. The other committee members here with me today are: Mr Ray Stevens, member for Mermaid Beach and deputy chair; Mr Michael Crandon, member for Coomera; and Mr Adrian Tantari, member for Hervey Bay. Mr Mark Bailey, the member for Miller, is participating as a substitute for Mrs Melissa McMahon, member for Macalister; and Ms Amanda Camm, member for Whitsunday, is participating as a substitute for Mr Dan Purdie, member for Ninderry.

The purpose of today's hearing is to enable the committee to explore with stakeholders some of the issues raised in submissions on the bill. We will also have an opportunity to hear further from the department in relation to the matters discussed today at the conclusion of the proceedings.

The hearing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. While the hearing is open to the public to watch, only the committee and invited witnesses may participate in the proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a very serious offence.

The proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules and my direction at all times. You may be filmed or photographed during the proceedings and images may also appear on the parliament's website or social media pages. Before we commence, I ask all present to please turn off their mobile phones or to turn them to silent mode.

## BENEDET, Mr Gerard, Executive Director, Pharmacy Guild of Australia, Queensland Branch

## OWEN, Mr Chris, President, Pharmacy Guild of Australia, Queensland Branch

## SEETO, Ms Amanda, Vice-President, Pharmacy Guild of Australia, Queensland Branch

## TWOMEY, Professor Trent, National President, Pharmacy Guild of Australia, Queensland Branch

**CHAIR:** Good morning, all. Would you like to make an opening statement before we start our questions? We are very tight for time, so we do encourage you to keep it strictly to the five-minute limit.

**Mr Owen:** Thank you for the opportunity to address you today on the Pharmacy Business Ownership Bill 2023. I am a third-generation Queensland pharmacist, pharmacy owner and the branch president of the Pharmacy Guild of Australia, Queensland branch. Joining me today are the national president, Trent; the executive director, Gerard; and my vice-president, Amanda.

The Pharmacy Guild of Australia is the peak national organisation representing community pharmacy in its role of delivering quality health outcomes for all Australians. The vast network of community pharmacies, of which there are over 1,200 in Queensland, provides Queenslanders with the most accessible entry point to our health system. The current community pharmacy model has been the key to delivering diverse and competitive primary healthcare choices to Queenslanders. At the heart of this highly successful community pharmacy model lies the ownership requirements, which are consistent in intent across all Australian jurisdictions. Those requirements are that the pharmacy

business must be owned and operated by registered pharmacists and that there is a limit to the number of pharmacy businesses in which a pharmacist may have a financial interest in Queensland. That number is five.

The bill under consideration aims to maintain public confidence in the pharmacy profession. It will achieve this by ensuring that the community pharmacy model, as defined by the Pharmacy Business Ownership Act 2001, is preserved and that ownership provisions are made fit for purpose for 2024 and beyond. Successive governments of all persuasions at both the state and the federal level have supported the community pharmacy model as a valuable contributor to the health outcome of patients. They have recognised the benefits of aligning clinical responsibility and small business.

Theoretical models proposed by free market economists have been consistently rejected by governments of the day, as the supposed efficiency gains in the perfect world are overvalued when it comes to when it ultimately all goes wrong. We have seen these negative consequences in First World economies around the globe, with closures and protests across this highly corporatised market. For example, there was the 'Pharmageddon' protests in November 2023, which included the CVS and Walgreens chains in the USA and Canada, due to the demands of their corporate owners regarding corporate power over pay and conditions. In the UK, a report in November 2023 showed that they have been losing eight pharmacies per week over the past few years, with over a third lost in locations that ranked in the top 20 per cent of the most deprived areas. In 2023 alone, the Lloyds group shut down 1,000 stores and Boots 300, citing simply changed markets conditions. In June 2023, 85 per cent of German pharmacies closed to protest an unviable network, with recent graduates saying they had difficulty seeing a path to pharmacy ownership.

Over the past 20 years, the ownership of all deregulated health professions has continued to consolidate into a smaller number of corporate owners, with consumers rarely the winners. Corporate ownership and influence on pharmacy businesses in Queensland would almost certainly reduce competition and access, increasing upward pressure on the cost of living over time. It is naive to expect that community pharmacy would be exempt from these same outcomes and market power exertion as we have seen repeatedly in the grocery sector.

To the detriment of Queenslanders, the lack of compliance activity and enforcement of the 2001 act has allowed the creep of corporate entities into the sector. While the ownership provisions remain the same, the guild welcomes the Pharmacy Business Ownership Bill 2023, which makes significant steps forward in restoring integrity in the pharmacy business ownership laws. This will be accomplished by the establishment of a regulatory council which will monitor and enforce compliance with the act, providing the same level of transparency around pharmacy business ownership afforded to both pharmacy owners and consumers in all other states and territories around Australia. This development was very welcomed by the guild. The guild has made a submission to the inquiry detailing our full position on the legislation and our proposed amendments to improve the bill to make sure some of the loopholes are closed.

I wish to share with you one example where a current loophole exists in the drafting of the bill. This is within core pharmacy services, which is clause 8. While we acknowledge the department's justification for choosing this definition, it is simply not fit for purpose. The inference that the only activities that should define a pharmacy business are the dispensing and compounding of medicines shows a fundamental misunderstanding of what community pharmacy does in practice in 2024. The definition must encompass the cognitive, consultative and other professional services connected with dispensing and compounding. Our alternative definition does not seek to capture other health professionals as a pharmacy business. Instead, a broader definition better serves the purposes of the bill and strengthens subsequent clauses, namely 13 and 22, currently open to exploitation while control of and financial interest in a pharmacy business is limited to dispensing and compounding of medicines.

For the committee's reference, 'dispense' as defined by the Medicines and Poisons Act 2019 is to dispense a medicine to a person on a prescription. If the current definition stands, it will allow the following two scenarios. No. 1, it will allow a corporate owner to have control of all pharmacy services provided by the pharmacy business not related to dispensing or compounding medicines, for example a vaccination service, as the pharmacist does not dispense nor compound that vaccination prior to administration. The corporate owner can operate the service in a way that is more for the benefit of profit than people, with no requirement for professional oversight from the pharmacy business owner who, as a pharmacist, is professionally bound to provide health services in the best interests of the patient. The second example is where a business is to sell, as defined by the

Medicines and Poisons Act, all schedule 2, 3 and 4 medicines other than on a prescription. As this business does not dispense or compound, it would erroneously be considered not a pharmacy under the bill.

Honourable members, we are in support of the vast majority of this bill and seek your committee to recommend its passage with some further consideration given to certain aspects. In our submission we have provided our suggestions as to how the bill could be improved to finish the job to preserve the community pharmacy model, ultimately ensuring that community pharmacies can continue to provide essential and accessible health care to all Queenslanders free from undue commercial influence. I wish to table my opening address to the committee. I am happy to take any questions you have. I also seek leave to table some correspondence to the committee that was sent to the chair on 5 February.

**CHAIR:** Thank you. We will receive that document. In relation to the tabling of your opening comments, is that what you have just said?

**Mr Owen:** Yes.

**CHAIR:** We do have Hansard here who will be recording that exactly, so that is probably superfluous. We will now turn to questions while we look at this.

**Mr STEVENS:** Mr Owen, in your submission and statements you have said—

... the inadequate definition of material interest opens the door for the exertion of inappropriate control over pharmacy owners.

Could you expand on how that may happen and also give some examples that you have experienced in that area?

**Mr Owen:** What we have experienced with the market at the moment is: we have seen an increased use of varying accounting and business legal practices that have allowed for the exertion of some control, whether it be financial or beneficial—whether it is the money or the power—by other entities apart from the pharmacy owner. There are certainly franchise operations that exist—and we do not seek to comment on any individual franchisees in the way they conduct their business, but we certainly see that is an area of concern going forward. If there is a lack of proper definition of what constitutes material interest, then that material interest can not only be financial but also be in the control of the pharmacy business itself.

**Mr STEVENS:** You do not have to mention names or current issues, but can you give a practical example of how there may be undue and inappropriate influence put on a pharmacy operation by the owners of the franchise or the franchisor?

**Prof. Twomey:** We are led to believe that there are varying examples of commercial arrangements that pharmacists have been forced to sign under duress that hand over control for the following things to third parties, whether that be a franchisor or another: hiring and firing staff; and refinancing of commercial agreements, whether that be your bank loan or a fixture and fitting loan. When you start to do things like that, you can see that there would be potential charges that would be able to be charged to the frontline clinician for providing those extra services that could vary with profit. It is a very clever way of accountants and lawyers sidestepping the pharmacy business ownership rule to take control of the pharmacist, which has a direct impact on clinical services that Queenslanders are able to provide such as whether vaccinations are available seven days a week or whether medication counselling services are available seven days a week.

It also gets to the heart of what products are ranged. It is our view as frontline clinicians that Queenslanders get to choose what brand of a particular product they get—whether they want the generic or the original, whether they want the one made in Australia or the one made in Bangladesh or Sri Lanka. Unfortunately, there are examples out there that currently force the frontline clinician to offer or not offer services, to range or not range certain products, and ultimately that gets in between what is the right of a client to ask their pharmacist.

**Mr STEVENS:** In other words, they can determine that you must take this brand of a drug? They may even produce that drug. It could be an opportunity as well.

**Prof. Twomey:** And that parent company could actually own that drug company as well, so they get a further conflict of interest; correct.

**CHAIR:** Mr Owen, are there unintended consequences that could come across from expanding the definition? Say a nurse practitioner or someone else was giving advice on the use of a pharmaceutical. If we expand that definition beyond the dispensing and compounding, is there the possibility of unintended consequences that you are concerned about?

**Mr Owen:** I will pass this one over to Gerard, if that is okay, as he was involved with the consultation on the drafting.

**CHAIR:** Certainly.

**Mr Benedet:** The short answer is that it depends on how you draft it. The South Australian legislation, which we could hold up as the model, ring fences the pharmacy services definition to the pursuit of someone as a pharmacist or being held out as a pharmacist or holding themselves out as a pharmacist. It does that for a few reasons. Given that it is a regulated environment, it allows for enforcement action if someone is holding themselves out as a pharmacist and they are not. That enables the state to take action in that circumstance. The other circumstance is that it limits it to not affect nurse practitioners, GPs or other health professionals because they are obviously not an Ahpra registered pharmacist. If you had a similar definition in this act, you would then rely on the definition of what a pharmacist is, and it has to be a registered pharmacist with Ahpra. There are safety mechanisms that already exist in the act if you enhance that definition that will avoid unintended consequences.

**Ms CAMM:** Mr Owen, in your submission you outlined some of your concerns that the bill would impose on existing structures like unit trusts or beneficiary trusts et cetera. Can you expand upon what that impact would be? Does that impact differ in metro versus regional and rural Queensland?

**Mr Owen:** I will pass over to Amanda to cover on the family trust aspects, but a very brief statement is that we currently have existing legislation that defines 'trust', in the 2001 act. It was not specific about unit or beneficial trusts. It was an oversight at the time. This is merely to bring it into line with current business practices. I will pass to Amanda for the family aspect.

**Ms Seeto:** As you are aware, our submission outlined our view that the exemption for ownership of the family members of pharmacists is actually too broad. The provisions of this act can be exploited by sophisticated corporate players looking for loopholes in it. Our submission has identified this and other examples that are required to modernise the act and make sure it withstands the test of corporate manoeuvring. The guild's preference is that natural persons who are pharmacists should own pharmacies. However, that does not meet the expectations of banks and insurers who expect trusts and corporate structures to provide adequate asset protection.

**Mr BAILEY:** In your executive summary you state 'experience shows that corporate entities continually operate in grey areas of the legislation, pushing the boundaries'. Can you elaborate a bit further on that? Is that related to what you were talking about in the first question or is it a separate thing? I would be interested to know what that means.

**Mr Owen:** Apart from the definition of core pharmacy services and understanding the definition in other jurisdictions, what we have had in Queensland is a lack of enforcement up until this point. In fact, the Queensland Audit Office's report in 2018, which was to the initial inquiry, was quite critical of Queensland Health and how they administered the act. Basically, the Queensland Audit Office report said that there was zero regulatory oversight and they had no idea how many pharmacies existed in Queensland. This new council will have the sole focus of understanding who owns these pharmacies.

There is a particular example that I thought of in the time that we have been here. There was a power of attorney by one group that was being asked to be signed by the pharmacy owner. If that does not exert influence then I do not know what does. These are the sorts of exploitations that we are seeing in the market because we have not had the regulatory oversight. That is why the council is necessary: to make sure that they have that sole focus and that it has the requisite representation of licensed pharmacy holders to carry that forward and understand, No. 1, what is happening in the market and, No. 2, the intent behind why they would put those documents in place.

**Mr TANTARI:** In relation to your submission, it is interesting that in the conclusion you noted—

> While it is not possible to predict the way in which community pharmacy will evolve in the future, it is critical that every effort is made to strengthen and future-proof the legislation to protect the current model of community pharmacy.

What do you see as that area of being critical moving into the future of pharmacy services?

**Prof. Twomey:** That is a great question, thank you. I will answer it in two ways. Firstly, laws that exist in the physical world should also exist in the virtual world. I am a big supporter of technology. We all walk around with these things. Our patients and our consumers are telling us that they want to be able to access pharmacy services as well as they do a range of other healthcare services in the virtual environment. At the moment, the bill does not allow for rules that apply in the physical world to also apply in the virtual world. I think that is point No. 1. The risk of that is that it could fracture the relationship between a frontline clinician and their patient. Take a pharmacy in a particular regional

location, going to the point of the member for Whitsunday. Unbeknownst to that patient, if they start accessing that pharmacy online it may be services provided out of Melbourne or Sydney and not services provided to that patient from that local community.

Secondly, not only should things that exist in the physical world also exist in the virtual world; the nature of what services a Queenslander can obtain from their pharmacy and their pharmacist is also changing. Traditionally, you would come in with a prescription. You would get counselled and you would leave with a product. Now, more often than not the new services that are coming online—and this state was the one that pioneered it in 2014 with vaccinations and this state, again, is the one that pioneered it with the urinary tract infection pilot and now the regional pilot for prescribing, which starts in only two weeks time in your part of the world—do not result in the sale of a product. We need to make sure, as my state president said, that the definition of a pharmacy service is contemporary and fit for purpose for not only the services that a Queenslander is receiving now, in 2024, but also the services that they are going to be receiving in the next 10 years and not in the previous 10.

**Mr STEVENS:** I have just spoken to a pharmacist in Tasmania. Basically, he tells me that this is nation-leading legislation coming through Queensland and they were hoping for something from that Tasmanian area. Is it the case that this is nation-leading legislation that we are proposing here for the pharmacy industry?

**Prof. Twomey:** As the national president, I might take that one. I have no favourites anymore but, Deputy Chair, as a Queenslander I am proudly parochial. I think this parliament not only has been the most progressive in ensuring its healthcare system remains contemporary and fit for purpose to meet consumers' and patients' expectations but also is nation-leading in two areas. One is in how we uphold pharmacy business ownership with the bill that is currently before you and the second is with what those services are, which goes to the previous question from the member for Hervey Bay: what Queenslanders can get from their pharmacy and what their pharmacy looks like. Those two things go hand in hand. If, as a Queenslander, you are going to receive more services from your pharmacy, you have to have trust and confidence that that practice is first and foremost set up for your clinical care and not first and foremost set up for profit. Those things go hand in glove.

**Mr CRANDON:** Mr Benedet referred to the South Australian legislation. My interpretation of what he said is that the South Australian legislation is the gold standard.

**Mr Benedet:** The definition of pharmacy services is better in South Australia, yes.

**Mr CRANDON:** How does this legislation differ from that in South Australia?

**Prof. Twomey:** There are different parts to this particular bill. One is the powers of the proposed statutory authority to enforce them—that is what is lacking from the current regulatory framework, so what documents they can request, what powers they have to either grant a licence or not grant a licence—but it is the terms and conditions over which it has those powers. I think what my executive director was saying to the member for Coomera is that the South Australian legislation, as it currently stands, is better than this proposed bill with respect to the definition of pharmacy services. The Tasmanian example is that the powers this council will have to enforce it are preferable to South Australia, so it is two slightly different parts of the act.

**CHAIR:** There being no further questions, I will end this session. Thank you very much for your appearance before the committee today and for providing evidence. I note that no questions were taken on notice. Is leave granted for the document to be tabled? Leave is granted. We will table that document.

## KING, Dr Stephen, Commissioner, Productivity Commission (via videoconference)

**CHAIR:** Good morning, Dr King. I invite you to make a brief opening statement before we ask some questions.

**Dr King:** Good morning, Chair and committee. The Productivity Commission thanks the Economics and Governance Committee for the invitation to appear today to make some brief opening remarks. The commission has two concerns regarding the Pharmacy Business Ownership Bill 2023. First, the bill establishes a new and potentially expensive licensing regime around the Queensland pharmacy ownership rules. Regardless of the merits of those ownership rules, any significant change to regulatory processes around the rules should meet a simple cost-benefit test: what is the problem to be solved and is the proposed solution the most cost-effective way to solve the problem? It is far from clear to the Productivity Commission that there is a problem that requires solving. As noted in our submission, the commission is unaware of any evidence of significant noncompliance with the pharmacy ownership rules under the current Queensland regulatory processes. The commission is also unaware of any evidence to show that other jurisdictions which have regulatory processes similar to those considered in the bill have better compliance with their pharmacy ownership laws than occurs in Queensland. In this sense, there is both no evidence of a problem and no evidence that if there were a problem the solution proposed by the bill would fix it.

The costs associated with the change in regulatory processes presented in the bill, however, are significant. The bill proposes the establishment of a new regulatory body, the Queensland Pharmacy Business Ownership Council, to administer the community pharmacy business ownership regulation. The commission understands that approximately $9.8 million will be allocated to the establishment of this council (indistinct) years and that the ongoing operations of the new council will be funded through fees imposed on Queensland pharmacies. These fees will inevitably increase the cost of operating a community pharmacy in Queensland and will inevitably be, partially at least, passed through to consumers, or there may be some offsetting cost savings through the Department of Health no longer having a direct role with the ownership rules. The Productivity Commission is unaware of the existence or size of these savings.

In summary, the first issue is that the commission considers the case has not been made for change to establish a new licensing regime and the council to monitor the Queensland pharmacy ownership rules. The burden of these changes will directly or indirectly fall on Queensland consumers. Second, the Productivity Commission considers that the existing ownership rules clearly have harmful consequences for consumers in terms of reduced access to medicines and reduced competition and innovation. The commission is unaware of any evidence that the ownership rules improve outcomes for consumers relative to the ownership structures that exist in other parts of the primary health system such as for GPs and for (indistinct). For example, the 2017 *Review of pharmacy remuneration and regulation* found that the ownership rules limit access to medicine for Aboriginal and Torres Strait Islander people and recommended the removal of 'any restrictions on the ability of an Aboriginal Health Service to own and operate a pharmacy located at that Aboriginal Health Service'. That was recommendation 3-2 of that review. The review noted that Aboriginal health services 'in the Northern Territory are able to own and operate a community pharmacy, subject to ministerial discretion'. That is at page 50 of the review, so the alternative already exists in other jurisdictions.

Similarly, rather than assuring high standards for consumers, the review found that ownership rules do not (indistinct) products with a sound medical evidence base to consumers. The review recommended a range of restrictions in product placement for community pharmacies—recommendations 4-2 and 4-3 of the review—and the banning of the sale of homeopathic products by community pharmacies. That is recommendation 4-4. The Productivity Commission recognises that the current bill relates to the enforcement of the Queensland pharmacy ownership rules rather than their rationale or effectiveness; however, the commission considers that a review of the impact of the rules should be undertaken before commencing significant reform to the enforcement infrastructure of those rules.

**CHAIR:** Thank you, Dr King.

**Mr STEVENS:** As part of the 2018 inquiry, did your commission look at jurisdictions outside of Australia—for instance, America—in terms of pharmacy ownership and location and some of the outcomes in those particular areas? If so, what did it find in relation to safeguarding consumers and the safe delivery of pharmacy services?

**Dr King:** The 2017 review that I referred to was an independent review set up by the federal government. I was chair of that review. That was prior to me joining the Productivity Commission. That review did indeed look at practice outside Australia. For example, we looked at Canada and the

provision of medicines safely through machine dispensing in remote parts of Canada. That was indeed one of our recommendations—that is, that the federal government trial machine dispensing with real-time interaction with a virtual pharmacist to provide the appropriate advice. That was one of the recommendations of that review. I will point out that for that independent review the panel was made up of me, a consumer representative and a representative of the Pharmacy Guild, so the recommendations of that review, I think, are particularly powerful by having both consumers and the Pharmacy Guild as active participants in the panel.

**Mr TANTARI:** Dr King, with regard to your submission where you talk about the removal of ownership of restrictions, you indicate that the removal of ownership restrictions in particular with regard to Indigenous communities would strengthen the Aboriginal community controlled health sector and that delivering services by community controlled organisations generally achieves better results and they are often preferred over mainstream services. Can you elaborate on that for the committee?

**Dr King:** Yes, I can. I was privileged during both the pharmacy review and since then as part of a number of health reviews for the Productivity Commission to travel to some of our remote Indigenous communities across Australia including in Queensland, the Northern Territory and Western Australia. It is clear that culturally capable health services—health services in general but pharmacy services in particular—are critical for medicine adherence by our Aboriginal and Torres Strait Islander people and it is not occurring at the moment. The pharmacists operating in those remote communities are wonderful professionals, but they are not Indigenous Australians in general and there are issues, for historic reasons, with participants—members of those remote communities—interacting with what they see as often authority figures providing medicines that are often inconsistent with the traditional medicines that those people are familiar with.

For example, I saw the situation of medicine hoarding being quite common. Individuals—community members, Aboriginal and Torres Strait Islander people—would have their scripts filled but then would not take the medicines. They would pop them in a cupboard with all of their traditional medicines because the communication was not there between the pharmacy and the community member. In Fitzroy Crossing, for example, the Aboriginal health service was working very hard to fix that problem by having local community members working with people and using community connections to improve medicine adherence, but that can only go so far. We have seen, for example, in the Northern Territory better outcomes, where there is stronger interaction between Aboriginal and Torres Strait Islander communities and their health services, with the medicine adherence program. Certainly our review considered that the Northern Territory experiment or the process of allowing Aboriginal health services to have pharmacy ownership was an element of improving medicine adherence.

**Mr STEVENS:** Dr King, thank you very much for providing that information on Indigenous pharmacies and their services. Can you tell the committee how many Indigenous pharmacists there are?

**Dr King:** Off the top of my head, no, I have no idea how many Indigenous pharmacists there are. Most of the pharmacists operating in remote communities are not Indigenous people, and, of course, a change of ownership to allow Aboriginal health services to own pharmacies would not necessarily mean that there was an Indigenous pharmacist, but it would enable closer cooperation between the pharmacist and the Indigenous community to ensure that culturally capable dispensing practice medicine adherence programs could be put in place.

**CHAIR:** Dr King, your submission essentially puts forward that ownership rules are restrictive in the administration and prescription of drugs and seems to indicate that both the intent of the existing act and the intent of this one to have community owned pharmacies should be rejected. Is that a fair characterisation?

**Dr King:** I think the problem with ownership rules in pharmacy is best characterised by saying that they create a necessary paradox for our allied health system: either pharmacists are fundamentally different to GPs, psychologists, physiotherapists and so on in that they are so untrustworthy that they must have these ownership rules to ensure their professional integrity, or the situation is that the pharmacy ownership rules create professional conduct in pharmacy that is lacking in other allied health professions around Australia. I have seen no evidence whatsoever that other parts of the Australian allied health professions—including GPs, psychologists, physiotherapists and others—act in anything other than the most professional way in the interests of their clients, regardless of the fact that they do not have those ownership rules. So I have to ask myself: what is it that is unique about pharmacy or pharmacists that means there is a view that they have to have this additional control? Finally, I would point out that there is zero evidence that we had seen to show that

there is a problem of pharmacists not subject to the ownership rules behaving badly. We have seen no evidence of that, so we have a restriction which has no evidence of positive benefit, and when I look at other allied health professions I do not see a bad conduct that would need to be fixed.

**CHAIR:** Just to clarify, when I said that there is a rejection of the intent of both acts, the answer is yes? Just for the simple question I had, you reject the intent of both acts?

**Dr King:** My apologies.

**Ms CAMM:** Dr King, just to expand upon that and your view around the lack of evidence comparing it with other allied health professionals, as a layperson the perception, whether true or not, is that pharmacists have an enormous power or risk profile with regard to what they administer which is very different to potentially a psychologist or a physiotherapist et cetera in that they are administering prescriptions of significant addictive dangerous drugs at different times. When you say that there is no evidence that they, through their ownership model et cetera and the ownership rules, should be restricted, is it your opinion that it is in the interests of community safety that for those individuals who are out there pharmacy shopping or doctor shopping et cetera it may provide the need for greater restriction and oversight?

**Dr King:** Again, I recognise that pharmacists are a key part of our health system and, yes, they dispense significant and dangerous products including section 8 medicines. They require a script to be able to dispense those under the PBS, and GPs are involved in that. GPs are also a part of our health system who provide access to scripts to dangerous medicines, including extremely dangerous medicines—section 8 medicines. The issue I have problems with is to say that we have ownership rules for pharmacists but we do not have ownership rules for GPs. Indeed, we allow pharmacies to run GP clinics at the back of their pharmacy. There is at least one in Cairns; I have been to it. That would seem to create some issues of (indistinct) that certainly concern me and certainly concerned the review panel back in 2017.

From our review in 2017 we came to the conclusion that there were clearly practices being undertaken by pharmacists which are not in the best interest of consumers, despite the existence of current ownership rules. For example, going into pharmacies and being able to use that halo created by the professional integrity of pharmacies to buy homeopathic medicines which, quite frankly, have no medical evidence whatsoever is a frightening prospect, not stopped by the ownership rule. Being able to walk into a pharmacy and see next to the behind-the-shelf medicines a range of vitamins or complementary medicines—again, benefiting by the reputation given to pharmacists by our health system—suggests that pharmacists are not necessarily acting in the best interests of consumers. I have a real problem in saying that these ownership rules will.

**CHAIR:** We saw in America the overprescription of OxyContin. Do the corporate ownership structures and the huge dominance of a limited number of companies within the United States contribute to the OxyContin overdoses and addiction problems within the United States?

**Dr King:** My understanding is that the OxyContin problem was related to a range of issues in the US health system—from the incentives to doctors to prescribe going through to the pharmacies and simply the availability of those medicines. I would hate to see a situation here in Australia along those lines, but there is no evidence that the ownership rules are stopping the same thing from happening here. The same thing has not happened in other countries that do not have those ownership rules.

**Mr STEVENS:** Currently in Australia we are looking at the corporate world in terms of the supermarkets and their potential, due to their size, to rip off consumers because of the company structures that are behind them and their dominance in the market. We are looking at the medical services and the lack of GPs because of the lack of bulk-billing GPs around due to the corporate ownership of a large number of medical centres and those types of things. Can you explain how corporatisation—if there were not this legislation—would be of great assistance to the pharmaceutical world in terms of delivering a better outcome for the consumer of products through the pharmacies?

**Dr King:** I think you set up a counterfactual there which is simply false, Deputy Chair. Your presumption is that in the absence of the ownership rules it would simply be a free-for-all in pharmacy ownership. I consider that that would almost certainly be a terrible outcome. I am not saying that the ownership rules should simply be let go, with no alternative. We have issues, for example, with vertical integration in Australia. I have already noted that the ownership rules help to stop that vertical integration. I would like to see bodies such as the ACCC resourced to further enforce and address the sorts of anticompetitive outcomes you just outlined, including higher levels of monopoly ownership

and the vertical integration that is not stopped by the current rules. In terms of the ACCC, I would love to see—I will point out a conflict of interest; I am a former ACCC commissioner—that enforcement empowered in this area, but the ownership rules do not do it.

**CHAIR:** There being no further questions, I thank Dr King for his appearance here today via videoconference.

**DALE, Dr Brett, Chief Executive Officer, Australian Medical Association Queensland**

**FLYNN, Mr James, State Manager, Royal Australian College of General Practitioners Queensland**

**HESTER, Dr Cathryn, Chair, Royal Australian College of General Practitioners Queensland**

**O'DONNELL, Ms Erin, Policy Lead, Australian Medical Association Queensland**

**CHAIR:** Good morning. Would each organisation be able to make a briefing opening statement? Then I might turn to members for questions. I am sure the deputy chair will have questions for you.

**Dr Dale:** Firstly, we thank the committee for the invitation to attend the public hearing on this bill. AMA Queensland remains extremely concerned about the threat the bill poses to patient access to and affordability of medication. Since making our submission we have had the opportunity to review the other 123 submissions. Of these, we note the vast majority were submitted by pharmacy owners or pharmacy owner lobby groups who stand to gain financially from its amendments. Those submissions are largely identical in their content. This includes a submission made by the interim pharmacy round table, some of whose members also hold committee positions with pharmacy owner lobby groups. By contrast, we note and endorse the submissions made by several highly respected and independent bodies including the Queensland Aboriginal and Islander Health Council and the Productivity Commission.

To be frank, it is outrageous that the bill shows disregard for the National Agreement on Closing the Gap and potentially will undermine the provisions for culturally safe services for First Nations communities. It suggests that commercially focused pharmacy business owners know what is best for First Nations communities. AMA Queensland fully supports the Productivity Commissioner's submission and notes it follows an extensive list of at least 11 similarly independent reviews, each of which advise against the very changes the bill proposes.

We echo the Productivity Commission's statement that the bill is a step in the wrong direction for Queensland pharmacy consumers. It is worth also highlighting that the commission states that pharmacy ownership rules hurt consumers and that such regulations have in fact reduced competition in local markets. There are now fewer pharmacies per head of population than when the regulations were first introduced and they have facilitated and established the local monopolies that exist today.

The bill entrenches completely outdated and anticompetitive regulations that serve no purpose other than to heighten barriers and protections for existing pharmacy business owners and to drive up the cost of medications. Worse still, it provides a vehicle in the form of a new statutory body by which established businesses can exert direct control over both entry to their market and their own competitors. To be frank, it beggars belief that these anticompetitive proposals have progressed this far in a modern economy such as Queensland's. Indeed, no other health business has such restrictions or protections in place today.

In line with our various submissions on the bill and its previous iterations, we urge the committee to recommend it not be passed. The committee should also explain why the draft bill disregards a plethora of previous competition and productivity reviews by federal and state governments, independent statutory authorities and research organisations indicating that increasing regulation would reduce competition, harm consumers and not improve the sector.

**Dr Hester:** The RACGP thanks the Queensland parliament Economics and Governance Committee for the opportunity to provide input into the Pharmacy Business Ownership Bill 2023. By way of introduction, the RACGP is Australia's largest professional general practice organisation and represents over 40,000 members who are working in or towards a speciality career in general practice. This includes four in five rural general practitioners. The RACGP sets the standards for community practice, facilitates lifelong learning for GPs, connects the general practice community and advocates for better health and wellbeing for all Australians.

The potential reforms outlined by the Pharmacy Business Ownership Bill have been carefully reviewed by the RACGP and the following feedback is provided from both a clinical and a population health perspective. The RACGP holds significant concerns regarding this bill. General practice is the foremost provider of primary care for our communities. GPs deliver millions of consultations every year to Queenslanders. More than half of these consultations will result in the generation of a

prescription or the advice to seek pharmaceutical intervention. Activities of general practice and of pharmacies are tightly interwoven in our communities, and the functions for each must be complementary to result in safe and cost-effective care.

Our overarching position is that any mechanisms that stifle competition in the pharmacy sector will be detrimental to primary care provision and the health of our communities. Reduced competition in this sector, as proposed in this bill, will risk limiting consumer access and choice, resulting in increased price of medication, impairing the ability to provide culturally safe care, deteriorating sector performance and adversely impacting on the primary care workforce itself.

The proposals in this bill are out of step with what other healthcare professions are seeking. The anticompetitive premises are out of keeping with what the community expects. To achieve a modern, thriving and fit-for-purpose primary healthcare sector, the archaic pharmacy ownership and location rules need to be stripped back. Pharmacists should be free to provide professional services from any primary care location including nursing homes, general practice and other allied healthcare settings. General practitioners should be able to store, supply and administer medications to their patients from their practices, especially in rural and remote locations. Aboriginal and Torres Strait Islander health services should also be able to own and operate a pharmacy within their premises. Consumers should be able to access pharmacy services at places that are most convenient for them, including in supermarkets. Pharmacy ownership should be possible for any motivated and inclined person, just as it is possible for anybody to own and operate a general practice, a nursing home or a day hospital.

We know from numerous reviews, research papers and experiences from overseas that these aims are actually possible, that stripping rather than reinforcing anticompetitive regulations is what is needed to improve access to team-based health care and workforce morale. I would like to see Queensland embrace contemporary models of care, to allow our pharmacy colleagues to work in the team-based setting of their choice and for the community at large to benefit from ease of access to pharmacy services.

GPs remain engaged and willing to assist our communities to access the best and most safe health care. The RACGP would welcome further involvement in the review of legislation and policies that directly impact on primary healthcare ownership, workforce and the delivery of care in our communities. We thank the Queensland parliament Economics and Governance Committee for its work and the opportunity to provide our input on this very important matter. If you have any queries, we are happy to be contacted. We look forward to working together to ensure the ongoing health and safety of the Queensland population.

**Mr STEVENS:** Dr Dale, your submission refers to review findings that it is the professionalism of the pharmacist who is running and overseeing the dispensary rather than the ownership. In other words, you are inferring that the owner does not have any input into the dispensing through the pharmacy, I take it, from that particular submission. You see no potential conflicts between ownership and the dispensing pharmacist in terms of whatever drugs he may dispense or whatever way he runs his pharmacy. Can you assure me that there is not any potential for direction from an ownership group other than a pharmacist to operate a certain pharmacy in certain ways in terms of rentals, in terms of staffing, in terms of doing up the shop from time to time as landlords require—all those types of things that would be directed by an owner over a pharmacist to run his pharmacy? I draw a bit of a corollary in another corporate owned world, which is the medical profession that have corporate ownerships. I have been going to a corporate owned medical service. Can you assure me there are no targets of patients that doctors have to particularly see for these corporate owned surgeries?

**Dr Dale:** I will start with the difference between a pharmacist owning a pharmacy and some other person owning a pharmacy.

**Mr STEVENS:** Or a corporate.

**Dr Dale:** Yes. The current practice allows for a pharmacist to live in Queensland and own a pharmacy in Victoria. The oversight and supervision that is required by the business owner is minimal. What is important at the point of dispensing is a qualified pharmacist. Whether that be an owner or whether it be a pharmacist employed by the organisation will make no difference.

As to the question, 'Is there any known intent by corporates to get in there and change or corrupt the current system?,' the answer is none at all. We see now the monopoly that is also created. We see pharmacies already acting like mini supermarkets with their products. We are simply concerned about access to cheap medications for our consumers. That is the sole motivation. When you talk about the concerns around corporate owned general practice, there are no known targets of patient types that are set for doctors to seek out and find, to my understanding. Certainly corporate

practices have different models—and it might be about high volume, and that is the nature of the patient who may, in fact, prefer a bulk-billing session or have the capacity to pay a gap. I probably refer back to the statement that was put forward to the Productivity Commission with regard to bulk billing and how general practice has not kept up with it. It is not about general practice keeping up with that; it is about the lack of investment from the federal government in the MBS program. It has nothing to do with general practice. We have the evidence to show that running a practice is costly and the gap between the patient's reimbursement by the MBS is a necessary quantum that helps keep the business sustainable.

**CHAIR:** I used to live in Boston in the United States and that is one of the markets where CVS is very dominant. They would have a CVS on one corner and then a CVS on the opposite corner in order to maintain monopoly. Is that a model that you would be comfortable with in Australia?

**Dr Dale:** I do not have a perceived model. What we do want is competition. We want the markets to be opened. If people think it is viable to open their own competitor across the road, that should be determined by the business owner. The reality is: what we want is to drive competition to drive down prices but, most importantly, to increase access. When we talk about the community controlled sector, I spent five years looking after general practice training in the Northern Territory, working with remote communities, and the issue of having access to everything that is required at point of care is so important. Provisions or exemptions must be a consideration for this bill at a minimum.

**Mr BAILEY:** In your organisation's submission you say the RACGP opposes ownership and location regulations in the pharmacy sector. It seems a fairly absolute comment. My question is: does your organisation advocate for any ownership limitations at all? What is your position in terms of that?

**Dr Hester:** What we are in favour of is not strengthening the restrictive practices around pharmacy ownership. As Dr King said before, we are not advocating for a free-for-all in terms of pharmacy ownership. In fact, if we see a system that is analogous to the GP ownership, you will see it is very much not a free-for-all. The industry is very tightly regulated, not only in terms of practice processes and practice accreditation but also in terms of the professional standards that GPs must maintain to maintain their registration. If we see a similar situation arise where pharmacists are able to set up practices in competitive locations, or are even able to practise out of a general practice setting or an Aboriginal and Torres Strait Islander setting or anywhere that is actually appropriate from a primary health point of view, we would see that as a positive and we would see that to be good for our communities.

**Ms CAMM:** Dr Hester, you outlined in your opening statement that, really, it is about access and affordability for medications and that that is very important. Referring to the chair's example in the United States, when we talk about corporate ownership and supermarkets and the amount of medications that you can now purchase yourself as a consumer in a supermarket in an unregulated way, if I want to go in and buy 10 packets of ibuprofen I can and nobody is going to check. From a general practice perspective, while accessibility is so very important—and I will shift the Aboriginal controlled organisations and some of our remote areas into a different basket, because it is a very different scenario. More broadly, with the opening up of greater competition—while we want accessible drugs to be low cost et cetera—do you see risk and concern, particularly understanding what ownership looks like in Queensland and what that could lead to?

**Dr Hester:** Not in this particular case, because we already know that this sector is tightly regulated, going right through from the TGA in setting what pack sizes are available for different medications in different settings. You will see the pack sizes that are provided in supermarkets are considerably smaller than the pack sizes available under a pharmacist professional service. Again, I refer back to the professional standards that pharmacists have to adhere to to maintain registration and their professional standards in the same way that general practices have to do this. Opening up the business ownership of general practices has not deteriorated the standards that GPs provide.

**Mr CRANDON:** In relation to Aboriginal and Torres Strait Islander communities and health services, how would the RACGP like to see Aboriginal and Torres Strait Islander health services included as pharmacy owners? How would that work?

**Dr Hester:** We may also hear from Brett, given that he has had considerable experience working in these communities as well. We would like Aboriginal and Torres Strait Islander facilities to be able to own and operate pharmacies from within their premises so that they can provide culturally safe pharmacy services at one port of call for their patients accessing the services.

**Dr Dale:** The approach in community controlled sectors is incredible. It is a team-based approach so it is complete holistic health care. Putting a pharmacy onsite that is owned by the community controlled sector will improve the compliance with medication and the accessibility. If you give a patient a script and they need to go elsewhere, the risk of commencement of that treatment is quite large. It is really important that at the point of care it is available. It is most culturally appropriate that it is owned by the community controlled sector that will not be driven by profit. They will be driven by a team-based approach.

**Mr STEVENS:** Dr Hester mentioned culturally safe products. Can you explain to me the difference with the products? What is a culturally safe product and what is not a culturally safe product?

**Dr Dale:** When you talk about culturally safe, it is more the environment than the product.

**Mr STEVENS:** Thank you.

**CHAIR:** There being no further questions, thank you very much for the information you have provided here.

## HARMER, Mr David, Deputy Chief Executive, Queensland Aboriginal and Islander Health Council

**CHAIR:** Welcome. Would you like to make an opening statement before we commence members' questions?

**Mr Harmer:** Thank you, Mr Chair. I would. Mr Matthew Cook, our chairman, had intended to be here in person this morning. Unfortunately, he has been called away to deal with a family emergency, but he did ask that I pass on his apologies. As noted, my name is David Harmer. I am now the deputy chief executive of Queensland Aboriginal and Islander Health Council, which I am going to refer to as QAIHC in this briefing. I would like to begin by acknowledging the traditional owners of the land on which we meet here in Meanjin today, the Yagara and Turrbal people, and pay my respects to their elders past and present. Thank you for the opportunity to attend and to give an opening statement.

Like other stakeholders who have made submissions this morning, including the Productivity Commission, the Royal Australian College of General Practitioners and the Australian Medical Association, QAIHC does not support the bill being enacted in its current form or the proposed establishment of the Queensland Pharmacy Ownership Council as a statutory body. QAIHC believes that the bill will only entrench existing ownership protections and antiquated and anticompetitive measures that create barriers to entry for new businesses and, importantly from QAIHC's perspective, needlessly restrict opportunities to develop Aboriginal community controlled pharmacy arrangements which would be invaluable if Aboriginal and Torres Strait Islander people living in Queensland are to be provided safe, culturally appropriate access to affordable medicines.

I note that a question was asked earlier in the briefing about how many Indigenous pharmacists there are. I understand there are approximately 30,000 pharmacists in the country. Of those, less than one per cent, or 0.3 per cent, are thought to be Indigenous pharmacists, so that is 900 approximately.

Little evidence has been offered to support that the current legislative arrangements in Queensland, or indeed the proposed new arrangements, are the best way to protect consumers or ensure the delivery of accessible and affordable pharmacy services. As you have heard, the bill ignores the findings of many reports and inquiries that have recommended and urged reform of pharmacy ownership and location rules. The AMA has listed these submissions so I do not intend to repeat them here, but I would like to draw your attention to the Productivity Commission's report, released last week, which was following its review of the National Agreement on Closing the Gap. In the report the commission found insufficient progress has been made to achieve Closing the Gap targets. In particular, it concluded that the shared commitment between governments and community controlled organisations to share decision-making is rarely being achieved in practice. Government policy does not reflect the true value of the community controlled sector or its ability to support Aboriginal and Torres Strait Islander peoples.

The transformation of government organisations has barely begun. In QAIHC's mind, this bill is further evidence of the failure of successive governments to deliver on Closing the Gap commitments or to engage in a genuine way with Closing the Gap obligations. In its report issued last week, the Productivity Commission recommended the power needs to be shared with community controlled organisations; mainstream systems and culture need to be fundamentally rethought; and stronger accountability of governments and government agencies is required if we are going to see meaningful behavioural change.

Applying these principles to this bill, QAIHC asks that the committee carefully consider the cultural needs of Aboriginal and Torres Strait Islander communities. Already this morning you have heard compelling submissions from people presenting about the importance of culturally safe service provision and the fact that if that is absent from the healthcare environment for Indigenous people they tend not to comply with the instructions related to the use of medicines and, as a consequence, do not use medicines appropriately or at all. This results in a significant underspend on the use of safe medicines for Aboriginal and Islander people. In fact, it is estimated that for every $1 spent on other Australians just 30 cents is spent on Aboriginal and Islander people. Aboriginal and Islander people in Queensland are not getting access to medicines that they would have if they were supported to do so through appropriate arrangements in pharmacy legislation.

Current pharmacy business ownership arrangements restrict opportunities for community controlled pharmacy ownership and innovative models of care supported by genuine partnership between Aboriginal and Torres Strait Islander community controlled health organisations. These arrangements, if they were to exist, would be completely consistent with government's obligations

under the National Agreement on Closing the Gap. As committee members are almost certainly aware, priority reform No. 2 of the Closing the Gap agreement commits governments to strengthening the Aboriginal community controlled sector to deliver high-quality, holistic, culturally safe care to Aboriginal and Torres Strait Islander peoples. Existing pharmacy arrangements in Queensland restrict these options and need to be changed. This has been reinforced in the reviews and evidence that have been referred to today and the evidence that has been given by others, particularly Dr Stephen King from the Productivity Commission.

However, while QAIHC does not support this bill, we acknowledge that if it is not enacted in an amended form existing anticompetitive arrangements will simply continue. For this reason, we recommend that the bill be amended to expressly exempt Aboriginal and Torres Strait Islander community controlled services from the ownership requirements posed in the bill and instead put in place requirements that would allow these services to own pharmacies, provided they are staffed by appropriately skilled and qualified pharmacists who operate from the health organisation's premises. QAIHC expects this would provide an opportunity to grow the number of Indigenous pharmacists, who I have mentioned currently account for such a tiny percentage of our health pharmacist workforce, and benefit our communities. QAIHC believes more fundamental reforms to pharmacy business ownership arrangements are required, but this would be a critical first step in improving Aboriginal and Torres Strait Islander people's access to pharmacy in the community.

**Mr STEVENS:** Thank you for the update on those numbers. You quoted 900 Aboriginal and Indigenous pharmacists out of 30,000—about three per cent, which is pretty close to the percentage of Indigenous people in the Australian population. How many of those Indigenous pharmacists—the 900—are actually in Indigenous communities looking after their people, if you like, in terms of providing culturally safe pharmaceutical service? Can you give me examples of the delivery of culturally safe services that Indigenous people really find difficult to accept? You mentioned that the numbers were very low in terms of their usage of pharmaceutical services compared to other areas. Is that because they are worried about the delivery of those pharmaceutical services in a particular manner, or do they not want to bother with having that particular type of pharmaceutical service?

**Mr Harmer:** Before I answer the second part of that question, I will clarify in case it was not recorded in this way. Less than one per cent—0.3 per cent—of all pharmacists are Indigenous.

**Mr STEVENS:** That is not 900, though, is it?

**Mr Harmer:** No, the maths is—

**Mr STEVENS:** You told me 900.

**Mr Harmer:** I did, and my apologies for that. It is 0.3 per cent of 30,000.

**Mr STEVENS:** It is about 90.

**Mr Harmer:** Just to clarify that point, there are very few Indigenous pharmacists.

**Mr STEVENS:** They were the numbers I was working on.

**Mr Harmer:** I understand. The second part of the question was related to cultural safety. As you have heard, in Aboriginal community controlled health services—I will call them ACCHOs just for brevity—there is very much a team-based approach. You have the clinicians working together in close connection with the people attending the services to guide them, build trusted relationships and continue to maintain positive relationships that allow them to work with people over time, interact with them, continue to provide guidance about their health care and encourage them to take medications appropriately. Those trusted relationships are really critical for many Aboriginal and Torres Strait Islander people to comply with the instructions they have been given about how to take medicines safely. In the absence of those trusted arrangements and mechanisms for continued engagements with clients, we see those behaviours fall away.

'Culturally safe' in this context is really about that team-based, holistic approach that ensures a trusted group of individuals are working with a client consistently over time to follow up, to check on them, to see how they are going with their medications and to see them regularly. If someone is sent away from one of our clinics with a script to a different location where they have to fill the script they may not follow through, whether for reasons of trust, distance or a range of factors. I hope that makes sense.

**Mr STEVENS:** There was another part to the question. Of the 90—we have the numbers right now—Indigenous pharmacists, how many are working in Indigenous communities?

**Mr Harmer:** I would like to take that question on notice. My colleague Associate Professor Sophia Couzos is our chief medical officer. I expect she will be able to provide that advice and we can clarify the numbers for you.

**Mr STEVENS:** Thank you very much.

**CHAIR:** I guess it is not just Indigenous communities but also Aboriginal community controlled health organisations that would be—

**Mr STEVENS:** All the pharmaceutical areas.

**Ms CAMM:** Is it the view of your organisation that—you talk about the exemption that is required, and I do not want to put words in your mouth—you would prefer a co-design model that you could create with individual organisations? I take the point of the chair that while we have rural, remote and regional community controlled organisations based upon geography, for example, in Far North Queensland—if I compare Yarrabah to Mornington Island or we have parts of our South-East Queensland community that also have community controlled organisations—

**CHAIR:** The Browns Plains Indigenous health organisation.

**Ms CAMM:** Exactly. Is your organisation of the view that it is not a one-size-fits-all situation? I refer to Dr Dale's previous comments that in the Northern Territory medications, for example, were dispensed in a model that was mechanical in nature but had oversight by a pharmacist who was Zoomed in, or virtual, because they could not recruit. What is the view of the council in a perfect world if an exemption were granted? How would you meet the need and how would you as an organisation then work with those communities to create that?

**Mr Harmer:** Just so there is no misapprehension, we observe low uptake or utilisation of PBS scripts across the board. Aboriginal and Torres Strait Islanders in urban settings and rural settings under-utilise the PBS. That is a significant challenge. In a perfect world, the solution would be to allow Aboriginal community controlled health services to operate pharmacies at their premises, regardless of where they are located in Queensland. Having said that, there are places where rural and remoteness pose challenges to establishing a sustainable pharmacy business that is a bricks-and-mortar operation. Where that is the case, innovative models like the ones you have heard described, such as machine dispensing, might well be appropriate, but I think we should take the first step—that is, allow Aboriginal community controlled health organisations to own bricks-and-mortar pharmacies at their site.

**Mr BAILEY:** The need for culturally relevant and sensitive pharmacies obviously is important. Are there any other states that are doing this particularly well that you are aware of in terms of delivery on the ground? I understand your submission. I am wondering whether there is a best practice. Is there another state or territory that does this well that we should be aware of?

**Mr Harmer:** You have heard already this morning that there are arrangements in the Northern Territory for this to happen with permission. That would be the obvious example in Australia. In other parts of the world, models for Indigenous people in Canada are worth exploring. To provide more detail, we would need to take it on notice. In Australia, as you have heard from the Pharmacy Guild, most pharmacy business ownership arrangements are broadly comparable, preventing what we are advocating for.

**Mr CRANDON:** You made a point about a low PBS take-up in Aboriginal and Torres Strait Islander communities. Could you elaborate on that for us? Is that compared with the broader community as a whole or is it compared with certain sectors of the community? For instance, do you make a comparison between Aboriginal and Torres Strait Islander communities broadly with elderly in the broader community and that type of thing, or is it just the comparison between the two?

**Mr Harmer:** It is a comparison with the broader Australian community. We have not unpacked that number to make direct comparisons between the take-up rate of Aboriginal and Torres Strait Islanders and a particular aged community somewhere. It is certainly a stark figure when you realise that the average Australian spends a dollar and the Aboriginal or Indigenous person receives just 30 cents in PBS benefits.

**CHAIR:** I was going to ask a similar question about socio-economic indicators. We talked about machine dispensing and Zoom dispensing. Is that a culturally safe practice? Are there difficulties there and so we should not make blanket recommendations but look at this in more depth?

**Mr Harmer:** I am not sure I am qualified to comment. The reason I say that is that machine dispensing of the type you have described is not currently permitted, so I cannot speak to current practice in Queensland or elsewhere in Australia. What I would say is: if machine dispensing were

permitted in an Aboriginal and community controlled health setting, the machine would be co-located with healthcare professionals who could guide people in the safe taking of medications. While we do not have current practice to rely on, we would probably say that if that was the only option available it might well be worth exploring, because you could rely on the community health service providers to guide people in taking the medicines safely.

**CHAIR:** Once a prescription is filled, we know that we have to do follow-up with patients, especially patients we know to have a history of not taking their full cycle of drugs. That is something that would have to happen from the community health organisation regardless. Would that be fair to say?

**Mr Harmer:** Yes, absolutely. If a prescription was being issued from the service by a GP, that service could play a role in following up regularly with a client, checking in—

**CHAIR:** Sorry to interrupt: they could do that regardless. If they have issued the script, they could do follow-up at a community health organisation level to see that the script had been filled and/or that it was being taken to completion.

**Mr Harmer:** Perhaps, but as we have already commented, the trust relationship falls down where someone leaves the community service and has to go somewhere else to get it. Yes, but where the answer is, 'Well, I haven't taken that because I didn't go to the pharmacy,' there is a problem.

**CHAIR:** There being no further questions, I want to thank you very much for participating. I am sorry about my confusion earlier. There were two questions taken on notice, and the secretariat can provide you with information about those questions taken on notice. If possible, could we have your responses by 5 pm on Friday, 16 February in order for us to consider them? Thank you very much.

**Proceedings suspended from 11.44 am to 12.24 pm.**

## CASTLE, Ms Karen, Policy Pharmacist, Pharmaceutical Society of Australia

## FLOYD, Ms Nicole, State Manager Queensland, Pharmaceutical Society of Australia

## WRIGHT, Ms Karla, Vice-President, Queensland Branch Committee, Pharmaceutical Society of Australia

**CHAIR:** Good afternoon. Would you like to make an opening statement, after which we will ask questions?

**Ms Floyd:** I begin today by acknowledging the Turrbal and Yagara people, the traditional custodians of the land on which we meet today, and pay my respects to their elders past and present. I extend that respect to Aboriginal and Torres Strait Islander peoples here today.

Thank you for the opportunity to speak at this hearing. My name is Nicole Floyd. I am representing the Pharmaceutical Society of Australia, PSA. I am a registered pharmacist with a background in community pharmacy as an employee and a previous pharmacy business owner. Joining me today is Karen Castle, a pharmacist with 20 years experience in community pharmacy, hospital pharmacy and healthcare regulation, and also Karla Wright, a pharmacist practising at Fernvale as an employee of a community pharmacy. Karla is also a credentialed pharmacist delivering home medicine reviews.

PSA is the peak national professional pharmacist organisation, representing Australia's 36,000 pharmacists working in all practice settings and across all locations. PSA is broadly supportive of parliament passing the bill with minor exceptions. We will limit our opening statement to comments on key areas of the bill.

Firstly, PSA supports the definition that a business will only be a pharmacy business if it provides the core pharmacy services of compounding medicines for sale to members of the public or dispensing by or under the supervision of a pharmacist to members of the public. PSA's approach to reviewing this proposed definition is twofold. One is to ensure the bill focuses on and strengthens the current world-class model and network of community pharmacies across this decentralised state. We can all agree that community pharmacies and the pharmacists and pharmacy staff working within them are core to our communities. The second is to ensure pharmacists working in non-dispensing roles in settings such as general practice, aged care and in patient homes providing medication management services are not included in the definition and burdened with unnecessary regulation which may prevent them delivering those much needed services. For the interests of clarity, these medication management services may include medication reviews, administration of medicines and providing health information. They are not supply roles. As we emphasised in our submission, the profession is already appropriately regulated through the Health Practitioner Regulation National Law.

Secondly, we support that the bill retains the current ownership restrictions while strengthening the application and enforcement by providing additional clarity. PSA supports that ownership should be restricted to practising pharmacists and that they should have general registration with the Pharmacy Board of Australia.

Medicines are not standard items of commerce. The restrictions ensure an appropriately qualified person who has the professional ethics associated with the qualification and a thorough understanding of the risks of the medicines stored and sold in the pharmacy has oversight and control of the pharmacy business. The owners will put the consumer needs first over commercial needs. They must. It is required of their registration as a pharmacist.

PSA supports the establishment of the Queensland Pharmacy Business Ownership Council as a statutory body and the implementation of an annual licensing scheme. These measures ensure that subject matter experts in pharmacy ownership will possess the necessary information to proficiently execute and uphold the objectives outlined in the bill.

We believe that the public register and publishing compliance and audit reports as proposed in the bill upholds the fundamental principles of consumer rights and expectations and gives them empowerment by ensuring transparency in the ownership structure of the pharmacy business, thereby fostering an environment where individuals can make informed decisions about where they access their health care.

PSA did raise in the submission that including reconstitution as part of the compound definition needs review. Reconstituting a scheduled medicine according to the manufacturer's instructions is not compounding and should not be captured under the definition. Reconstitution is undertaken by a

variety of health professionals in myriad practice settings and it may be construed that they will fall under the bill's remit, which would be unintended. PSA appreciates the opportunity to give evidence today. We welcome any questions from the committee.

**Mr STEVENS:** Ms Floyd, we have submissions from the Pharmacy Guild of Australia and your submission from the Pharmaceutical Society of Australia. Could you identify the differences between the body that you represent and the guild and your different directions, if you like? There are around 1,234 pharmacies in Queensland. How many do you represent and how many does the guild represent? I will have some further questions after I understand where you are coming from.

**Ms Floyd:** Absolutely. Looking at the membership is probably the best way to define the differences. The guild represents community pharmacy owners or pharmacy business owners. The Pharmaceutical Society represents individual pharmacists regardless of practice setting.

**Mr STEVENS:** Even those working for another pharmacist?

**Ms Floyd:** Yes, an employee pharmacist at a community pharmacy. The pharmacy owner could be a member of the Pharmaceutical Society or a hospital pharmacist, an aged-care pharmacist, a defence pharmacist. We are a broad church of different pharmacists so the individual pharmacist.

**Mr STEVENS:** How many members would you have?

**Ms Floyd:** Currently practising in Queensland there are about 6,000 pharmacists—I can get you the exact figures—and about 50 per cent of those pharmacists are members of the PSA. The Pharmacy Board has the statistics on the number of pharmacists who are registered in Queensland. We have around 50 per cent of those.

**Mr STEVENS:** So you have about 3,000?

**Ms Floyd:** Yes, around that. I can take that on notice.

**Mr STEVENS:** That is the number I am looking for. Today a number of stakeholders have said that in pharmacy it is the dispensing that is important and not the ownership of the pharmacy. We have heard that there could be a differentiation between the owner's interests and the pharmacist's interests in terms of requirements on the pharmacist by an owner that is not identifiable, which is what this legislation heads towards preventing. Can you give us your society's view on that matter in relation to ownership? I believe you are supportive of this bill in terms of that type of thing. In terms of a pharmacy being located in or close to a supermarket, do you see that as a problem for the individual pharmacist that you represent?

**Ms Floyd:** I will start with the first question, which related to whether we support the position that a pharmacy business owner is a pharmacist. We unequivocally do support that position. We also note that the pharmacist themselves, the pharmacy owner, might be actively providing pharmacy services out of that pharmacy but they also might have employee pharmacists. Both of those bodies are regulated by Ahpra as a profession. That is the point there. We support them both. Because medicines need to be stored securely, there are lots of considerations with that, particularly as we get into new medications and storage requirements. There are medications that are high risk that need to be stored and also sold and supplied appropriately to consumers. There are lots of implications with that. That is why we support that a pharmacist owns a pharmacy business and obviously that pharmacists are involved in supply.

**Mr STEVENS:** And the supermarket part of it?

**Ms Floyd:** Our position is that we support that pharmacy businesses are not co-located in supermarkets, purely because pharmacy services are a health service and they need to be delivered in a way that is construed so that consumers come first and foremost. In the retail environment, we note that medicines are not ordinary items of commerce that you would find in a supermarket, so we do not think it is a conducive environment for a consumer to access appropriate health services.

**Mr BAILEY:** We have heard a number of stakeholders refer to the bill's ownership provisions as being anticompetitive and they have referenced a number of reports identifying that there is no evidence that ownership restrictions and regulations of this nature support better health outcomes. It is their view that it is the professionalism and ethics of dispensing pharmacists that drive benefits and that the connection with regulation for community benefit is at this point and not at the ownership level. Could you comment on that? Obviously, that is a key argument.

**Ms Floyd:** Our position is that it is important to have a pharmacist involved at the ownership level. It is a unique business. It has unique items of trade. Medicines and the supply of medicines come with a raft of considerations for consumer benefit. Having a pharmacist in control of that business means that the consumer is put first.

**Mr BAILEY:** Underlying that is the sense that the owner understands all of the implications around it rather than, say, an owner who is not a pharmacist and who might not be so well versed in the medical—

**Ms Floyd:** Absolutely. Obviously, there are commercial considerations with running a pharmacy business. It has to be sustainable but, ultimately, that pharmacy owner is a pharmacist so they have to put the consumer needs first and that is a priority over the commercial needs. They might consider, for example, stocking some high-risk drugs or high-cost drugs that are not commercially viable. The fees involved in dispensing them may not cover the cost of storage and supply, but pharmacy owners, as pharmacists, know that they are important and they will stock them for their local community.

**CHAIR:** We heard about the very important issue of people being prescribed a drug and possibly even picking up the drug but then not taking the full script or following instructions. I know that this is a serious issue of both public waste and patient health. It applies to a variety of different groups such as people of non-English-speaking backgrounds, people who have a distrust of medical professions, those with low-education issues and, of course, Aboriginal and Torres Strait Islander peoples. Is that something that is connected with the issues of ownership or is it a broader issue? How does the Pharmaceutical Society address those sorts of issues?

**Ms Floyd:** In relation to adherence, yes, it is very important that you can be prescribed a medication but if you do not take it then obviously the outcome will not be there. A community pharmacy owner will consider the services that that pharmacy delivers that will support adherence. Thinking about dose administration aids is a very good example. Dose administration aids are mechanisms to help a patient in the home environment or in other environments to take their medication. It is all prepacked for them and it makes the process simpler. The pharmacy owner makes the decision about providing that service. Sometimes the revenue from that service is not very large but they make it to help with adherence. I think the owner is definitely considerate of adherence issues and there is a wide variety of services that a pharmacy would offer, and pharmacists within that, to support adherence.

**CHAIR:** More specifically on the question with Aboriginal and Torres Strait Islander people and building confidence, they use the expression 'culturally safe'. Everyone wants to have confidence and trust in their pharmacist. What is the process for doing that?

**Ms Castle:** I would highlight a recent development in relation to the Medical Services Advisory Committee, which is a subcommittee of the Department of Health and Aged Care. They are currently tasked with appraising new medical services for public funding. They recently supported public funding for the integration of non-dispensing pharmacists into every Aboriginal health service in Australia. They found that that service was providing cost benefits. It had wideranging benefits for all Aboriginal health service clients. That is something that is currently under consideration, we believe, in the next Australian federal budget. PSA is strongly supportive of this program going ahead. We are also aware of the Remote Area Aboriginal Health Services Program that operates in remote areas to support the supply of medicines to Aboriginal and Torres Strait Islander peoples. We are strongly supportive of those services that currently exist.

**Mr LISTER:** I represent a country electorate and I am very interested in what you said about compounding and so forth. Could you give me a bit of a 'politician's five' on what that involves? Is it making Upton's Paste or paracetamol? Does it have a particular importance to pharmacies in areas like mine that have lots of small towns away from the capital city?

**Ms Wright:** If we look at the definition of compounding as such, it can be skewed in terms of whether we are making up a cream that someone needs to apply or, for example, an antibiotic mixture that we are mixing up according to the manufacturer's directions by adding water to the powder. If you look at the definition of compounding, something as simple as administering a vaccination could fall under that in terms of the diluent that needs to be added to the vaccine before it can be administered. To look at compounding as such, it is a very broad term. The definition needs to be specified in terms of how that can impact on administration.

**Ms Floyd:** I can probably add to that a little bit, too. There is breadth in compounding. There is simple compounding, which is what we all learn in undergraduate, which is around how to make creams or ointments or certain tonics and so forth. There is quite complex compounding available at some pharmacies where they actually invest in significant resources to have the highest technology. Predominantly when there is not a current product available, approved by the TGA, for an individual they would compound a particular medicine, or it might be a form. Someone might not be able to take a tablet and there might not be a liquid form of that medication. The compounding pharmacy would

find a way to find a dosage form that that patient can take. There is a breadth to it. They are very important. Generally, the growth of compounding services has been significant over the past couple of years. You will probably find in most areas that there is some form of compounding pharmacy in communities.

The point around reconstitution that we raise in our submission is just a technical issue. Currently in the Medicines and Poisons Act they have a different definition of compounding, and we support that that definition continues or is replicated.

**Mr CRANDON:** I am thinking about the co-locating concept. I think it is pretty clear that most do not support the idea of Woolworths owning pharmacies that are located within the shops. Around my electorate, which is a little different to yours—

**Mr LISTER:** There are not as many people.

**Mr CRANDON:** There are not as many people, no. I know that there is a lot of co-location in terms of a doctor surgery being right next door to a pharmacy. In fact, they will even have a doorway between the two, which is a great convenience, I think. We also have pharmacies co-located immediately outside Woolies or Coles. In some locations they are inside the shopping centre: the pharmacy is there and right next to that is the supermarket. Do you think there is any confusion caused by that sort of thing? Do you see any need to restrict location?

**Ms Floyd:** We would support what is being proposed in the bill, that that pharmacy business or that community pharmacy is separated from the supermarket.

**Mr CRANDON:** If the supermarket takes the primary lease and subleases to a pharmacy, do you support that?

**Ms Floyd:** It is around location, so how it is set up in relation to the leasing arrangements, which is what I will probably comment on. In relation to location, I would think you would all agree that, particularly through the COVID pandemic, community pharmacies really stepped up with the delivery of a variety of new services like vaccination services and so forth. They are really being seen by the community as a health hub. If they are located closely to a supermarket, from my understanding, the consumer would very much delineate the difference between a community pharmacy and going into Woolworths or Coles. As a consumer, I can certainly feel the difference. I am probably a bit more knowledgeable in relation to what a pharmacist does, but I think about when I go into Woolies and look at some of the medicines and how easily I can access them, and I think a consumer can definitely identify that they would be able to access great advice without an appointment in the community pharmacy model.

**Mr CRANDON:** Sitting right next to the front door of the supermarket is no issue for you?

**Ms Floyd:** No. I think it comes down to a point of convenience. We talked about convenience being important but, in reality, they are a separate health service; they are not a supermarket. They should be separated and the community should be, I believe, cognisant of that.

**CHAIR:** There are no further questions. I note that no questions were taken on notice. We really appreciate your feedback and we also have your submission. Thank you very much.

## NARDI, Mr Angus, Chief Executive, Shopping Centre Council of Australia (via videoconference)

## NEWTON, Mr James, Head of Policy and Regulatory Affairs, Shopping Centre Council of Australia

**CHAIR:** Welcome. Would you like to make an opening statement, after which we will have some questions for you?

**Mr Newton:** Thank you, Chair and committee members, for inviting us to today's public hearing to discuss our submission and the bill. Shopping Centre Council of Australia members own and operate or manage 140 shopping centres in Queensland. This equates to around 75 per cent of the market. These centres comprise 10,000 retail tenancies, which are approximately 80 per cent of the shopping centre tenancies in Queensland. The majority of our members own and operate or manage shopping centres in Queensland, ranging from one to over 30 centres. Approximately 20 per cent of these are larger or CBD-based centres. The remaining 80 per cent are smaller neighbourhood or medium size subregional centres. Our interest in this bill stems from the over 140 pharmacies in our members' shopping centres. This shakes out to be 1.1 pharmacies per centre on average, representing about 1.6 per cent of our total tenant mix.

The purpose of our submission and for us appearing here today is not to inappropriately or unjustifiably affect the business models of pharmacies as regards the provision of medical or health services; however, we do not wish to see our rights infringed by the granting of additional rights to pharmacies or to see our rights as landlords overridden. I cannot stress that enough. Pharmacies are highly valued tenants, critical to the fabric of our members' centres and tenancy mix. The bill would legislate a number of issues; however, our focus and interests are limited to how pharmacy tenancies intersect with leases in our shopping centres.

Shopping centre owners lease space to tenants for an agreed use, for an agreed period of time and for an agreed amount. The lease is a legally binding contract that regulates the relationship between landlord and tenant. As the ultimate owners of the land on which our tenants operate, shopping centre landlords may set certain conditions or expectations, provided they make certain disclosures and meet certain conditions, for the benefit of the entire centre. Disclosures by tenants are also made in return, and leases are entered into with eyes wide open. Conditions and expectations are known to all parties. Leases balance the right of a landlord as the ultimate owner of the land with the rights of a tenant, who has the right to operate their premises in accordance with the lease. As general principles, legislation in our view should not undermine the legal rights of one business to advantage another or provide for unrationalised or competitive advantages or carve-outs.

Our concern is that the bill could enable pharmacies to affect well-established legal rights, including under the guise of health services, meaning that the bill confers rights that extend well beyond medicines and the health services that they provide. We respectfully seek that the bill be amended to ensure that third parties, in our instance shopping centres, do not have their rights and expectations of tenants unjustifiably interfered with and that the bill is appropriately balanced.

In our submission we made five targeted recommendations on the bill in order to strike what, in our view, we would consider a better balance. One of these is highly pertinent. Clause 22(1) (b) would provide pharmacies with the unfettered right to deliver any and all health services. We are deeply concerned about the flow-on impacts of establishing opioid dependency treatment or a Queensland Needle and Syringe Program service in shopping centres where the owner has no right to consider or approve the delivery of such service. We are happy to talk to this or answer any questions that committee members might have with regard to our submission. Thank you once again for having us today.

**Mr STEVENS:** Thank you, Mr Newton. In your submission you state—

> … restricting or voiding certain agreed lease terms and limiting third party control … pharmacy businesses are given a legal and commercial advantage. This could ultimately give rise to … impacts on other tenants ...

You have about 12 per cent of the pharmacy market in Queensland—roughly 140 pharmacies, or one per centre if you like. Can you expand on the concern about your other tenants, given the fact that pharmacies are an independent operation in the health field? Is this a financial objection or a health provision objection? You mentioned right at the end your worry as a landlord about them delivering opioids—marijuana is now a new treatment, as I understand it—and a few other things like that that have gone into injections for vaccinations et cetera. Are you worried about those particular health services in your shopping centres?

**Mr Newton:** That drives two of our recommendations. I will go through them in order. The first goes to the right to deliver health services. Our view is that 'health service' is not well defined in the bill. Certainly the two examples that are provided there are of concern. I looked at the Department of Health's website this morning. From what I can see, for instance, the Needle and Syringe Program does not deliver those services in shopping centres. This bill would introduce the capacity to do that, combined with opioid dependency treatment, in the middle of shopping centres. As landlords, we would strike a lease agreement with the tenancies with the understanding that those services would not be delivered, but I think those two examples in particular are of concern in a shopping centre environment. The bill as drafted now would enable tenants to start to deliver those services. We absolutely do not object to the delivery of those services—it is not our place to do that—but, when it comes to them taking place in a shopping centre, there are concerns about surrounding tenants in terms of the surrounding foot traffic. Many thousands of customers come through shopping centres each day. Those services have flow-on effects that we would absolutely want to talk to the tenant about and not allow them unfettered capacity to start delivering those services.

When it comes to the second part of your question, that drives that turnover rent. It is established—it is not necessarily something we would agree with—that, ultimately, turnover rent cannot be required of pharmacy tenants. What we have recommended in the bill is, ultimately, a significant proportion of turnover that goes through a pharmacy is not related to medicines or services. In a sense, they provide the same goods that other retail tenancies provide as well. The recommendation there is essentially asking that that be delineated and the delivery of medicines and services be delineated from general retail.

**Mr STEVENS:** So it is a financial objection?

**Mr Newton:** It is not so much a financial objection. Angus will most certainly jump in if I am not telling the whole story here. Turnover rent is security for both parties. It is not a financial objective for the tenant as such. When the tenant trades well, the tenant obviously benefits from that as does the shopping centre landlord. The vast majority of shopping centre leases have a turnover component to them.

**Mr STEVENS:** What happens when the turnover drops?

**Mr Newton:** If the turnover drops they pay less rent as a result, if that threshold is not met.

**CHAIR:** On the particular services that are put forward, effectively the landlord would get to choose which health services are delivered and which are not; is that correct?

**Mr Newton:** No. On our read of the bill, and certainly the two examples that are provided, we understand that a number of services are provided within pharmacies that are beyond the dispensing of medication. Our concern is that the bill as drafted provides an unfettered right to deliver any health services without reference to the landlord or without consultation.

**CHAIR:** I am just wondering how to phrase that. I give the example of a diabetic who needs needle services. The landlord would make the decision about whether that would be able to be provided?

**Mr Newton:** I would suggest that something like that would be of no concern whatsoever.

**CHAIR:** But the things that are of concern—

**Mr Newton:** We would want to have a discussion.

**CHAIR:** If a landlord had a moral concern about, say, voluntary assisted dying or the provision of the pill by a pharmacist, would that be something controlled by the landlord?

**Mr Newton:** I would not want to make a comment on those specific examples. I would not expect that in the general course of business that would be something a landlord would object to on conscientious grounds, if you like. It is those programs that would have a material effect on other customers through a shopping centre, though. Certainly, the two examples in the bill are of concern and we would want to have a discussion before anything of that nature was permitted.

**CHAIR:** We have a collective responsibility to help those with addiction problems through things like methadone programs. That is something that a landlord would be able to veto out of that collective responsibility we have in the community to reduce opioid dependency?

**Mr Nardi:** I know that it is difficult with me being on online, and apologies that I cannot be there. It is not for us to veto. It is that, No. 1, we are made aware of these things. To give an example, during COVID we, at the request of a lot of governments, enabled testing and vaccination within our centres. Some of those activities gave rise to additional queuing in certain parts of the centre or could have impeded access of people with mobility limitations. It is largely about there being an awareness of it

and, by and large, being able to understand and manage that. As stated in our submission, we are not in the business of opposing any provision of health services by the pharmacy to the community, but where that service could give rise to an externality or whatever the landlord should be made aware and there is an ability to work through and manage any issues that may arise.

**CHAIR:** Understood.

**Mr CRANDON:** We have been talking about people with addictions and so forth. There is no restriction on people with addictions entering shopping centres, is there?

**Mr Newton:** No, not as such.

**Mr CRANDON:** If it is easier for them to go to a shopping centre pharmacy as opposed to one that is not attached to the shopping centre for their medical needs, doesn't that fly in the face of what you have been saying about not having a problem with this, that and the other thing but, 'We don't want you people with an addiction anywhere near us'?

**Mr Newton:** I think as the bill is drafted it provides pharmacists with the unfettered right to make that determination and not be obliged to have a conversation. I think as landlords our members have responsibility to the wider customer base. Essentially, I think those kinds of scenarios would need to be managed, and I think the exposure to a much wider customer base—we would need to have a conversation with the pharmacy before that was just enabled.

**Mr CRANDON:** The pharmacist could not foretell all of the potential scenarios in relation to those sorts of services, so it sounds to me more like you want to control the idea of anyone with an addiction that needs support from the shopping centre arena. It is a permanent thing that you are setting up-front. Would it not be better for the pharmacist to make the call on who they can assist and who they cannot assist?

**Mr Newton:** Eighty per cent of community pharmacies are located outside of shopping centres, so I think the services would still be delivered by the broader health system. Take, for example, the Needle and Syringe Program. From what I can see, none of those are currently delivered inside shopping centres. I guess the question would be: 'Do those services need to be provided in shopping centres and could they be delivered elsewhere?' I think perhaps that is a decision that should be made by the landlord with the tenant and not retrospectively made by a tenant.

**Mr CRANDON:** I am concerned with what you are saying in that you are talking about 80 per cent are remote from shopping centre situations, but quite often you will find that people with those sorts of addictions are perhaps located, whether it be sleeping rough or whatever it might be, closer to shopping centres than perhaps some of those other pharmacies that you are talking about that might be more remote.

**Mr Newton:** Possibly.

**Mr BAILEY:** Would you agree that addiction is a health matter?

**Mr Newton:** Absolutely.

**Mr BAILEY:** Would you also agree that health matters should be a matter between a client and their medical practitioner or, indeed, a pharmacist?

**Mr Newton:** The way I would answer that is ultimately about the conditions that we allow a business to operate on under their lease, and I think these are discussions that should happen when a lease is signed.

**Mr CRANDON:** I am someone who is an asthmatic so often if I run out of Ventolin—I have already talked about adherence and not being good at it. I am there first thing in the morning at a chemist which is often a time when people who have opioid addictions are there. This is something that I think chemists do quite professionally and carefully and there is generally very good behaviour from the people involved. I do not generally turn up at a bottle shop at nine o'clock in the morning or 10 o'clock in the morning when they open at a supermarket.

**Mr STEVENS:** Alcoholics do.

**CHAIR:** But there are some people who have quite bad behaviour and have a dependence on alcohol. Are tenancies taken away because there are concerns over the addiction of people with alcohol and early-morning visits to bottle shops?

**Mr Newton:** No, tenancies are not taken away as such. I think at the end of the day landlords have a responsibility that is not just to a small number of customers of a certain tenant; it is a responsibility to everyone who steps in the doors of the shopping centre.

**Mr CRANDON:** We are talking about the people who are under treatment for opioid addiction.

**Mr Newton:** Yes.

**Mr CRANDON:** They recognise their issues, they are looking for support and they are looking for that as close as they can possibly get it. I am just thinking back to what I was saying: if that is their nearest pharmacy and they have a long way to go to the next pharmacy that could provide the service, then it may be the difference between them going backwards in their treatment as opposed to being able to get the treatment they need through the pharmacy in the shopping centre.

**Mr Newton:** I would go back to what I said before. For instance, the Needle and Syringe Program is not delivered in shopping centres. There are hundreds of locations elsewhere in standalone clinics, in hospitals and in other settings. I would stick to that response. I think the services will be delivered to the community, but it should not be incumbent on shopping centres to enable a number of pharmacies to expand their service offering in a setting that we ultimately have responsibility for.

**Mr LISTER:** Thank you for your appearance today. I want to put something to you which concerns the main theme of your attendance today. You said yourself that the service might perhaps be better provided elsewhere. As a regional member who is concerned about businesses and so forth, particularly with trading hours and the like, am I to understand it that the Shopping Centre Council of Australia has advocated for liberalisation of trading hours? If that is the case, are you not on the one hand saying, 'We want something that makes it harder for a small business in the main street to compete,' but at the same time, 'We would like to have that main street business be the provider of services which we feel are not appropriate for the particular venue'? Can you see how that might be seen as having a bet each way?

**Mr Newton:** Respectfully, I would say that that is a long bow to draw.

**Mr LISTER:** Do you have anything further to say on that?

**Mr Newton:** No, nothing further to say.

**CHAIR:** There being no further questions, I appreciate your appearance here today.

## WALKER, Mrs Lucy, Member, Interim Pharmacy Roundtable

## WATSON, Ms Fiona, Chair, Interim Pharmacy Roundtable

**CHAIR:** Welcome. Would you like to make a brief opening statement before we turn to members' questions?

**Ms Watson:** Thank you, Chairman and committee members, for the invitation to provide an opening statement to the inquiry into the Pharmacy Business Ownership Bill 2023. My name is Fiona Watson and I am chair of the Interim Pharmacy Roundtable. I am also a member of the Pharmacy Guild and I am also a member of the PSA. I have been the owner of a community pharmacy in Redland Bay for 14 years and I have been living and working in that community during that time. I am very fortunate to have the wonderful Kim Richards as my local member. I am joined by my fellow IPR member and community pharmacy owner Lucy Walker.

The IPR was established in 2019 to be an advisory body to the Department of Health while work was underway to enact the recommendations of the 2018 *Inquiry into the establishment of a pharmacy council and transfer of pharmacy ownership in Queensland*. The IPR was tasked with providing expert advice to the department on the 2001 act and pharmacy ownership and operation in Queensland. Since 2019 the IPR has provided regular feedback to the department on the development of the new bill and we welcome its introduction to parliament.

While the bill does much to achieve its main purposes, the IPR has some unresolved concerns with the bill which I will now discuss. First is the definition of 'core pharmacy services' in clause 8. The IPR has consistently raised the issue of the narrow definition included in the bill. In our submission we stated that a broader definition would help to ensure that pharmacy services are provided in line with community expectations and that unregulated persons do not provide services that the community would expect to be provided at a regulated pharmacy business. Our concerns have crystallised upon reading the department's response to the issue raised by our colleagues at the Pharmaceutical Society of Australia.

The department has confirmed that the current definition of 'core pharmacy services' is not intended to capture businesses that only sell scheduled medicines that can be lawfully sold without a prescription. In practice, this means that businesses can sell schedule 2, which are pharmacy-only medicines; schedule 3, which are pharmacist-only medicines; and some schedule 4, which are prescription-only medicines, and not be determined by the legislation to be a pharmacy business. This would not be acceptable. These businesses would look like a pharmacy, they would employ pharmacists and they would provide many of the services that the public would commonly expect of a pharmacy yet not be subject to the regulations of this bill. Further, as they are not deemed to be a pharmacy business they would not need to adhere to the Medicines and Poisons Act 2019 and subordinate legislation the Medicines and Poisons (Medicines) Regulation 2001, the pieces of legislation that control the use of medicines and poisons in Queensland. This would undermine the practice of community pharmacy and the integrity of the community pharmacy model, and it makes a mockery of the bill and the years of collaborative work that have been undertaken to this point.

Our second concern is the membership of the Pharmacy Business Ownership Council. The regulatory strength of the new act relies on how proactively the council monitors and enforces compliance. Meaningful and effective oversight of the regulation will only be achieved by a council with a majority of pharmacy business owners with relevant experience. We do not dispute the value of a diversity of skills and experience in the membership of the council, but we still believe that the foundation must be built on members with practical experience in the industry. This means that the council will have the internal expertise it needs to execute its functions without the need for extensive and ongoing external counsel.

The department explains in its response that the balance of the council will be considered through the membership appointment process. This approach to membership of the council is unique to Queensland. In every other state and territory it is legislated that the membership of the relevant councils are at least 50 per cent pharmacy business owners. It would be a disappointment to invest the time, money and resources into establishing this long-awaited council for it to fail in its functions due to lack of industry expertise.

Our final concern for discussion today is the ambiguity surrounding the policy intent for fit and proper persons in clause 72. The department explains that the clause has been drafted in such a way to account for circumstances where the council wishes to exercise flexibility when deciding to issue a pharmacy business licence. The council needs direction which removes doubt as to the policy intent

of the fit and proper persons test. The council must be compelled to deny licensing where prohibited activity is identified signalling that non-eligible persons hold a material interest in a pharmacy business. Without such direction the policy intent is uncertain and the council's position is weakened.

The IPR appreciates the collaborative relationship formed with the department over the past 4½ years and we look forward to the enactment of the bill and the establishment of the council. However, the concerns raised in this statement must be adequately addressed to ensure the council has appropriate oversight and the legislative power to do its job to regulate the industry.

**Mr STEVENS:** Thank you very much. That was a great presentation. We have had presentations from the Pharmacy Guild and from the Pharmaceutical Society of Australia. Can you tell me how the Interim Pharmacy Roundtable was established, what members you represent, why is it interim and where it is going? That is the first bit. Secondly, in terms of the loopholes that you identified in schedule 2, 3 and 4 medicines that people could sell, could you tell me what types of drugs that covers and how important it is to make sure that loophole is closed in the legislation?

**Ms Watson:** To start, the Interim Pharmacy Roundtable was interim until this bit gets done—the bill gets changed.

**Mr STEVENS:** So it is all about this bill?

**Ms Watson:** It is all about this, yes. We were a ministerial appointment by the then minister for health and ambulance services, Steven Miles, back in 2018. There were three pharmacy owners: the chair at that time was Tim Logan, myself and Lucy. There was also an academic representative, a representative with accounting/financial and a consumer rep who was an Aboriginal and Torres Strait Islander representative. We have been giving advice to the department. We have had long, intensive discussions about how to improve the oversight of pharmacy ownership. The Audit Office in 2018 issued a report as part of that inquiry identifying that Queensland Health were essentially unable to implement the current bill so it did not have any oversight into how many pharmacies were actually owed by an individual and it was not able, essentially, to do its job.

**CHAIR:** It was not fit for purpose.

**Ms Watson:** Yes, it was not fit for purpose. Could you repeat the second question, sorry?

**CHAIR:** The second question was about the loopholes.

**Mr STEVENS:** Loopholes and—

**CHAIR:** I specifically had the question of where you had a prescription drug how it would not be defined as dispensing, which is under the current act. What would be the model in which—

**Mr STEVENS:** Hang on. Chair, please can we answer my question?

**CHAIR:** And I take it is your question.

**Ms Watson:** It is sort of the same.

**CHAIR:** I just had a more specific version of your question.

**Ms Watson:** Yours is just specific—

**Mr STEVENS:** Thank you. My interpreter.

**CHAIR:** You said the loopholes, yes?

**Mr STEVENS:** Yes.

**CHAIR:** All right. I will put Ray's question about loopholes.

**Ms Watson:** The position of the IPR is that a pharmacy business, for all intents and purposes, looks like a pharmacy. To the community, if it employs a pharmacist, looks like a pharmacy and has some form of medication there, then the community has an expectation that it will be held to the same standards as my business. There are circumstances with schedule 4 where the EPA, which is the extended practice authority, allows pharmacists to administer prescription-only medications such as vaccinations.

**Mrs Walker:** Now also the pilot in Queensland to do a full range of activities. Then you have your schedule 2, which is your pharmacy medicine, so everything behind the counter, and everything that a pharmacist then has to label as a pharmacist-only medicine. We do not necessarily dispense if you come into a pharmacy and get a large size of Nurofen tablets. In that case you are really coming in and seeing a pharmacy, but if you are not dispensing something in the current wording then—

**Ms Watson:** It is just about tidying the wording up a little bit.

**CHAIR:** I am just trying to understand—

**Mr STEVENS:** Over to you.

**CHAIR:** I am just trying to understand how that would not be commonly seen as dispensing, especially when it was—I cannot use any other word—dispensing a prescription drug. I am trying to understand this.

**Ms Watson:** We agree, so in the bill as it is written at the moment, unless it is a pharmacist dispensing under a prescription—in this particular instance there is not a prescription—it is excluded.

**Mrs Walker:** Pharmacists can already supply medicines not on a prescription from a doctor but instead from a pharmacist.

**Mr CRANDON:** Somac is a classic example, isn't it?

**Mrs Walker:** Yes. So that is a schedule 2 item, so we do not necessarily, under the classic definition, maybe dispense that.

**Ms Watson:** But we sell it.

**Mrs Walker:** Yes, we sell it.

**Mr STEVENS:** Got you.

**Mr CRANDON:** It is five times the price.

**Mr STEVENS:** Yes, not dispensing yourself—

**Mrs Walker:** Because it is not PBS—

**Mr CRANDON:** Yes.

**Ms Watson:** Because you are not subsidised.

**CHAIR:** So a proton-pump inhibitor such as Somac is a drug which you only as pharmacists under the TGA have the ability to give out in limited quantities as it is highly regulated and only as pharmacists, so I am trying to look for an example of where a non-prescription drug could not be dispensed when only pharmacists can give that out anyway, can they?

**Ms Watson:** But the bill is not ensuring that. That is what we are trying to get to.

**Mr STEVENS:** That is the loophole.

**CHAIR:** But it is not a loophole because the TGA says only pharmacists and there is a different definition that captures that.

**Ms Watson:** That is a pharmacist versus a pharmacy business. In the definitions in the bill, a pharmacy business is only those that provide core pharmacy services, and core pharmacy services are identified as only dispensing and compounding.

**CHAIR:** Just to get this clear, so what you are saying is that a business that looks like a pharmacy that employs a pharmacist could prescribe Somac but could not dispense any other drugs, which is not really a realistic business model, is it?

**Ms Watson:** I cannot comment on the realistic business models, but we have spent a lot of time talking about competition in the pharmacy sector and other people wanting to view pharmacy as being uncompetitive where—

**CHAIR:** I understand that people are looking for loopholes. I am just wondering whether it is a realistic one and that is why I asked exactly what that meant. If it was only a very limited class of drugs and the complete inability to do dispensing of prescription drugs, I am sure the act where it says about the ability to do drugs like Somac uses the word 'dispensing' as well even though it is not connected to a script, but even then I am not sure that it is a—

**Ms Watson:** If I could just say, too, that part of the role of the IPR was to look at the longevity of the potential bill. The current bill, we can agree, was not fit for purpose. Part of the IPR's role was to look at what pharmacy practice is going to look like in the future, so what being a pharmacist in five years and being a pharmacist in 10 years and 15 years looks like and how we can ensure the community expectation of a pharmacy business is still being met and regulated.

**CHAIR:** No worries.

**Mr LISTER:** Thank you both very much for coming in. I want to give a special acknowledgement to Lucy Walker, who is a living legend in my electorate being the pharmacy operator of Lucy Walker Pharmacy.

**Mr STEVENS:** There is no politicking here!

**Mrs Walker:** He is only saying this because I usually vaccinate him!

**Mr STEVENS:** Why do you not give her a how-to-vote card?

**Mr LISTER:** I will get one; just give me a second. Are we not the first to have made this voyage of discovery? If you have been created for the rare purpose of providing advice to government, have you not raised these objections or these concerns in the drafting stage of consultation and what response did you get? Were you assured by someone saying, 'No, we'll take that on board,' and have they disappointed you relative to that? Can you fill us in, please?

**CHAIR:** The member for Southern Downs may be unaware of our initial hearing with the department, but please fill in Mr Lister.

**Mrs Walker:** We have dealt a lot with the department—it is nice to see them behind us; we know them all very well—and we have had multiple conversations about what we see as a definition of a pharmacy service and these very conversations. Pharmacy businesses are different to a supermarket. You have just heard from the supermarkets and how they do not want necessarily all pharmacy services to be—health services—available. That was one of the great chances to actually see why a pharmacist owner is such an important thing when you are looking at a pharmacy business, because a pharmacy business is not a supermarket business. It is very specialised and it requires you as a pharmacist owner to put the needs of your patients and your community above what looks nice or what you want. I think having that discussion just before us was a really clear way of why Fiona and I in our free time will talk about why pharmacy owners should be pharmacists.

We have both worked overseas, in the UK. I hated working for Boots the chemist because I did not feel I had that autonomy to do what was right. I have travelled on a Churchill Fellowship and worked and seen what is happening in the States. Pharmacies there in the supermarkets are trying to encourage insulin users because that is where they make their money. If we cannot offer a Needle and Syringe Program to our patients, how are we supposed to work? We are here because we have been trying to work with the department to form solutions and make everyone happy together, because we believe—and it has already been decided—that pharmacies should be owned by pharmacists. Now we just have to get the little nuances correct in this next bill so that we can go for the next 10 or 20 years successfully caring for our patients.

**CHAIR:** Ms Watson, did you want to say something? Are there any further questions?

**Ms Watson:** I just want to rebut some of the interesting testimonials that we have heard so far today. Stephen King mentioned an inquiry in 2017 and he specifically referenced that there was a Pharmacy Guild representative on that. That was Bill, whose last name escapes me, but he actually issued a dissenting report. While the inquiry involved the Pharmacy Guild representative, there was a dissenting report put forward at that time, so that is relevant to Stephen King's point.

To the point of the AMA and the RACGP, I find it very disappointing to hear other health professionals put forward what was essentially a bit of an hysterical argument when at the end of the day it comes down to patient care. I have a GP clinic that is near me. It is owned by the GP themselves. When I talk to most GPs, they say that they wish that corporatisation had not happened within their industry, so it seems sour grapes to say that the last-standing regulated profession should 'join the rest of us' when the 'rest of us' do not like what we have, because the GPs are leaving in droves. There are 18 per cent of medical graduates joining GP land and that is just disappointing, because to me, at the end of the day, it is about the patient, and my GPs have an excellent relationship with me and most of my fellow pharmacy colleagues have an excellent relationship with their GPs.

**Mr STEVENS:** Mrs Walker, earlier Dr King was basically saying that this legislation was very negative for Indigenous cultures and Indigenous services in communities. Can you give us an explanation of how that is either correct or not correct and how it affects Indigenous communities?

**Mrs Walker:** I think every health professional wants to be able to do more to help Indigenous populations. I was quite fascinated listening to new models on how we can do better care. Within the pharmacy sector, we already have scholarships and different means of trying to get Aboriginal and Torres Strait Islanders to study pharmacy. I have two pharmacy assistants who identify as First Nations people and it is great within a pharmacy environment to have that within what we have. All of their medicines are under close the gap, so there is no charge to that and we can offer more services like blister packing at no charge as well.

What has been quite interesting is that as part of the IPR we have had a First Nations person consumer and we have always been focused on how we can do more. If a pharmacist who is a First Nations person could develop their own pharmacy that was particularly for First Nations people, that would be fantastic. At the moment we all do cultural training and I have worked in the same pharmacy for the last 15 years, so I am well known and there is that continuity of care that they all talk about needing and I work well with all of the local clinics and things like that, too.

**Mr CRANDON:** Obviously you are a legend out there. We have heard that personal testimony from the—

**Mr LISTER:** Can I say it again?

**Mr CRANDON:**—member next to me. Just coming back to the conversation that we were having about Somac and all of those other potentials, are you saying that there is a potential for this bill to give an opportunity for the corporates to do a backdoor job and—

**Mrs Walker:** Mmm.

**Mr CRANDON:** Okay. I did not quite get that before, so you are concerned that there is a potential for the backdooring of your industry by supermarkets et cetera?

**Ms Watson:** Yes.

**Mrs Walker:** We are worried that there might be the potential to have at Bunnings or shopping centres vaccination hubs on the side, and that is what we do not want.

**Mr CRANDON:** Right, as opposed to sausage sizzles?

**Mrs Walker:** Yes.

**CHAIR:** There being no further questions, we really appreciate you being here today and thank you very much for your submission as well.

**LAW, Ms Kirsten, Director, Legislative Policy Unit, Queensland Health**

**LEE, Mr Justin, Director, Queensland Public Health and Scientific Services, Queensland Health**

**SANDERSON, Ms Kate, Manager, Legislative Policy Unit, Queensland Health**

**STEELE, Mr Nick, Deputy Director-General, Queensland Public Health and Scientific Services, Queensland Health**

**CHAIR:** Good afternoon. Thank you for joining us. We have invited the department here today to give the department an opportunity to address the myriad issues raised by both witnesses today and submissions provided prior to today's hearing, as well as provide members an opportunity to ask further questions to drill down on some of those issues and to seek clarification in terms of the bill's provisions and the concerns that have been raised. Are there any particular matters you would like to address by way of an opening statement before I invite members to ask questions?

**Mr Steele:** I might just make a couple of opening comments and then we will leave it open to questions, in the interests of time. Thanks for inviting us back today to talk about the Pharmacy Business Ownership Bill 2023. I acknowledge the traditional owners of the land on which we meet today and pay my respects to elders past, present and emerging. I also put on record our thanks to everybody who has been part of the consultation process. We received over 800 bits of feedback through the two formal consultations, so thank you to everybody who has participated and also to everybody who has attended today. Having listened in to the hearing this morning, I think a lot of issues that have been raised we have already covered in our written response, so I will not go through those again. I will leave it open to questions, and between the four of us we will try to answer them.

**Mr STEVENS:** Thank you very much for your attendance here today, following up on your earlier presentations. The Interim Pharmacy Roundtable, which has been involved in this since 2017, has raised what I believe is a serious concern, even though it may not be, as the chair alluded to, a commercially viable opportunity at this point in time. It has taken 20-odd years to change the 2001 legislation. The delivery of schedule 2, 3 and 4 drugs is not captured, as I understand it, by this bill. Why do we not include those schedule 2, 3 and 4 drugs in the bill? It could be a recommendation from the Economics and Governance Committee, whose job it is to make better legislation.

**CHAIR:** Mr Steele, I note that Ms Sanderson is also nodding.

**Mr Steele:** I was going to go to Kate to answer that one. I thank the Interim Pharmacy Roundtable for the work they have done over the last 4½ years. I think that has been a really valuable partnership.

**CHAIR:** They have had enough confluence from the member for Southern Downs.

**Mr Steele:** I will pass on to Ms Sanderson to give you the detail on that one.

**Ms Sanderson:** As we have discussed before and in the previous hearing, the bill defines 'core pharmacy services' very narrowly and for particular purposes. The intent is not to limit the services that a pharmacy can provide or imply that that is all that a pharmacy business does. It is very much to capture particular businesses for the purpose of this act.

I acknowledge the IPR's concerns. I would say that, although a business that offered only those medicines and did not dispense other medicines or compounds would not be captured under this definition, that business would still be regulated. It would still be subject to the medicines and poisons legislative regime. The pharmacists working within that business would still need to comply with the Health Practitioner Regulation National Law. In no way is it an unregulated business. It is simply not captured for the purpose of the ownership restrictions. They are still subject to all other professional obligations and the medicines and poisons regulations.

**CHAIR:** One of the concerns was of someone putting themselves forward as a pharmacist or, in the case of those drugs, as an actual pharmacist but within a different corporate structure. They then might push, for want of a better word—promote or encourage—people to buy drugs that are not on the register and that have limited therapeutic value. There could be a business model around that. Is it possible to define it as such that we can capture that and anticipate that evolving business in the future?

**Ms Sanderson:** If it is a pharmacist who is doing the selling of those products, they already have many professional obligations and legislative obligations under other laws. The ownership is not really a factor when it comes to that point. There are other obligations that should stop them from pushing drugs that are not necessary.

**CHAIR:** I understand that. We also hear that Boots or CVS or Walgreens—large corporates—have forces that are not necessarily in the patients' best interests and that compromise some of those values in the longer term or over time, especially for younger pharmacists who may not be able to stand up for their professional ethics. Is there a way to perhaps construct the definition in that way?

**Ms Sanderson:** That would be a matter for government in deciding to change the direction in that way.

**CHAIR:** I will put it another way. With the South Australian definition, are there unintended people who would be captured? What are the concerns there?

**Ms Sanderson:** Our concern around the South Australian definition is that it goes to any service provided by a pharmacist. Therefore, it would capture a pharmacist who was employed by a general practice surgery. It would capture a pharmacist who was doing medication reviews for an aged-care home. That business would then be a pharmacy business for the purpose of the ownership restrictions, which goes beyond the scope of this bill.

**Mr CRANDON:** The Interim Pharmacy Roundtable made it clear that they are concerned about the backdooring of the whole operation. Could these businesses that would potentially be within a supermarket call themselves a pharmacy?

**Ms Sanderson:** Under the bill as drafted?

**CHAIR:** These are theoretical businesses that are yet to exist, admittedly.

**Ms Sanderson:** Sorry, are we talking about a business that was only selling S2, S3 and S4 drugs and was not doing any other dispensing or compounding?

**Mr CRANDON:** We are now talking about the non-prescription—

**CHAIR:** But embedded within a larger business selling other products.

**Mr STEVENS:** Nurofen and Panadol.

**Mr CRANDON:** Those three aisles there are—

**Ms Sanderson:** They would not be captured by the definition.

**Mr CRANDON:** So they could call themselves a pharmacy?

**Ms Sanderson:** There are no title protections within the current act.

**Mr CRANDON:** There is no title protection. The point, I believe, that is being made by the Interim Pharmacy Roundtable is that mum and dad walk in off the street and they do not know the difference.

**CHAIR:** They cannot fill a script.

**Mr CRANDON:** They do not know the nuances between what that is and what these folk are over here. It seems to me that that makes a lot of sense—that there should be a greater restriction so that we do not have that backdooring happening. Why couldn't we make sure of that? What is the harm in that?

**Ms Law:** I think Kate has generally covered the points. This definition is about defining what is traditionally understood to be a community pharmacy business. I think most people would agree that in walking into a pharmacy you expect them to dispense a medication prescription. Noting that Nurofen and Panadol can be sold by a range of people other than a pharmacist and the category of medications that we are talking about here, I think it would be an unusual business model to be setting up a community pharmacy that is purely selling non-prescription medicines. I do not think that is what is traditionally understood as a community pharmacy and the pharmacy business that we are talking about here.

**CHAIR:** For instance, if someone were a registered pharmacist working for an Aboriginal community health organisation who was not dispensing but was providing advice on the nature of drugs, the regularity of taking them, the importance and value of taking them, and building up that trust relationship, we would not want this act to capture their activities because they are not dispensing or prescribing; is that fair to say?

**Ms Sanderson:** That is correct.

**Ms Law:** The bill is very specifically set up not to capture those types of pharmacists working and providing services other than compounding and dispensing.

**Mr Lee:** It is important also to recognise that S2 and S3 medicines, which are typically considered to be largely over-the-counter and pharmacist-only medicines, are not medicines that can be sold in supermarkets. What can be sold in supermarkets are what are termed unscheduled medicines. Any medicine that is scheduled still falls under the regulatory framework of the Medicines

and Poisons Act, so there are provisions in there that prevent these medicines from being sold as such. For example, there may be S2 medicines that are supplied by a shipmaster because the legislation allows that in those circumstances for travel sickness and so on. What I am saying is that, in the context of how medicines are supplied, there are a variety of circumstances where an S2 and S3 medicine may be supplied other than through a pharmacy, but all of those are regulated quite specifically in the Medicines and Poisons Act. It is not that S2 and S3 medicines are available for anyone to offer for sale.

**Mr CRANDON:** That is understood, but we are talking about the future. We are talking about the potential for those drugs to be sold in a supermarket because there is a pharmacist in the store. The pharmacist is behind the counter. That will undermine the potential of the pharmacy industry to survive because a lot of their business will be drawn to the supermarket. We are not talking about now. We are not talking about yesterday. We are talking about the future. They have mentioned that on several occasions—that this could happen in the next 10 or 20 years. We are not suggesting that Somac would be on the shelf for you to just buy it like you do Panadol. We are talking about the future set-up, with these very smart people who look to ways they can infiltrate other markets within a supermarket setting. They would still be called a pharmacy because the act does not stop that. They would be down the back and all those medicines would be behind the counter and a pharmacist would be sitting there, but they would not be a pharmacy in the way that the Interim Pharmacy Roundtable have outlined.

**CHAIR:** That seems to be the same question you put before. Just to clarify, those people cannot fill a script. In the common understanding of what people go to a chemist for, they are not going to mistake that as a chemist.

**Ms Law:** That is right. They will not be able to fill a script. I think what Justin has raised is that there are other restrictions on who and where medicines can be sold and the circumstances. Justin will correct me if I am wrong. I think there was mention of a vaccination clinic in Bunnings. There are restrictions in the medicines and poisons legislation around where vaccinations can be undertaken. There is other legislation that covers those types of rules.

**CHAIR:** I certainly got vaccinated in Bunnings myself.

**Mr STEVENS:** Just so we are clear in what we are talking about and not going round and round in circles here, how many drugs are there involved in schedules 2, 3 and 4? Is it a large amount of drugs that we are selling and not prescribing?

**Mr Lee:** It is not possible for me at this stage to be able to quantify the number. The Commonwealth produces what is called the Poisons Standard, which lists all the substances in those categories. There are a lot of substances in schedules 2, 3 and 4.

**Mr STEVENS:** In other words, just like Woolies and Coles have alcohol shops set up right next to their supermarkets, they could set up a pharmacy that looks like a pharmacy right next to a supermarket that sells all the normal Panadols and Nurofens plus all the schedule 2, 3 and 4 drugs. There would be a pharmacist there and it would look like a pharmacy.

**CHAIR:** It would look like one but it cannot fill scripts.

**Mr STEVENS:** The only thing they cannot do is fill a script.

**CHAIR:** That is pretty important for a pharmacy.

**Mr STEVENS:** It is pretty important.

**CHAIR:** Mr Lee, it might be worth taking on notice the nature of those two classes of drugs and also what the poisons legislation, both state and Commonwealth, says in terms of restrictions on sale. For the benefit of the committee, if you could take that on notice that would be great.

**Mr LISTER:** In answer to the theme that is being pursued by the member for Mermaid Beach and the member for Coomera, apart from—and we agree on this—the ability to fill a script, I am talking about a fairly large swag of what constitutes a business that enables a pharmacist to exist to provide that service. How does the view of, 'Oh, that will still be regulated another regime,' sit with the committee's recommendations? Page 3 of the explanatory notes state—

> The Committee expressed concerns that any removal or relaxation of the ownership requirements would result in reduced access to medicines and quality of services, particularly in rural and regional areas of Queensland. It was concerned that heightened competition from large corporations would force many small, independent pharmacies to close and it was not clear that they would be replaced by a corporate pharmacy.

That is what concerns me here. How do you reconcile what you have said to us—'No, they will be looked after under an alternative regulatory regime'—with that particular unequivocal finding of the committee?

**CHAIR:** It was not a finding of the committee.

**Ms Sanderson:** I would say that the bill does retain the current ownership restrictions, which is what the committee recommended. It ensures that pharmacy businesses are primarily owned by pharmacists.

**CHAIR:** What the round table recommended.

**Ms Sanderson:** Sorry, it was the 2018 parliamentary committee. Their recommendation was that the current restrictions be retained. The bill does retain those. It clarifies a number of ambiguities in the current act which contribute to the current act being difficult to administer and enforce. The bill adds a level of clarity that is not in the current act by providing clear definitions of what is captured and what is not captured. It does retain those ownership restrictions as set out in the 2001 act.

**CHAIR:** We have an undertaking to get some further information on notice about the nature of restrictions on those classes of drugs and restrictions on their sale. There being no further questions, I really appreciate the department coming here to speak to us today and also the information you gave us in your response that we have taken onboard. Thank you to the Hansard reporters. A transcript of these proceedings will be available on the committee's webpage in due course. With that, I declare this public hearing closed.

**The committee adjourned at 1.46 pm.**