The Queensland Government
Inquiry into the establishment of a pharmacy council & transfer of pharmacy ownership

Consultation Submission
July 2018

This is a submission to the Queensland Government Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (HCDSDFVPC). It is a response to the current call for submissions in the *Inquiry into the establishment of a pharmacy council and transfer of pharmacy ownership in Queensland*. This document has been structured to enable direct responses to questions listed in the Issues Paper[1].

True Relationships and Reproductive Health

True Relationships and Reproductive Health (True) is a non-profit organisation that provides expert reproductive and sexual healthcare. For over 45 years, True has been prominent in the delivery of clinical services and professional training for medical practitioners, teachers and sector professionals.

True has seven offices, five clinics and fourteen pop-up clinics across Queensland. Clinics specialise in contraceptive choices including long acting reversible contraception (LARC). Clinical services include pregnancy planning, pre-conception care, pregnancy and postnatal care, menstruation concerns, menopause, cervical screening and sexual health screening.

True offers a wide range of workforce development solutions that are tailored for specific needs and groups. True provides professional development and adult education to approximately 20,000 people per year. True is a member of Family Planning Alliance Australia, the nation's peak body in reproductive and sexual health.

Issues for Consideration

True's clinical and health education services work closely with pharmacies in metropolitan, regional and remote areas of Queensland. Pharmacies are for some populations the most accessible health professionals[2]. Local pharmacies are critical for access to reproductive and sexual health outcomes. They function not only for dispensary of products but also for triage, personalised medicine and community based health literacy[3]. Localised knowledge and practice leadership enables our health systems to embed social determinants of health[4].

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[1] Queensland Parliament, Paper No.2 56th Parliament, June 2018. http://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2018/5618T747.pdf

[2] Madden, Mary; Morrissey, Hana and Ball, Patrick. Current research: Pharmacy in challenging environments: Report [online]. AJP: The Australian Journal of Pharmacy, Vol. 96, No. 1146, Dec 2015: 60-63.

[3] Hattingh, H.L., King, M.A. & Smith, N.A. Pharm World Sci (2009) 31: 542. https://doi.org/10.1007/s11096-009-9309-9

[4] Smith, J. , Griffiths, K. , Judd, J. , Crawford, G. , D'Antoine, H. , Fisher, M. , Bainbridge, R. and Harris, P. (2018), Ten years on from the World Health Organization Commission of

1. **Are pharmacy ownership restrictions imposed by the Pharmacy Business Ownership Act 2001 (Qld) (Act) necessary to protect consumers and deliver accessible and affordable medicines and services? Why or why not?**

   Yes. Pharmacy ownership restrictions are necessary to maintain a pharmaceutical model that is founded on localised support and contextual knowledge[5]. This protects consumers by maintaining locally owned businesses, increasing access and equity particularly for those in regional and remote areas of Queensland.

2. **Are the ownership restrictions sufficiently clear, particularly regarding the restrictions on corporations owning pharmacies? If not, how could the restrictions be made clearer?**

   True is not best placed to respond to this line of enquiry.

3. **Would changing the pharmacy ownership restrictions under the Act improve community outcomes? If so, how should the restrictions be changed?**

   If pharmacy ownership had a reduced level of regulation, Queensland would have a reduced number of 'corner shop pharmacies' and a greater number of corporate retailers. This would have fundamental impacts on the shape and functions of our health systems.

   Any change to restrictions need to consider pharmacists as health professionals who with adequate resourcing and governance can provide patient centred care and improve community health outcomes, particularly for regional and remote Queenslanders and populations most at risk of social isolation or violence.

4. **Should the Act be amended to allow any party to own a pharmacy, subject to requirements for dispensing only by a qualified pharmacist? Would the community be better off under such a scenario? Why or why not?**

   No. Pharmacy ownership by pharmacists promotes integrity, quality and accountability in service provision. It enables health professional leadership, informed guidance and maintains health care ethics.

5. **Is there any difference in performance of pharmacies owned by non-pharmacists in Queensland (such as those run by friendly societies or the Master Misericordiae Health Services Brisbane Limited) in relation to protecting consumers and delivering accessible and affordable medicines and services?**

   True is not best placed to respond to this line of enquiry.

6. **Does the Act provide adequate protections to promote the professional, safe and competent provision of pharmacy services, and to maintain**

Social Determinants of Health: Progress or procrastination?. Health Promot J Austral, 29: 3-7. doi:10.1002/hpja.48

[5] Pharmacy Guild of Australia (2016), Submission to Review of Pharmacy Remuneration and Regulation, Canberra.

public confidence in the pharmacy profession now and in the future? If not, what additional protections should be included in the Act and why?

The Act would be strengthened with a pharmacy council that could lead, monitor and implement associated standards and guidelines.

Increased public awareness of the role and scope of pharmacists could increase community health outcomes[6]. Given the increasing prevalence of pharmacies in Queensland using franchise models, work is required to maintain public confidence in the pharmacy profession.

7. **Are you aware of any transfers of pharmacy ownership which have not conformed to the requirements under the Pharmacy Business Ownership Act 2001 (Qld) (Act)?**

   True is not best placed to respond to this line of enquiry.

8. **Are the offences prescribed in the Act necessary and sufficient to ensure the objectives and intent of the legislation are being met, and are the maximum offences that apply appropriate?**

   Prescribed offenses are necessary. Maximum penalties could be reviewed and potentially increased, particularly provisions 139B, 139C, and 139H[7].

9. **Do you think there should be restrictions on the number of pharmacies a pharmacist may own in Queensland? Are the current restrictions under the Pharmacy Business Ownership Act 2001 (Qld) Appropriate?**

   Yes. There should be restrictions on the number of pharmacies a pharmacist can own in Queensland. The current restriction of five pharmacies is appropriate. A strong pharmacist presence within pharmacies is crucial. This ensures due diligence in community practice, pharmaceutical practice governance, quality consumer service and safety[8].

10. **Given there are no restrictions in the Australian Capital Territory and the Northern Territory, are community outcomes in the Australian Territories different from the Australian states? If so, how are they different?**

    True is not best placed to respond to this line of enquiry.

11. **Has pharmacy ownership regulation in other Australian jurisdictions improved community outcomes (relative to Queensland)? If so, how?**

    True is not best placed to respond to this line of enquiry.

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[6] McMillan, S. S., Kelly, F. , Sav, A. , King, M. A., Whitty, J. A. and Wheeler, A. J. (2014), Consumer and carer views of community pharmacy. Journal of Pharmaceutical Health Services Research, 5: 29-36. doi:10.1111/jphs.12043; and
Kairuz, T. E., Bellamy, K. M., Lord, E. , Ostini, R. and Emmerton, L. M. (2015), Health literacy among consumers in community pharmacy: perceptions of pharmacy staff. Health Expect, 18: 1041-1051. doi:10.1111/hex.12077

[7] Pharmacy Business Ownership Act 2001 (Qld)

[8] Tan, A. C., Emmerton, L. M. and Hattingh, H. L. (2012), Issues with medication supply and management in a rural community in Queensland. Australian Journal of Rural Health, 20: 138-143.

12. What functions might a pharmacy council perform in Queensland? How would these functions differ from the current functions performed by Queensland Health?

A pharmacy council would be representative of Queensland based specialists, bringing their knowledge as health professionals with a unique and valuable skill set to govern and oversee professional practice. As an external body, the council model would enhance accountability and enable best practice in clinical governance, policy relevance and accuracy, health access and equity. It would also serve as an advisory with regard to pharmaceutical scope of practice.

13. How would the establishment of a pharmacy council in Queensland improve community outcomes?

Valuing pharmacists as facilitators of patient centred and community led health care, a pharmacy council could provide a body of state based knowledge and specialised practice. A pharmacy council representative of regional and remote communities would bring an understanding of the geographical, cultural and industrial considerations unique to Queensland[9]. It will provide practice leadership in developing, monitoring and evaluating practice guidelines, which will improve outcomes for communities[10]. A pharmacy council is likely to enhance community centred care, which will enable Queenslanders to stay in regional and remote areas, make informed health choices and access lifelong localised care.

14. What would the costs and benefits to the community of establishing a pharmacy council in Queensland?

That would depend upon the governance model and accountability structures of the pharmacy council. Community representation and consultation with Aboriginal and Torres Strait Islander Elders would be advisable in the development of the model[11].

15. What other viable alternatives should be considered to deliver superior community outcomes?

A health consumer advisory group could be established to compliment the pharmacy council, either linked to the council or Queensland Health. The consumer advisory group could inform policy development, training and development, and resource development for pharmacists in Queensland[12].

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[9] Smith Kaye, Fatima Yaqoot, Knight Sabina (2017) Are primary healthcare services culturally appropriate for Aboriginal people? Findings from a remote community. *Australian Journal of Primary Health* 23**,** 236-242;
Baldwin, Louise & Fleming, Mary-Lou (2016) Improving Health and Wellbeing in Regional Queensland: Assessing health needs and identifying evidence based responses: A population health approach. Wesley Medical Research, Brisbane, QLD.

[10] Hattingh, H.L., King, M.A. & Smith, N.A. Pharm World Sci (2009) 31: 542. https://doi.org/10.1007/s11096-009-9309-9

[11] Smith Kaye, Fatima Yaqoot, Knight Sabina (2017) Are primary healthcare services culturally appropriate for Aboriginal people? Findings from a remote community. *Australian Journal of Primary Health* 23, 236-242.

[12] Health Consumers Queensland 2017, Consumer and Community Engagement Framework viewed on 9 July 2018 at < http://www.hcq.org.au/wp-content/uploads/2017/03/HCQ-CCE-Framework-2017.pdf>.

16. If a pharmacy council was established in Queensland, what issues would need to be considered in its interactions with other agencies or individuals involved in regulating pharmacy businesses and practice? What legislation would need to be changed?

The council would require reproductive and sexual health expertise, given pharmacists influence women's access to contraceptive choices through advice, information, referral and dispensary. The council would also require representation from or close collaboration with both the Australian Medical Association and the Royal Australian College of General Practitioners, because collaboration between General Practitioners and Pharmacists is vital for patient centred care and patient safety.

17. What effect would relaxing pharmacy ownership restrictions have on community outcomes (such as protecting consumers and delivering accessible and affordable medicines and services in Queensland? What are the potential risks to consumers?

Communities in centralised and metropolitan areas would have greater access to manufactured medicine, which could reduce product price for consumers. This could decrease access to personalised medicine and compromise the quality of non-dispensary pharmaceutical services including health information, advice and referral. There could be detrimental impacts on community based health literacy. Community members who currently access pharmacies as a triage mechanism may go elsewhere. Support and advice would need to be provided through an alternative health professional, putting pressure on other areas of the health system[13].

Communities in regional and remote areas would be less likely to have access to pharmaceutical services given the increased cost of service provision. There could be increasing reliance on electronic dispensary, which requires technology access and literacy. There could be detrimental impacts on community health outcomes, including those most marginalised such as people with disability, Aboriginal and Torres Strait Islander populations, transient and seasonal workers, aging populations, and people experiencing homelessness. People with complex health needs would be more reliant on centralised services, may travel more frequently or relocate to metropolitan areas. With decreased localised advice and support there could be increased pressure on emergency services and after hours general practitioners to provide triage services[14].

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

Extension of scope may be done with additional training to meet minimum standards, with support and guidance from a pharmacy council in determining required standards and mandatory training. This would need to occur in consultation with various health specialist industry colleges and associations.

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[13] O'Loughlin, M. , Harriss, L. , Thompson, F. , McDermott, R. and Mills, J. (2018), Exploring factors that influence adult presentation to an emergency department in regional Queensland: A linked, cross-sectional, patient perspective study. Emergency Medicine Australasia.

[14] Toloo, G., Aitken, P., Crilly, J., FitzGerald, G., (2016), Agreement between triage category and patient's perceptions of priority in emergency departments, Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine2016 24:126

An example where the scope of practice should not be extended is in the provision of oral contraceptive pills. Currently Medical Officers can provide a number of repeat prescriptions for contraceptive pills. Enabling scope of practice for Pharmacists to prescribe repeat contraceptive pills beyond this scope carries increased risk to patients. Health variances may occur between patient presentations which may lead to significant contraindications for ongoing contraceptive pill prescription[15]. Consequently regular assessment by a Medical Officer for contraceptive review is needed[16] and this should not be included in a Pharmacists scope of practice. A pharmacy council could increase consumer safety by informing or developing protocols for determining if/when referral to a Medical Officer is required for contraceptive review. The pharmacy council could then support or endorse professional development aligned with these procedures.

An example of where the scope of practice could be enhanced is in the provision of emergency contraception. Access to emergency contraception should continue to be provided over the counter through a pharmacist. If counselling is required, this should be provided confidentially in a private room or a an alternative space that maintains consumer privacy and safety. A pharmacy council could further increase consumer safety by informing or developing protocols for determining if/when counselling is required, where that counselling should take place and what questions are appropriate. The pharmacy council could then support or endorse professional development aligned with these procedures.

There are situations where a pharmacy council could offer an extended scope of practice through a licensing arrangement. This could be in rural or remote communities where there is a lack of clinician availability. Licenses could be determined by the pharmacy council in consultation with the local community and local health providers, with an annual revise process. Consequently the licence could be revoked should enhanced clinical capacity become available.

19. What additional training for pharmacists/pharmacy assistants, or other risk reduction measures, should be implemented to ensure patient safety?

Training for pharmacists and pharmacy assistants could be better integrated into broader health professional training[17]. True's clinical education programs specifically list which modules are relevant to pharmacists.

Given the nature of personalised medicine, in addition to reproductive and sexual health clinical skills[18] pharmacists also need communications and consultation skills with diverse communities to ensure access and equity[19].

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[15] Downing, S. G., Payze, C. , Doyle-Adams, S. and Gorton, C. (2011), Emergency contraception over-the-counter: Practices and attitudes of pharmacists and pharmacy assistants in far North Queensland. Australian and New Zealand Journal of Obstetrics and Gynaecology, 51: 527-531.

[16] Goldhammer, D., Frazer, C., Wigginton, B., Harris, M., Bateson, D., Loxton, D., Stewart, M., Coombe, J., Lucke, J., (2017), BMC Family Practice, 2017 18:35

[17] Panzera Annette June, Murray Richard, Stewart Ruth, Mills Jane, Beaton Neil, Larkins Sarah (2016) Regional health workforce planning through action research: lessons for commissioning health services from a case study in Far North Queensland. *Australian Journal of Primary Health* 22, 63-68.

[18] Emmerton, Lynne; Skinner, Monika Buhrer; Gardiner, Elliroma; Nissen, Lisa and Debattista, Joseph. A Trial of the Distribution of Chlamydia Self-collection Postal Specimen Kits from Australian Community Pharmacies [online]. Sexual Health, Vol. 8, No. 1, 2011: 130-132.

Pharmacists and pharmacy assistants are well placed to prevent violence, child sexual abuse and suicide. Training opportunities exist in areas of domestic violence, family violence, sexual violence, reproductive coercion, technology abuse and suicide prevention[20]. Such a need for professional development is enhanced, should the pharmacy scope of practice be extended.

Further Information

For further information on this submission please contact Alice Evans.

Alice Evans, CEO.

[19] Bellamy, K. , Ostini, R. , Martini, N. and Kairuz, T. (2017), Perspectives of resettled African refugees on accessing medicines and pharmacy services in Queensland, Australia. Int J Pharm Pract, 25: 358-364.
[20] Commission for Children and Young People and Child Guardian (CCYPCG). Reducing youth suicide in Queensland discussion paper. 2009;
Queensland Government 2015, Not Now Not Ever – Putting an End to Domestic and Family Violence in Queensland.