Committee Secretary
HCDSDFVPC
PARLIAMENT HOUSE QLD 4000

12 July 2018

Re: Inquiry into the establishment of a pharmacy council and pharmacy ownership in Queensland

Introduction

Thank you for the opportunity to provide a written submission to the inquiry into the establishment of a pharmacy council and pharmacy ownership in Queensland.

The Australian College of Pharmacy (the College) is a Registered Training Organisation (RTO) and accredited to accredit Continuing Professional Development (CPD) for pharmacists. It is a member-based professional organisation which from its earliest antecedent, has operated continuously since 1978.

The College is governed by a Board and in 2011 established an Academic Board to oversee the development of education in its three faculties- clinical, business and compounding.

Currently, the College scope of registration includes:

- Advanced Diploma of Leadership and Management
- Diploma of Leadership and Management
- Diploma of Business Administration
- Diploma of Human Resources Management

The College aims to provide high quality education to assist pharmacists to maintain their competence in all aspects of their role.

The role of the pharmacist has been expanding such that pharmacists are now providing health care services, which include improving the quality use of medicines, disease/condition management professional services, and primary health initiatives such as immunisation services.

Consistent with the evolution of the pharmacist's role, the College has extended the scope of education and continuing professional development (CPD) activities we develop and accredit.

It is College policy and practice to develop and accredit CPD to the highest standard possible, to contribute to the overall advancement of the pharmacy profession.

We have reviewed the issues paper (Paper no. 2 56th Parliament June, 2018) and provide the following comments on the issues outlined in the paper.

1. **Ownership Regulation and Administration of Pharmacy Ownership Regulation (Issue 1, 2, 3 and 4)**

The Australian College of Pharmacy agrees that the pharmacy landscape has evolved and shifted in recent time. In particular, the changes to sophisticated franchise and banner groups, and “corporatisation” of the distribution of medicines, which have altered the supply chain away from traditional wholesalers.

We note that Queensland remains the only Australian State that does not have an independent pharmacy administration authority and is the only State/Territory which does not register/license pharmacy premises.

The boundary between public hospital, private hospital and community pharmacy supply of medicines, and professional services has become blurred and more complex arrangements now exist.

These (largely funding and therefore purchasing) arrangements are problematic in that the ownership structure’s buying and supply arrangements have the potential to impact patient care. For example, the quantity and brand of medicines supplied on discharge from a hospital.

In the interests of the public, the College supports high quality regulatory controls with regard to pharmacy ownership and pharmacy premises, in particular to manage the risk associated with inadequately controlled premises, facilities, equipment and therapeutic goods supply mechanisms.

Although the supply of therapeutic goods has various state and Commonwealth regulatory controls, we contend that given the supply chain models which have emerged within corporate, franchise and banner groups ownership structures, there is a need to place the overarching control of such matters within the purview of an independent state-based pharmacy authority.

Regulatory independence is a key principle in regulatory best practice. An independent authority such as a pharmacy council would provide the Queensland Government further control regarding how therapeutic goods are handled and facilitate the ability for the Government to ensure that relevant premises are secure and regulated in accordance with legislation such as the *Health (Drugs and Poisons) Regulation 1996* and *Health Regulation 1996*.

An independent authority such as a pharmacy council, with the remit to oversight matters such as ownership and annual registration of pharmacy premises, would ensure applications of controls to protect the public and pharmacy staff, including storage of narcotics and supply of (complex) compounded medicines (e.g. laminar flow hoods).

We believe that the *Business Ownership Act 2001* (QLD) (Act) is necessary to protect consumers and to deliver accessible and affordable medicines and services. It appears that in the case of franchisee arrangements the controls may not go far enough.

We understand that in accordance with Section 139B (ab) the *Business Ownership Act 2001* (QLD) (Act) allows for corporations:

- whose directors and shareholders are a combination of pharmacists and relatives of the pharmacists; and
- in which the majority of shares are held by pharmacists; and
- in which only pharmacists hold voting shares.

We understand that a franchise is an authorisation granted by a company to an individual or group, enabling them to carry out specified commercial activities. Thus in cases where the corporation itself does not meet the terms of the *Business Ownership Act 2001* (QLD) (Act) there is a need for any franchise agreement with a pharmacist owner not to impinge on that pharmacist's duty of care, and any commercial arrangements which may advantage shareholders of the corporation and not the customers of the franchisee pharmacy.

Australia's National Medicines Policy aims 'to meet medication and related service needs, so that both optimal health outcomes and economic objectives are achieved for Australians'. It has four central objectives:

- timely access to the medicines that Australians need, **at a cost individuals and the community can afford;**
- medicines meeting appropriate standards of quality, safety and efficacy;
- quality use of medicines; and
- maintaining a responsible and viable medicines industry.

We contend that the shift in the pharmacy landscape to sophisticated franchise and banner group models, together with Pharmaceutical Benefits Scheme (PBS) reform, has resulted in medicine purchasing decisions being made by corporations' head offices. We contend that any efficiencies which flow from purchasing decisions stay with the corporation and are not able be used to offset franchisee owners operating costs, making it less likely that the consumer will benefit from cost effective purchasing decisions in the form of more affordable medicines.

2. Pharmacy Ownership Regulation in Other Australian Jurisdictions (Issue 9 and 10)

The National Registration and Accreditation Scheme was set up in July 2010. Its aims include:

- protecting the public by ensuring that only suitably trained and qualified practitioners are registered;
- facilitating workforce mobility across Australia; and
- enabling the continuous development of a flexible, responsive and sustainable Australian health workforce

The principle which underpins the first aim is that the public interest is served by competent (registered) health professionals. There is a tension between this principle and some pharmacy ownership provisions. The public interest is served if the competent professional has direct oversight and is accountable for all aspects of the planning and delivery of pharmacy services. If the practitioner abuses the privilege or is found to be no longer competent, the practitioner is de-registered and thereby forgoes the right to own a pharmacy.

Therefore in the public interest, ownership provisions need to support the accountability of registered practitioners.

The College contends that there is a limit to which registered practitioners can adequately oversight more than one pharmacy. Given the large geographical spread of potential pharmacy sites in Queensland, the College doesn't believe a single practitioner can provide regular direct oversight to the number of pharmacies permitted in some jurisdictions. Therefore, we believe the maximum allowable number of pharmacies owned per pharmacist, for which direct oversight is feasible, is four.

In general, the Territories at this point in time do not have vast numbers of large population centres; limiting the scope for multiple ownerships across large geographical areas. This means the practitioner may maintain direct oversight; however, the College would prefer to see national consistency with regard to the maximum allowable number of pharmacies per pharmacist in each jurisdiction, and nationally. We contend that the national limit should not be greater than or equal to the sum of the maximum number currently permitted in each state (24).

3. Administration of Pharmacy Ownership Regulation in Other Jurisdictions (Issues 4, 12, 14)

The College believes that the models of pharmacy ownership and premises regulation which exist in other jurisdictions are part of the risk management framework of pharmacy regulation. The 'local' level regulation is more responsive and local networks usually are the first to gather intelligence of impending issues and problems, making them effective administrators of pharmacy regulation. The independent governing bodies have a level of focussed expertise. Queensland Health needs to manage a very broad range of regulatory functions and we understand that the consistent interpretation and application of knowledge of pharmacy regulation may be problematic.

Despite competition policy pressure, we are firmly of the view that the Australian public expect health practitioners to be fully accountable for the care they provide. The public expect practitioners NOT to be registered if they fail to meet professional standards. The system of accountability of individual pharmacists is paramount to the delivery of trusted care to the public. We are concerned that the evolution of "corporate" ownership arrangements blurs the lines of accountability and undermines the regulation of pharmacy by the Australian Health Practitioner Regulation Agency (AHPRA) and the Pharmacy Board of Australia (PBA). We do not support changes to the Act which would allow any party to own

a pharmacy as we believe the public is best served with clear lines of accountability and penalty for failure to meet professional Codes, Standard and Guidelines.

Possible role and scope of responsibility of a pharmacy council

Given that regulatory independence is essential, and in keeping with regulatory best practice, the College believes that the enforcement of the ownership and annual licensing/registration of premises power should be discharged by an independent authority such as a pharmacy council.

An independent authority model would have the advantage of being able to secure and maintain the confidence of pharmacists, particularly if it was constituted with representation from the pharmacy profession. Further, an independent body with appropriate specialist professional and business expertise, and consumer representation, with the support of an appropriate secretariat, would be in the best position to respond with independence to enforce the legislation.

The main role of the council would be to:

- provide independent administration and enforcement of the ownership and registration provisions of the legislation through an annual registration/licensing process;
- provide specialist knowledge as to the state of pharmacy services in Queensland;
- determine whether pharmacy premises meet appropriate standards; and
- provide advice on the developments in dispensary standards in pharmacies, including the development of improvement programs that promote quality and safety in the dispensing and use of medicines.

In particular the council should:

- Maintain a register of pharmacies in order to:
    - facilitate public access to the information regarding location, opening hours, and contact details of pharmacies in Queensland,
    - help identify gaps to public access of services, and facilitate public access to specific pharmacy services or specialised medicines such as:
      - needle and syringe programs
      - opioid dependence treatment services
      - medicinal cannabis
      - immunisation
- Conduct pharmacy business inspections to ensure pharmacy premises are of a minimum standard of fitness for safe and competent delivery of pharmacy services,
- In the event of a major health priority/ emergency act as a facilitator of information and liaison e.g. Flu Pandemic etc.

This is consistent with the scope of pharmacy registering authorities in other Australian jurisdictions. The mapping of pharmacy and related professional services would help ensure equitable access to pharmacy services is maintained and would assist future planning.

Cost
An independent body would not result in additional costs to the Government, as it could be self-funded by fees from annual pharmacy ownership and premises registration. This self-funding model, as is the case in other jurisdictions, is supported by the key pharmacy professional organisations in Queensland.

4. Pharmacy and Pharmacy Assistants' Roles and Scopes of Practice (Issues 18,19)

Pharmacists
There are approximately 4,500 engaged pharmacists in community pharmacies in Queensland.

Pharmacists have tertiary qualifications comprising a four year bachelor or higher degree, an additional year of practice under supervision, and mandatory continuing professional development as a requirement of annual registration by AHPRA.

There are four universities offering pharmacy degree programs in Queensland, namely:

- University of Queensland, School of Pharmacy;
- Queensland University of Technology, School of Clinical Sciences;
- Griffith University, School of Pharmacy and Pharmacology; and
- James Cook University, College of Medicine and Dentistry.

As stated above, AHPRA was set up, and aims to:

- facilitate workforce mobility across Australia; and
- enable the continuous development of a flexible, responsive and sustainable Australian health workforce

Given the pressures on the health practitioner workforce to deliver high quality care to a culturally diverse, ageing population who live in diverse locations, it has proved very challenging to ensure there is a sustainable workforce where Australians live and work.

To meet the challenges there is a need to examine ways of providing healthcare in more flexible models of care including:

- developing models of care, for example multidisciplinary care, remote access care (eg telehealth, robotics)
- revising scopes of practice of the health practitioner workforce, to relieve the burden on some practitioners by using the skills sets of others.

The current pharmacy programs of study equip pharmacists to undertake roles which would benefit Queenslanders by relieving the burden on other health professional groups.

Pharmacist Competency Standards (The National Competency Standards Framework for Pharmacist in Australia 2016) outline the competencies and scope of practice for pharmacists in Australia. The PBA deals with matters concerning professional practice including the application of professional standards, Codes of Practice and Board Guidelines.

Immunisation is a recent example which the PBA deemed was within a pharmacist's scope of practice. However, additional accredited training was required before a pharmacist was authorised to administer vaccines.

We note that other jurisdictions including Canada, New Zealand and the United Kingdom have expanded the scope of practice of pharmacists over the last decade, to a degree that is broader than in Queensland.

Examples of key areas where an enhanced role for Queensland pharmacists could occur include medicine adherence and management (including post-acute setting and aged care), a broader role in rural and remote settings to complement or fill gaps in health services, health screening and risk assessment services, preventative health interventions (in particular to minimise avoidable hospital admissions), treatment of minor ailments, and better management of long term health conditions.

Expansion of pharmacists' scope of practice is desirable to address the unmet health needs of Queenslanders. Such services should focus on optimal consumer outcomes e.g. in rural and remote areas, healthcare in the home, after-hours health service, to streamline access to healthcare, to relieve patient burden in Queensland hospitals, and general practice.

Pharmacists can contribute to ensure continuity of care by continued access to medicines, to provide medicines and health services to consumers who do not regularly engage with the health care system, and address expectations of health consumers for convenient access to healthcare.

In particular, expanded scope of practice services for Queensland pharmacists include:

1. Vaccinations: with the recent success of the QPIP program, pharmacists have demonstrated an ability to follow a prescribing protocol that has improved access of health consumers to vaccinations, and has demonstrated acceptance of this expanded scope of practice for pharmacists among health consumers. The benefits of improved influenza vaccination rates include: increased work participation due to less time off work due to illness, access to influenza vaccination for health consumers who have not previously received an influenza vaccine, confidence to the community that influenza vaccines are accessible via the pharmacy service. To extend the scope of immunisation services there is a need to:
    a. Remove all legislative barriers to expand the reach and scope of pharmacist vaccination (the PBA has deemed that it is within the scope of practice for pharmacists to deliver all vaccines) however currently Queensland limits the vaccines that can be delivered by pharmacists. There is a need to expand the scope of vaccines that may be delivered to include all vaccines, e.g. travel vaccines, pneumococcal etc
    b. Remove the legislated age barriers to receipt of vaccines from pharmacists in Queensland (currently vaccines can only be given by pharmacists to consumers aged 18 years and older). The PBA has deemed that it is within the scope of practice of pharmacists trained in vaccination to administer a vaccine to a health consumer of any age. NOTE: additional training may be required.

2. Continued dispensing
    a. Remove all legislative barriers to pharmacists providing continuity of supply of all medicines to health consumers with ongoing need, e.g. for chronic illness such cardiovascular disease (e.g. hypertension), skin conditions (e.g. dermatitis), respiratory conditions, erectile dysfunction and diabetes and for ongoing supply of an oral contraceptive.
    Case study: A patient with diabetes has run out of prescriptions for their medicines and needs a continued supply to cover them until a General Practitioner can be consulted for a new prescription. Currently, in Queensland this is restricted to supply of three days of medicine, which is often not sufficient to meet consumers' needs and allow adherence to their regimen.
    b. Removal of all legislative barriers to provision of a medicine from different types of doctors' orders. Currently the Queensland legislation requires that supply of medicine is initiated by a doctor's prescription, which does not identify that doctors also prescribe medicines via written orders such as hospital discharge summaries and medication charts in care facilities.

3. Pharmacist role in treating minor ailments
    a. Remove all legislative barriers to pharmacists' expanded role in treating minor ailments, supported by evidence of health consumer benefit e.g. treatment of urinary tract infections, cellulitis, uncomplicated respiratory tract infections. To improve access to these services for health consumers who cannot access timely treatment from general practise, or a Queensland Health service, and to prevent unnecessary hospital admissions.
    b. Further facilitation of provision of opioid replacement therapy. For example, other Australian jurisdictions such as Tasmania and the Australian Capital Territory have funded programs for opioid replacement therapy services delivered from pharmacies.

4. Pharmacist prescribing
    a. Removal of all legislative barriers to prescribing of all medicines by pharmacists, once the PBA has determined the model for pharmacist prescribing.

Although the College supports an extension of scope of practice of pharmacists we support the development of services of extended scope in which there is demonstrated evidence that:

- all undergraduate programs of study across Australia deliver the education which underpins the delivery of the extended scope of professional practice (it is recognised that many undergraduate pharmacy degree programs will need to be redesigned to cover training of new pharmacists to address expanded scope of practice); and
- all registered pharmacists are competent to deliver extended scope services.

Even if undergraduate programs of study are found to consistently produce graduates who are competent to deliver extended scope services, we contend there is a need to upskill

existing registered pharmacists to address knowledge and skills gaps such that they can deliver new professional services within an expanded scope of practice.

We believe that a transitional arrangement needs to be in place when new services are introduced. A requirement for accredited training should be introduced for new scope of practice services. Based on our experience with the accreditation of immunisation training, we believe the Australian Pharmacy Council (APC) standards approach should be strengthened. The APC uses a process standard approach, which based on our experience as a continuing professional development (CPD) and Registered Training Organisation (RTO), could be improved to include more elements which relate the theory and practice of teaching, and how these influence learning outcomes.

Pharmacy assistants

Pharmacy assistants are the largest part of the pharmacy workforce, with approximately 10,000 pharmacy assistants employed in Queensland pharmacies.

The term 'pharmacy assistants' currently applies to a broad range of non-pharmacist personnel working within a pharmacy setting, ranging from those employees who work mainly in a customer or patient-focused role, to those who work primarily in the dispensary or in administrative roles.

The College believes that the pharmacy assistant sector is changing, and the role of the pharmacy assist will also change, in particular:

- as the scope of services provided by pharmacists extends to include more professional services
- as a result of increased use of technology/automation.

The College contends that a skilled pharmacy assistant workforce is necessary to support pharmacists in the provision of both the supply of medicines, and patient care services.

With an ageing population, more Queenslanders will require Dose Administration Aids for their medicines, and we believe that the quality of such services needs to be assured by good pharmacy systems and pharmacy oversight, and the use of trained pharmacy assistant staff.

The ordinary duties of pharmacy assistants, under pharmacist supervision, require them to order, handle and supply therapeutic goods, as well as respond and ask specific questions when requested by health consumers for *Pharmacy Medicines,* and *Pharmacist Only Medicines*, and refer to a pharmacist, as required.

It is essential that pharmacy assistants receive appropriate training about therapeutic goods, to allow the pharmacist to focus on patient-centred care. There is increasing recognition of the need for pharmacy assistants to be trained to support the changing nature of pharmacy services, and pharmacy workflow, and to contribute the delivery of an extended range of patient services.

Pharmacy assistants are bound by the COAG Health Council National Code of Conduct for Health Care Workers that is designed to guide the behaviour of unregistered health care workers providing a health service, and is, or will be enforceable in some jurisdictions. There is no minimum mandatory training for pharmacy assistants in Queensland (with the exception of the delegation frameworks that exist for pharmacy assistants in Queensland hospitals and the requirements of the Quality Care Pharmacy Program).

The College believes a minimum mandatory training requirement should be introduced. The minimum qualification should be universal for all pharmacy assistants, regardless of their area of practice, to enable workforce mobility.

The review should consider the introduction of a set of mandatory competencies to make up a minimum vocational education skill set/or entry level qualification for pharmacy assistants. We suggest that, initially, a vocational education skill set should be required, moving in a phased in approach over a period of time, say five years, to a minimum mandatory entry level qualification of at least Certificate level.

Yours sincerely,

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