Committee Secretary
HCDSDFVPC
Parliament House
George Street
Brisbane Qld 4000
Via email: pharmacy@parliament.qld.gov.au

Dear Mr. Hansen,

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

My name is Fiona Watson and I am a pharmacist practicing in Queensland. I own a community pharmacy in partnership with my mother and sister. My mother has been the community pharmacist at Redland Bay for over 20 years and I have had the benefit of seeing the impact she has had on the local community, and my sister and I aspire to have the same positive impact.

Response to Issues Paper

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?

Definitely. Pharmacists are health professionals first. There are plenty of overseas examples of corporatisation of health care where the needs of the patient are put below the needs of the company and shareholder expectations. Restricting the ownership of pharmacies to pharmacists goes some way to protect the general public. When pharmacists have the autonomy to recommend as per their moral and ethical guidelines the patient is the direct beneficiary - this can include the refusal to supply something that has no benefit or may be a risk to the patient. For an example of where corporate greed has corrupted this process please refer to 'How Boots Went Rogue' a UK Guardian article, and the follow up piece 'Yours, a stressed pharmacist'. It includes numerous examples where the UK Board acknowledged that individual pharmacists who lost their license due to inappropriate practice had nothing to gain other than to satisfy the targets set by their head office and as such relieve workplace stress. This resulted in substandard service provision and the over servicing of public health initiatives (at great cost to the taxpayer). In these situations there was no change to workplace practice - the corporate employer simply employed another pharmacist and continued to expect them to meet unrealistic targets. When ownership is restricted to pharmacists there is a greater respect for the individual's professional opinion about how to achieve the best outcome for the patient.

Another risk that I believe exists is the vertical integration of health services which results in a restriction to consumer choice and the decimation of small businesses. This can be seen in Australia in the dental industry. BUPA and other immense corporate entities own the dental practice (but often the patients are unaware of this). The 'preferred provider system'

means that at the clinics that BUPA own people get more back than if they were to see a non-Bupa dentist. Bupa determine what can be charged for services at their clinics which has a direct effect on market competition, and the employee dentist has little or no autonomy. When someone calls Bupa with an inquiry about their own dentist they are actively encouraged to move to a Bupa owned practice - this has a dramatic effect on the viability of a small business where the dentist owns the practice and struggles to compete with these aggressive corporate tactics. In the large percentage of dentists owned by corporate entities the employee dentists are set monetary targets. Unfortunately there is the risk of a lower quality of care due to these employee dentists feeling they need to rush to see more patients and do more treatments due to the lower fees.

Another potential risk of deregulated ownership is that pharmacies and pharmacists have ready access to substances that are open to abuse and diversion. At the moment if a pharmacist were to become involved with a criminal entity to supply these products they will lose their licence and as such lose all access to these substances, for most pharmacists this risk is untenable. I believe that there would be an increase in access to these substances by criminal entities if the ownership regulations were relaxed.

I believe the current restrictions allow community pharmacy to be a competitive and innovative industry. This provides many benefits to the community not least of which is the provision of PBS medication as per the National Medicine Policy. There are multiple surveys and inquiries which have shown community pharmacy to be the most accessible health professional. I believe there is a big risk to the community that this accessibility would change if ownership restrictions were reduced. I can't imagine that big corporates will be interested in investing in rural and remote locations where there is limited potential for big financial gains.

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

I think the restrictions are adequate - providing they are appropriately monitored and there is a transparency to the process. It is impossible to know who has a controlling financial interest in pharmacies at the moment. There are complex set ups where the directors, shareholders etc are unknown, where there may be entities benefiting financially from trust distributions that are corporate structures and are not pharmacists.

The restrictions are clear, however there are multiple examples of corporate structures circumventing these rules to obtain a proprietary interest in Queensland pharmacies.
I think a Board or independent panel such as exists in other states, eg the Victorian Pharmacy Authority would be a viable option.

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?

I don't believe that allowing corporatisation of community pharmacy would be in the public's best interest. I think there are multiple examples of where big corporates have 'cherry picked' the profitable parts of an industry and left the less profitable parts to the public purse (see BUPA UK cherry picking profitable surgery and leaving complex costly cases to the NHS for example). I often hear customers tell me that the corporate pharmacy located nearby 'can't' make the cream that the doctor has prescribed. This is incorrect - they choose not to make it as they consider that it doesn't bring them enough financial remuneration. I make decisions every day that are not in my best financial interest - but are in the best interests of my patients.

I also think that the ultimate penalty of loss of licence is an added protection to the general public that exists currently but would be lost if non-pharmacists owned pharmacies. If a pharmacist does really do the wrong thing they will be forced to sell their pharmacy. When corporate structures behave badly they just pay the fine and count it as a cost of doing business.

Another area which I feel would be negatively impacted if non-pharmacists and corporates could own pharmacies is that of availability. Pharmacies are often the only health professional open late nights and on the weekend, and we see a lot of patients who would otherwise clog up the emergency department or cost the taxpayer a small fortune by using the afterhours GP service un-necessarily. To be honest I see our extended hours as a community service. It is not financially viable for me to be open on public holidays and weekends (due to high wages etc) but I open so that we are available to our local community. I know many other community pharmacies who do the same. Many pharmacist owners I know work the weekend shifts themselves to reduce costs (my family included). If a corporate owner were making the decision purely on financial considerations I don't believe they would open.

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?
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?

I believe that there should be a restriction on the number of pharmacies an individual pharmacist can own. I believe this contributes to the diverse and vibrant network of community pharmacies as it makes it easier for young pharmacists to get into ownership by encouraging partnerships. The current number of 5 pharmacies is an fair and reasonable number.

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

Ideally this council would ensure that pharmacies abide by the Pharmacy Business Ownership Act. They could do this by a yearly declaration similar to the one in Victoria.

Another example of a state board is the Pharmacy Registration Board of Western Australia, their functions include;

1. to advise the Minister on matters to which the Act applies;
2. to administer the scheme of registration;
3. to monitor, and enforce, compliance with the Act;
4. to perform other functions that are conferred on the Board under the Act or any other Act.

They are made up of pharmacists and community members.

I believe that a Queensland Pharmacy Council could be funded by a registration fee paid by pharmacies.

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?

I hear multiple examples from patients about the poor healthcare they receive from big corporate medical centres that practice '6-minute medicine'. Just recently one of my local GPs has relocated from such a medical centre due to being reprimanded for spending too long with patients. He was advised to increase the number of patients seen per hour - and to increase his 'billing'. He preferred to maintain his focus on high quality patient care and has left this practice. Unfortunately this is not an isolated example. I have patients tell me that there is a stop watch on the desk when they visit the GP and that they are told they can only discuss one issue - for example if they have come for a blood pressure medication script and they want to get a funny skin spot looked at they are told to make another appointment. This has been recently brought to very public light in the SMH article https://www.smh.com.au/national/bulk-billing-clinics-turning-away-complex-patients-20180704-p4zpij.html
The president of the RACGP states that it is common for long appointments to be refused as they are not as financially attractive as multiple short appointments.

A few years ago we had a situation at our work where the intern pharmacist came and spoke to me about her concerns about the mental state of a patient. This patient (AB) had literally walked from her GP appointment to the pharmacy (she was the last patient of the day and the GP closed as she left) and had given her script to my intern (NE). NE had spent some time talking to the patient and was concerned that she was suicidal. Both myself and NE had recently completed a mental health first aid course and this had given us both a lot of practical tools about how to approach this situation. We took AB into our private consult room and I asked her if she was thinking about harming herself, she replied 'not at the moment but I don't know what to do now, I can't even move'. We spoke about her options and were able to call a family member who walked down to the pharmacy. As neither lady could drive we took them both back to AB's house in the pharmacy car so they could pick up

essential medications etc and then dropped them back at the family member's house. AB was admitted to hospital later that night with the support of her family. This interaction took a considerable amount of time, for both myself and my intern. We were very concerned about the wellbeing of our patient and did everything we could to make sure she received the appropriate care. In a corporate environment where every minute is monitored I don't believe that an intern would have felt confident to spend the time listening to this patient - let alone ask her how she really was.

I feel that allowing non-pharmacists to own pharmacies allows ruthless corporatisation to override the clinical judgement of the individual health professional. This can only be at the detriment of community health.

At our pharmacy we provide a lot of services that have limited financial benefit. One of these is the opioid substitution program. I believe this is an important harm minimisation service which supports patients to reduce their risk of overdose, reduce transmission of disease and to improve a patient's general health and social functioning. We also provide free home delivery. Sometimes my staff are the only people that our patient sees that week and as such can provide some vital information to the GP. There are also services such as the needle and syringe program which are provided on a voluntary basis. I believe that there is a risk to the community that these services would be financially unattractive to a corporate and would be phased out (or in the case of delivery potentially outsourced to a non-clinical provider).

I think the risks to the patient and to the community of relaxed ownership rules are many, including reduced access to those services that are not financially attractive, reduced competition as big corporates corner more of the market, reduced access to a pharmacist due to the corporate practice of lower staff to script ratios, over servicing of taxpayer funded health services, just to name a few.

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

I think that before we talk about extending the scope of practice we should focus on optimising the functions that are already within our scope but we are restricted from performing due to outdated legislation. Pharmacists (myself included) are trained to administer vaccinations, however when a family come in to get their flu vaccine and they kids are aged 16, 17 and 21, I can only vaccinate the parents and the 21 year old. The other two children need to go to the doctor, get a script, come back to the pharmacy, have it dispensed and then take it back to the doctor to have the vaccine administered by a nurse. This has happened a few times this year and I don't believe that the children have gone to the added effort to get their vaccine. Parents have commented to me about the inconvenience of waiting times at the GP, and we have received a lot of positive feedback about the experience of vaccinating in pharmacy. I personally have vaccinated multiple people this year who were getting their flu vaccine for the first time, and as we register these vaccines with the electronic register the information is readily available to the patient's GP.

At our pharmacy we provide dose administration aids. I believe these are a highly valuable service that improves medication compliance and can allow someone to remain in their own home by assisting them to manage their medications. In order to maintain compliance we often have to supply the patient's regular medications before receiving the script from the doctor. To comply with the legislation we would only be able to supply a maximum of 3 days. Ideally we should be able to supply a full box in this situation. There are also many situations where we are asked to supply emergency medication, for example when people are traveling and have run out of medication, or it is the weekend and the patient's GP is closed but they didn't realise they were out of scripts for their blood pressure medication, or even during the week when the patient didn't realise their script had expired and there is a two week wait to get into the GP, just to name a few. In all these situations I believe if we can verify the medication (and the introduction of the My Health Record will make this a much simpler process) we should be able to supply a complete box (in most cases a month's supply).

I think that pharmacists have the capacity and the desire to do so much more. We are perfectly positioned to alleviate some of the burden on the health care system by freeing up GP time, we can provide community based screening for common health conditions and increase the rate of early intervention. We can assist with the management of chronic conditions and help improve the outcomes for these patients. There are so many opportunities for pharmacists to contribute to community health outcomes.

In summary I strongly believe that the current restrictions on ownership of pharmacies play a vital role in protecting the general public. I also support pharmacists working to the full scope of their practice, with the potential for expanded scope with appropriate training, professional guidelines and legislation.

Thank you for considering my submission.

Sincerely,

Fiona Watson
Owner, Redland Bay Discount Drug Store

Postal Address: Shop 21/133 Broadwater Tce Redland Bay QLD 4165.