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To: Pharmacy
Subject: Pharmacy Submission - attached
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Submission regarding Inquiry into the establishment of a pharmacy council and transfer of pharmacy ownership in Queensland: Pharmacists' and pharmacy assistants' roles and scopes of practice

I submit my concerns as a General Practitioner, drawing upon my own personal experience, and discussions with colleagues who share my concerns. I also provide some supporting articles where relevant.

My greatest concerns arising from this proposition are:

- fragmentation of care

- conflict of interest

- potential for missed diagnoses/missed management/incorrect management

- reduction in preventative care

I: Should the scope of practice of pharmacists and pharmacy assistants in Queensland be extended? If so, in what areas of practice?

I am aware that pharmacists already provide influenza vaccinations. I already have some concerns about this such as fragmentation of care (a patient's regular GP may not be made aware of the flu vaccination that has been given) and furthermore, the capacity of the pharmacist to manage an adverse reaction to a vaccination.

If pharmacists are able to provide increased vaccination programs, this will further fragment care (patients often cannot remember their last vaccination, and it is entirely possible that some patients will get repeat doses or subsequently have an adverse reaction to this).

Furthermore, the greater number of vaccinations, the greater the risk of adverse reactions. Are pharmacists trained to manage the potential anaphylactic adverse reactions that may occur?

II:

"Key areas where an enhanced role could occur are in medicine adherence and management..... treatment of minor ailments.... prescription renewals......

“For example, opportunities to enhance pharmacy care include:
· allowing pharmacists to provide certain medicines to treat cardiovascular disease, respiratory illnesses and dermatitis without long-term patients needing to obtain a repeat prescription from a GP
· vaccinating against a wider range of illnesses and a broader range of people than currently allowed,
· and supplying pharmaceuticals such as contraceptive pills and erectile dysfunction pills over the counter without the need for a repeat prescription.”

I have already outlined my concerns around vaccinations.

I also have concerns regarding pharmacists acting as prescribers.

1) Firstly, there is a direct conflict of interest. If the prescriber is also the dispenser and stands to make money from dispensing more/a certain brand/a certain type of medication, then what are the checks and balances for this?

2) Secondly - fragmentation of care. There are two types of care - fragmented care and continuity of care. In the first, a patient may see multiple providers, with no one overseeing their overall care. Thus, a patient may see one provider for one condition, another provider for another, and so on. But as no one has the overall picture, dangerous medical conditions can be missed. Diabetes may go undiagnosed. High blood pressure may not be followed up with if a person sees a different provider each time. Furthermore, each time a patient sees a different provider, that provider has to go over the entire past history each time, and therefore will not have the ability to explore other issues such as preventative care, or psychosocial care, if their primary focus is just the problem at hand.

In contrast, when a patient has continuity of care with the same service provider, there are certain advantages. Their regular practitioner has the advantage of knowing their baseline, and being able to immediately discern how unwell a patient is, in comparison. Ongoing care means that a medical problem may be diagnosed over time. Also, subsequent presentations by the patient are more efficient, and thus there is also more time to look at preventative health care.

Fragmenting health care is both inefficient and dangerous in the long run.

I point out the following opinion pieces:

1. Australian Health Care — The Challenge of Reform in a Fragmented System, The New England Journal of Medicine: https://www.nejm.org/doi/full/10.1056/NEJMp1410737

2. The Problem of Fragmentation and the Need for Integrative Solutions, Annals of Family Medicine: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2653966/

3) Thirdly - repeat prescriptions. Currently, patients with chronic conditions such as cardiovascular and respiratory illnesses receive 6-monthly prescriptions. When a patient makes an appointment to see a doctor every 6 months, that is an opportunity to assess their progress and make changes to their management if required. In the majority of these cases, another intervention is required such as a blood test (to check other risk factors such

as for further heart attacks, strokes). Sometimes, this may be the only contact a patient has with a doctor throughout the year. Should pharmacists take over this role, it is possible that a patient may go without seeing a doctor for years. This in turn may lead to sub-optimal management of their chronic condition (some secondary conditions are in fact asymptomatic, and may not be detected by a pharmacist providing a repeat prescription)

4) Fourthly - contraceptive pills and erectile dysfunction pills over the counter without the need for a repeat prescription."

In the case of the oral contraceptive pill, there are certain contraindications to the pill such as being a smoker over the age of 35, and greater risks in someone aged over 50 years. In some cases, a "repeat prescription appointment for the contraceptive pill" may turn into a lengthier discussion about smoking cessation, or alternative contraceptive options. A pharmacist is neither qualified to provide this service, nor can guarantee a patient will attend their doctor to discuss the above. A patient seeking the convenience of a pharmacy contraceptive pill script may not go out of their way to see a doctor to discuss the above if there is a more convenient (yet dangerous) alternative.

In the case of erectile dysfunction pills - this also ties back to the chronic condition issue raised previously. Erectile dysfunction always has a cause, and that underlying condition will in most cases need ongoing management. Another issue raised here is that as many erectile dysfunction pills are on a private script, what obligations does a pharmacist have to discuss the different types and costs, where some brands may be more beneficial than others? There is also the option for missed diagnosis, if a patient were to continue erectile dysfunction pills indefinitely without ever seeing a doctor again.

These concerns are in no way directed to individual pharmacists, but at the proposed system as a whole, taking into account patient behaviours and current trends.
I ask that the Inquiry take these concerns into consideration.

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