AMA QUEENSLAND

PHARMACY COUNCIL SUBMISSION

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INTRODUCTION

AMA Queensland welcomes the opportunity to provide feedback to the Queensland Parliament's Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee on the proposal to establish a pharmacy council in Queensland.

AMA Queensland is the state's peak medical advocacy group, representing over 6000 medical practitioners across Queensland and throughout all levels of the health system. Our members value the specific expertise of Non-Medical Health Practitioners (NMHP). We support the collaborative arrangements between medical practitioners and other health practitioners, including pharmacists.

However, pharmacists do not have the education, training or skills to independently formulate medical diagnoses, independently interpret diagnostic tests, prescribe medication, issue repeat prescriptions, or decide on the admission of patients to, and discharge from, hospital. The move to expand the scope of practice for pharmacists away from collaborative care relationships puts patient safety at risk, exposes staff to medico-legal risk and rather than providing efficiencies in health care delivery, may prove to be costlier overall.

We have serious concerns with the proposal for a pharmacy council put forward in the issues paper. AMA Queensland will confine our submission to Questions 1, 16, 18 and 19 as these questions are those that go to the heart of the proposal and issues of patient safety in health care.

I commend this submission to the members of the Committee and I thank all our members who have provided their valuable input into its development.

Dilip Dhupelia
President, AMA Queensland

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?

In 2017, the *Review of Pharmacy Remuneration and Regulation Final Report* noted that pharmacy location rules have "not established robust competition between independent pharmacies in some locations. Rather, in some locations, either individual pharmacists or small groups of pharmacists have been able to monopolise some or all pharmacies. This is inconsistent with the objective of Australia's competition laws.[1]" AMA Queensland agrees with this statement.

AMA Queensland endorses the Federal AMA position[2] to allow broader ownership of pharmacy businesses. The AMA agrees that control of medicines dispensing should remain the responsibility of registered pharmacists, however the current ownership restrictions prevent the development of healthcare models that could benefit patient care. For example, co-located medical practitioners and pharmacists would facilitate coordinated and enhanced care for patients, as well as increase convenience for patients. Under current regulations, this model is only possible under very limited circumstances.

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?

AMA Queensland does not support the establishment of a pharmacy council in Queensland. Based on the issues paper from the committee, it would appear most of its proposed functions and powers are already vested in legislation and the Pharmacy Board of Australia, thus duplicating processes that already exist for what may be very little benefit.

It is the view of AMA Queensland that the current arrangements have been serving patients and the broader health system extremely well and that the move to an 'independent' body whose secretariat and executive could potentially be stacked with pharmacy industry representatives presents a serious threat to that stability.

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SHOULD THE SCOPE OF PRACTICE OF PHARMACISTS AND PHARMACY ASSISTANTS IN QUEENSLAND BE EXTENDED?

An the interests of patient safety and quality in health care, AMA Queensland does not support extending the scope of pharmacists and pharmacy assistants for the following reasons.

CONFLICT OF INTEREST

AMA Queensland agrees with the Pharmacy Guild who say that the "separation of prescribing and dispensing of medicines provides a safety mechanism as it ensures independent review of a prescription occurs prior to the commencement of treatment."[3] If, the scope of practice for pharmacists and pharmacy assistants was to be extended to allow them to become both a prescriber and a dispenser, this safety mechanism would be put at risk and exposes the pharmacist to an inherent conflict of interest.

Doctors are careful to consider whether or not they have a conflict of interest in providing advice. In this, doctors in Australia are guided by two documents. The first is the Medical Board of Australia's (MBA) *Good Medical Practice: A Code of Conduct for doctors in Australia*. The second is the *AMA Code of Ethics*.

As defined by the MBA, a conflict of interest arises when a doctor, entrusted with acting in the best interests of patients, also has financial, professional or personal interests, or relationships, which may affect their care of the patient[4]. Doctors may also be influenced by interests that extend to other persons connected to the provider. The AMA Code of Ethics states in section 3.5.1 that doctors must ensure their financial or other interests are secondary to their primary duty of serving patients interests[5].

Whilst having multiple interests is common and generally appropriate, doctors can manage a conflict of interest by taking action to manage the separation of the conflicting duties and ensure the primary duty to patients remains paramount. In some cases, this may entail withdrawal from or the curtailing of a particular activity, while in others, it may be sufficient to delegate functions or roles to an individual or group.

If the scope of pharmacists or pharmacy assistants was to be extended, it is the view of AMA Queensland that it would be impossible for pharmacists to manage this conflict of interest in a way that would be acceptable to most parties. A pharmacist that is both a prescriber and a dispenser has an inherent conflict of interest, a point which should underline the continued need for a separation between these two actions.

Beyond this inherent conflict of interest, there is also the concern that pharmacists may use the opportunity to upsell to patients. Upselling often involves the selling of products that have few, if any, proven health benefits. Our general practitioner (GP) members have offered many examples of upselling experienced by their patients, such as a pharmacist recommending Inner Health Plus when dispensing antibiotics or Glucosamine when the patient has their arthritis medication dispensed. Others have provided examples of when pharmacists have persuaded patients not to fill a script and use an over the counter medicine instead, without input from the original prescribing doctor.

This was already a concern noted by the Federal Government's Pharmacy Review in 2016 which noted in its discussion paper that the Panel had "heard that some consumers are concerned that pharmacists may compromise on the level of professional advice provided to patients on the quality use of medicines and feel financial pressure to 'up-sell' to consumers, for example by recommending medicines or products that may not be necessary for the patient."[6]

If this is a concern now, when pharmacists are simply dispensing, the potential for upselling and conflict of interest issues would be much greater if pharmacists were allowed to become both prescribers *and* dispensers.

EXPERIENCE, QUALITY AND TRAINING

General practitioners are highly trained medical professionals who, on average, have 14 years of training as compared to pharmacists who have only four.

Using their training, GPs holistically diagnose, examine, investigate with appropriate pathology and radiology and appropriate referral to other specialists and coordinate multidisciplinary teams for patients in the privacy of dedicated consulting rooms. Pharmacists do not.

Pharmacists are not trained to diagnose, examine and investigate with pathology and radiology. GPs are.

There is already ample evidence which shows that men are less likely to visit their GP than women[7]. AMA Queensland is concerned that allowing pharmacists to become prescribers would see both men and women lose out on vital consultations with their GP as they opt for convenience over better health outcomes.

However, convenience when it comes to health is potentially dangerous. Any interaction that occurs between a GP and a patient is an opportunity for that GP to make the patient healthier beyond the initial reason they have presented to the doctor on that particular day. Analysis of data from the Bettering Evaluation and Care of Health (BEACH) dataset shows that even in "low value" care request encounters, additional health care was usually provided at most GP consultations, particularly for chronic disease[8].

Our GP members have provided numerous instances of where a repeat prescription encounter became a life-saving opportunity.

"Diagnosing three malignant melanomas on backs of women during a female health check."

"A female patient who came in for a repeat prescription for her contraceptive pill. The GP checked her blood pressure and noticed a worrying skin lesion on her upper arm. The patient agreed to have it removed, and the GP found it was a level 2 melanoma."

"A GP was asked for a script for Viagra, which she identified as the first presentation of arterial disease that had not been considered as a diagnosis before. This allowed treatment to begin and prevented a potential heart attack or stroke."

"A patient came in for a script renewal which resulted in the GP identifying a missed faecal occult blood test. The test identified asymptomatic bowel cancer, saving the patient's life."

Deprescribing, which is the process of tapering, stopping, discontinuing, or withdrawing drugs, with the goal of managing polypharmacy and improving patient outcomes, is also an important aspect of GP care.[9] One GP provides an example of this.

"A patient came in for a repeat script for puffers for his chronic lung condition and the GP took the patients' blood pressure, which was very low. He admitted he had been feeling light headed and had almost fainted two days earlier. He had taken his GPs advice, improved his diet, lost weight and become fitter. As a result, his blood pressure medications needed to be reduced and one of the agents ceased."

These encounters all started as "just a script", but show the benefit to public health which any interaction with general practice provides. GPs can perform physical examinations which will detect such conditions at consultations, whereas pharmacists cannot. Only GPs know the detailed context of the request and have access to the patient's full medical record.

Changes to pharmacist scope of practice run directly contrary to the best available evidence about how care should be delivered; long term continuity of care with the same doctor in a therapeutic relationship based on mutual trust and respect. Whereas public opinion suggests that visiting a pharmacist may be more convenient than visiting a GP, empirical evidence from the ABS , the BEACH data[11], the OECD[12], the *British Medical Journal*[13] and numerous other sources clearly demonstrates that you are likely to live longer and achieve better health outcomes overall by seeing your GP regularly.

Taking shortcuts with your health is simply not worth it.

PRESCRIBING SAFETY

There is no convincing evidence to demonstrate the safety of non-medical prescribing (NMP) from the United Kingdom (UK)[14] and New Zealand (NZ)[15].

NMP was first allowed in the UK in 1992. Since that time, various pieces of legislation have enabled independent prescribing for pharmacists, nurses, and a range of allied health professionals. Despite this practice being allowed for over 25 years, there is no convincing evidence to demonstrate the safety of non-medical prescribing in that country.

Most of the studies or evaluation of NMP have related to job satisfaction of the NMPs themselves, other healthcare professionals and patients, or from the perspective of the outcome of their prescribing[16]. There is some evidence which shows that some doctors who work with NMPs felt that it improved team work, but others have suggested that it can add significant time to their workload due to the support they need to provide to the NMPs[17].

However, there is compelling evidence of better outcomes where pharmacists and GPs work together in a collaborative model for the betterment of the patient, as part of the non-prescribing and non-dispensing pharmacist model. In 2015, the Federal AMA called for a funding program to integrate non-dispensing pharmacists within general practices, a call which was acted upon by the Commonwealth Government as part of their 2018 Budget via the Workforce Incentive Program[18].

A systematic review of pharmacists working in collaboration with GPs concluded that "pharmacists co-located in general practice clinics delivered a range of interventions with favourable results in various areas of chronic disease management and quality use of medicines." Independent analysis undertaken for the AMA by Deloitte Access Economics also shows that the integration of pharmacists within general practices will deliver net savings to the health system of the order of $545m over four years, primarily through fewer avoidable hospital admissions and a reduction in the utilisation of medications[19].

These findings correlate with two[20] other[21] systematic reviews and one meta-analysis of evidence showing the benefits achieved from integrating pharmacists into the general practice team. The results from this research demonstrate significant improvements for those consumers with chronic diseases such as diabetes, osteoporosis and cardiovascular disease. Further, individual studies have shown improvements in other outcomes, including identification and reduction of medicine-related problems, process measures such as appropriateness of prescribing, and reduction in total number of medicines.

This would support the hospital avoidance programs that the Queensland Government is currently endeavouring to implement through GP Liaison Officers and Primary Health Networks. Early results from the REMAIN HOME project, which aims to investigate whether a model of structured integrated pharmacist and GP care reduces unplanned hospital readmissions in high-risk patients, shows promising trends in reducing 30 day hospital readmissions. The impact of which will have significant clinical and economic benefits to patients who need it most and to the health system.[22] Reducing preventable hospital admissions for people with chronic conditions, often on multiple medications, requires people to see their GP more frequently, not less. Fragmentation of care and denying general practitioners the opportunity to review their patients will only increase preventable hospital admissions and bad outcomes.

AMA Queensland believes expanding pharmacist's scope of practice is short-sighted. Instead, the Queensland Government should, in cooperation with the Commonwealth, find better ways of integrating non-dispensing pharmacists into general practice.

SCHEDULING

Scheduling is a national classification system that controls how medicines and poisons are made available to the public. Medicines and poisons are classified into Schedules according to the level of regulatory control over the availability of the medicine or poison required to protect public health and safety.

Currently pharmacists are able to dispense schedule 2 and 3 medicines without prescription. These are called "Pharmacy medicines" and "Pharmacists only medicines." A doctor's prescription is needed to ensure schedule 4 drugs are dispensed appropriately to the public.

At a time when Queensland coroners are calling for a real time prescription monitoring (RTPM) system to ensure that s4 medicines and above are controlled to prevent needless deaths, a call which AMA Queensland supports, it is inappropriate to potentially make it even easier for people to obtain drugs by allowing pharmacists or NMPs to prescribe and dispense them.

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WHAT ADDITIONAL TRAINING FOR PHARMACISTS/PHARMACY ASSISTANTS, OR OTHER RISK REDUCTION MEASURES, SHOULD BE IMPLEMENTED TO ENSURE PATIENT SAFETY?

AMA Queensland does not believe that there is a compelling, evidence based argument for increasing the scope of practice for pharmacists and pharmacy assistants, even in rural and remote areas where anyone with access to the internet can use websites like Doctors on Demand to access prescriptions and have consultations with registered, qualified medical practitioners. We therefore cannot support any measures which would facilitate pharmacists becoming prescribers.

However, there are some options which should be considered by the Committee to help ensure patient safety.

REAL-TIME PRESCRIPTION MONITORING

There is a crisis in Queensland around the misuse of opioids and benzodiazepines resulting in many unnecessary deaths.

Everyday there are four Australians who die from misuse of drugs, and half of them are from prescription medications. Many of these deaths could be prevented if Queensland had a real-time prescription monitoring system supported by government, prescribers, dispensers and the community. This is an example of where doctors and pharmacists need to collaborate in the interests of safety and quality healthcare.

The current system in Queensland does not give real time information to prescribers and dispensers. Instead, drug prescriptions are uploaded manually once at the end of each calendar month by 1,996 pharmacists to Queensland Health's "Monitoring of Drugs of Dependence System" (MODDS). This system is maintained by a unit within Queensland Health called the Medicines, Regulations and Quality (MRQ) unit.

In 2017, AMA Queensland released a position statement which called on the Queensland Government to urgently establish a memorandum of understanding between MRQ and pharmacies.[23]

This memorandum would be used to facilitate a system where the MODDS reporting delay would be reduced from one month to no more than 24 hours. Extra funding would need to be provided to MRQ and consultation would need to be undertaken between stakeholders (such as doctors and pharmacists) to ensure that the system meets their needs. We believe that an MoU could be implemented within the space of one year.

With the MoU in place, the Queensland Government would be free to implement a software-based solution, which would begin the move to a state wide real-time monitoring system. By working with medical software manufacturers to implement an update to their software, pharmacists could scan prescriptions in real time into the MODDS system and doctors would be able to access this data directly from their desktop. The Queensland Government would need time to fund such a project and work with software manufacturers to implement it, so we would expect a reasonable time frame for such a project to be put in place to be within the next two and a half years.

This system could then operate within Queensland until a national RTPM system is established.

CONCLUSION

In closing, AMA Queensland appreciated the opportunity to provide a submission on this issue. If you require further information or assistance in this matter, please contact Mr Leif Bremermann, Senior Policy Advisor, on (07) 3872 2200.

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