RACGP
Royal Australian College *of* General Practitioners

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RACGP submission to the Queensland Parliamentary Inquiry into the establishment of a pharmacy council and transfer of pharmacy ownership in Queensland

The Royal Australian College of General Practitioners (RACGP) thanks the Health, Communities, Disability Services and Family Violence Prevention Committee of the Parliament of Queensland for the opportunity to make a submission into its *Inquiry into the establishment of a pharmacy council and pharmacy ownership in Queensland*.

The RACGP is Australia's largest professional general practice organisation, with over 39,000 members (include over 8,000 members in Queensland), and representing 90% of Australia's urban and rural general practitioners (GPs). The RACGP is the national leader in setting and maintaining the standards for quality clinical practice, education and research in general practice.

Fellows of the RACGP are Australian Health Practitioner Regulation Agency (AHPRA) recognised specialists, with expertise in primary medical care, which includes illness prevention and chronic disease management

1. Overview

- The RACGP welcomes and encourages other healthcare providers' contribution to patient care. International and Australian experience have repeatedly demonstrated the best outcomes are achieved with general practice as the centre of the multidisciplinary primary healthcare model, and with most Australians identify GPs as their coordinator of medical care. From the perspective of the community and patients, there is a need to promote a healthcare system that is coordinated, delivers consistent and unbiased healthcare messages and prevents fragmentation of care.

- The current pharmacy ownership rules restrict patient choice and inflate costs for consumers. The RACGP believes that existing rules are also stifling competition and limiting potential improvements to the pharmacy model. The rules are an out-dated method of promoting access and it is unclear why these regulations apply exclusively to pharmacy.[1]

- The RACGP cannot support the establishment of a Pharmacy Council. It is unclear what the problem is this proposal is trying to solve. There are better alternatives than establishing another governance body. It is inappropriate for a Pharmacy Council to set standards about pharmacists' and pharmacy assistants' roles and scope of practice. Should a Pharmacy Council nevertheless be established, despite recommendations to the contrary, representation from consumers and doctors' groups is essential to avoid further fragmentation of care, duplication of services, and confusion for consumers.

- The RACGP advocates against multiple health professionals offering the same services. Pharmacists add value when providing services related to the safe, effective and efficient use of medicines. The increasing push to expand the scope of pharmacy beyond this puts patients at risk of poorly coordinated care and wastes valuable health resources.

It is the RACGPs position that:

- Pharmacists do not have the appropriate diagnostic skills to identify all potential health issues that arise from a consultation – attending to 'minor ailments' or issuing repeat prescriptions is not always as straightforward as it may initially appear, and could be an indication of deeper health issues.
- Pharmacy-based preventative care programs will lead to duplication of services, fragmentation of care and an increased risk of adverse events.
- Fragmentation of care invariably causes wasted, valuable, health resources, and results in poorer health outcomes for patients.
- Access to primary healthcare, including preventative health interventions, should be provided within the general practice setting to avoid fragmentation of care.

2. Pharmacy prescribing

2.1 Risking patient safety and high-quality health care

The more prescribers, the more risks for errors. Medication misadventure is one of the leading causes of hospital admission. Multiple prescribers and the involvement of less qualified prescribers will inevitably risk patient safety and increase mortality and morbidity. A particular concern is the prospect that these pharmacy prescriptions would be provided to the most vulnerable patients in our society, and those with chronic diseases.

For a large number of patients, interactions with community pharmacy are episodic and ad hoc. A pharmacist does not have comprehensive knowledge of a patient's history or the appropriate medical training on which to draw in order to provide safe and high quality medical care, spanning triage, diagnosis and treatment.

Seeking to duplicate general practice services in pharmacy will thus result in serious health risks to patients. Suggestions in the *Issues Paper* that pharmacy expand its roles to include services traditionally provided within the general practice setting, such as vaccination, 'minor ailments,' and repeat prescriptions for a wide range of medications raise several concerns.

Recently, codeine-containing medications were up-scheduled to become prescription only, rather than over-the-counter. If it has been determined that it is not safe to dispense such medications over the counter, it raises the question of how can it be considered safe for pharmacists to prescribe a variety of other medications that can also be dangerous when inappropriately prescribed (e.g. for patients with certain medical conditions that put them at higher risk).

2.2 Patients will miss-out on important preventative healthcare services

A visit to the doctor is not just about a prescription. A recent analysis of over 1.5 million GP–patient encounters in Australia confirmed that most medication requests to GPs result in additional health care needs being addressed during the same visit. According to the authors, losing this important opportunity for comprehensive and integrated care could be detrimental to patients.[2]

When a patient presents to their regular GP for a planned (e.g. for vaccination) or ad hoc consultation, a range of other opportunistic healthcare services are provided including:

- Preventive health screening and advice
- Health checks (e.g. for patients with diabetes) and
- Health education
- Updating of their health record
- Building of the therapeutic relationship between patient and doctor

Examples:

- GPs often treat pre-cancerous solar keratosis ('sun spots') on the hands and forearms of older patients when checking blood pressure before they turn cancerous, saving the patient an excision and saving the patient and the health system money.
- GPs frequently see patients who have attended 'just for a script renewal' and who then go on to express (for example) depressive feelings, which have led to initiation of treatment which in turn saves an un-quantifiable number of lives.

Drawing on often long-term personal relationships as well as information held by the practice about the patient's medical history, current treatments and medications, the patient's regular GP can provide informed, tailored advice to patients. Evidence shows that continuity of care through long-term ongoing relationships between patients and GPs is associated with lower preventable hospital admissions and

lower risk of mortality. These effects are shown to be particularly beneficial for older patients and patients with multi-morbidity and polypharmacy. Note that the information referred to above is not available in the national My Health Record, which is only a summary of the patient record.

Using some of the medications from the *Issues Paper*:

i. *Oral contraceptive prescriptions:* these provide an important opportunity to conduct cervical screening tests (previously known as Pap smears) and screening for sexually transmitted diseases. In addition, many patients need to be advised of newer more effective means of contraception other than the oral contraceptive pill. These methods of contraception require minor procedures and therefore cannot be provided by a pharmacy. Pharmacist providing oral contraceptive prescriptions will therefore potentially deny these patients of more appropriate contraception.

   An RACGP Queensland Board member provided the following real life example to highlight the potential risks. A new patient who was 19 years old attended an appointment with a GP for a repeat prescription for the contraceptive pill, as she was leaving for overseas the following weekend. The GP noticed her grimace as she laid down on the examination table for an overdue pap smear. The patient advised that she thought she had strained her calf at the gym. Examination revealed the problem to be a Deep Vein Thrombosis (DVT), a life-threatening condition that required urgent management. As a result of this finding, the patient was advised not to fly which could potentially have resulted in fatality, and required an alternative contraceptive as the oral contraceptive pill is not appropriate in the setting of DVT. It is highly unlikely a pharmacist would have discovered this.

ii. *Medications for erectile dysfunction*: erectile dysfunction is often the first sign of more significant cardiovascular disease which can lead to heart attacks and strokes. Proper screening and monitoring for these conditions at the time of prescription and repeat prescription is essential.

iii. *Asthma reliever medications:* Since Asthma reliever medications were made available over-the-counter without prescription, GPs have seen a significant increase in patients inappropriately using reliever medications instead of preventive medications, resulting in poor control of asthma in the community.[3,4]

iv. *Vaccinations:* Pharmacists are not adequately trained to deal with the complexities that come with vaccination programs, including appropriate counselling prior to administration and the management of potential adverse reactions, including anaphylaxis. Pharmacy settings do not

provide the necessary safe, private and comfortable setting to discuss confidential patient details prior to administering a vaccine.

2.3 Patients will miss-out on appropriate monitoring of chronic medical conditions

All medications for chronic medical conditions can be prescribed for either a 6 or 12-month period. This would require patients to attend that medical practitioner once or twice per year for review. For most chronic medical conditions, this is regarded as a minimum to properly monitor the medical condition.

Many patients suffer from multiple chronic conditions. There is often a complex interplay of medical conditions requiring a medical practitioner with training across a number of disciplines achieved over at least 9 years in graduate and postgraduate training. Pharmacists do not have the same level of broad medical training and should not be expected to provide the same level of care. In contrast, pharmacists train for four years to develop very specific knowledge and skills relating to their role as medicine procurers, advisors and dispensers.

2.4 Patient convenience or access to services is unlikely to be a benefit of expanded pharmacy prescribing

Convenience does not always equal best quality. While providing certain primary health services from within the community pharmacy may increase access, access to services alone does not benefit patients. Patients need access to safe and high-quality health services that are carried out by an appropriately trained and informed medical health professional.

Any system of pharmacy prescriptions will require the pharmacists to spend time reviewing the patient. This will eventually, if not immediately, result in a need for appointments in the same way as is required with a general practitioner; therefore, patient convenience is unlikely to be improved. Furthermore, pharmacies are generally not configured to provide the privacy and examination facilities to provide the services.

3. Pharmacy Ownership

Patient choice, competition, innovation and efficiency in the pharmacy sector will be significantly improved by opening up pharmacy ownership to non-pharmacists, as per recommendations in the final report of the *Review of Pharmacy Remuneration and Regulation*. The RACGP strongly supports this recommendation and believes favourable consideration should also be given to reducing the restrictions on pharmacy ownership, as per the rules for medical practices and other allied health practices. Changes to ownership rules will increase competition, and therefore improve patient access.

Several recent reviews have also concluded that pharmacy ownership (and location) rules significantly prevent competition in the sector, stifle innovation and restrict patient choice.

These reviews include the:

- National Commission of Audit's *Towards Responsible Government* (2014)
- Australian National Audit Office's (ANAO) Report No. 25 of 2014–15 on the *Administration of the Fifth Community Pharmacy Agreement* (2015)
- Federal Government's *Competition Policy Review* (2015)

The pharmacy ownership rules restrict the number of pharmacies that can be established and, in turn inflate the price of existing pharmacies. This has made it difficult for pharmacists to purchase an existing pharmacy and start their own business. The removal of the pharmacy ownership and location rules will reduce barriers for pharmacists and others to purchase or operate pharmacies.

Claims that deregulation of pharmacy location and ownership rules will result in corporatisation and poorer service provision are unfounded. Friendly societies are permitted to own pharmacies in some states and territories. In 2008, amendments were made to the *Pharmacy Practice Act 2004* to indefinitely extend the growth cap for friendly society ownership, encouraging growth of these non-pharmacist-owned pharmacies. There is no evidence to suggest that friendly society pharmacies are operating at a lower standard than those owned by pharmacists.

As part of recent CPAs, a suite of incentives and supports have been introduced via the Rural Pharmacy Workforce Program to encourage retention of the existing pharmacy workforce and to attract other pharmacists to work in rural and remote areas. These processes include allowances for attending professional development activities, start-up and maintenance allowances, pre-registrant allowances and scholarship programs.

The move to an incentive-based system to promote access and sustainability more closely aligns to other parts of the Australian healthcare system. The location and ownership rules are an outdated method of promoting access, and should be removed in favour of an incentive-based approach.[1]

4. Conflict of interest

The RACGP holds great concerns regarding a pecuniary interest for a pharmacist prescriber. A prescriber receiving a material benefit for providing that prescription may consciously or unconsciously be induced to 'up-sell' or 'add-on' additional unrequired medicines, whether by pharmacy prescription or over-the-counter medicines.

The RACGP has long held concerns that pharmacists may compromise the level of professional advice provided to patients on the quality use of medicines due to financial pressure to 'up-sell'.

The RACGP is aware of joint ventures between pharmacies and supplement companies that have incentivised pharmacists to sell vitamins and supplements alongside prescription medication. This practice can encourage a patient to delay or dismiss consultation with a registered medical practitioner or reject conventional medical approaches, resulting in serious and sometimes fatal consequences.

5. Undermining of the therapeutics goods administration process

Safety comes first. The Therapeutic Goods Administration (TGA) already has a process in place for medications to be down-regulated from schedule-4 (S4) prescription-only medications to schedule-3 (S3) pharmacist-only medications. The provision of S4 medications via pharmacy prescription will result in a de facto S3 classification, going against the expert, considered advice of the TGA, and exposing patients to unnecessary risk.

Any adverse events caused by the adoption of a system not supported by the TGA and used anywhere else in Australia, could prove very costly to and reflect poorly on Queensland Health and the Queensland Government.

6. De-prescribing

Sometimes less is more. The RACGP recognises that medications can be a major cause of hospital admission and readmission at significant cost to the community and morbidity and mortality to patients. De-prescribing (reducing the amount of medications) is an active process for GPs, and is increasingly becoming the focus of quality improvement activities within general practice.

De-prescribing requires a thorough knowledge of the often multiple medical conditions a patient is suffering, the likely cause(s) and prognosis, disease/disease interactions, disease/medication interactions, and medication/medication interactions. It also requires an intimate knowledge of the patient's personal and medical circumstances. GPs are therefore best placed to make decisions regarding de-prescribing.

If patients simply present to a pharmacy to get a repeat for a script, there is no opportunity to meaningfully review the medications the patient is on, and de-prescribe medications no longer required.

7. Recommendations

The RACGP is open to working with The Queensland Government and relevant stakeholders in the primary care sector to ensure patients have access to safe and high-quality healthcare.

The RACGP recommends that:

- Community pharmacists can be better integrated into primary healthcare through:
    - incorporating clinical pharmacists into general practice settings to deliver medication safety initiatives, such as the management of practice drug surveillance and medication safety systems
    - providing medication management services, such as identifying and monitoring medication use and safety in partnership with GPs
    - collaboration with a patient's healthcare professionals to optimise medication therapy and achieve treatment goals
    - supporting GPs in health literacy promotion, empowering patients to achieve their medication self-management goals and share decision-making with their GPs

- A review be conducted regarding of the amount of medication currently able to be dispensed under the PBS. Currently the amount is restricted to one month's supply at a time. Accessibility to medications for the community could be substantially improved by extending the period of time for which allocations could be dispensed at once from one month to 3 months. This would have a flow on effect of increasing efficiency in the system.

- Guidelines are developed in partnership with all relevant stakeholders for community pharmacy that:
    - outline the services a pharmacist should and should not provide, based on their expertise in pharmacology
    - set minimum standards for the facilities used for pharmacy dispensing, just as independent accreditation, similar to that of general practices

8. RACGP Contact

The RACGP welcomes the opportunity to address the Inquiry in person. To arrange a suitable time please contact Dr Bruce Willett, Chair RACGP Queensland, via the RACGP Queensland State Manager, James Flynn, on [redacted] or [redacted]

1. https://www.racgp.org.au/yourracgp/news/media-releases/wa-pharmacy-ownership-rules-anti-competitive,-not-in-patients'-best-interest/

2. https://www.mja.com.au/journal/2018/208/3/administrative-encounters-general-practice-low-value-or-hidden-value-care

3. https://www.doctorportal.com.au/mjainsight/2016/12/over-counter-asthma-prevention/

4. https://ajp.com.au/news/otc-asthma-preventers-restricted-relievers-proposed/