HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:
Mr AD Harper MP (Chair)
Mr MC Berkman MP
Ms NA Boyd MP
Mr MA Hunt MP
Mr MF McArdle MP
Mr BL O'Rourke MP

Staff present:
Mr R Hansen (Committee Secretary)

PUBLIC HEARING—INQUIRY INTO THE ESTABLISHMENT OF A PHARMACY COUNCIL AND TRANSFER OF PHARMACY OWNERSHIP IN QUEENSLAND

TRANSCRIPT OF PROCEEDINGS

MONDAY, 10 SEPTEMBER 2018

Townsville

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The committee met at 9.00 am.

CHAIR: Good morning, everybody. Welcome to the pharmacy inquiry regional hearing in Townsville. Before we start, I request that mobile phones be switched off or silent. I declare this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. I would like to start by acknowledging the traditional owners of the land on which we are meeting today—that is, the Wulgurukaba and Bindal people here in Townsville. I think we are blessed to stand on the land of two of the world's oldest living cultures. We often say this at the beginning of a parliamentary inquiry or out in the community. We have two of the world's oldest living cultures in Aboriginal and Torres Strait Islander people. We are, indeed, blessed to meet in North Queensland in sunny Townsville.

I am Aaron Harper, the chair of the committee and the member for Thuringowa. The other members of the committee with me are: Mark McArdle, the member for Caloundra and our deputy chair; Michael Berkman, the member for Maiwar; Marty Hunt, the member for Nicklin; Barry O'Rourke, the member for Rockhampton; and Nikki Boyd, the member for Pine Rivers, who is standing in for Joan Pease, the member for Lytton.

Today's hearing is part of the committee's inquiry into the establishment of a pharmacy council and pharmacy ownership in Queensland. The inquiry was referred to the committee on 3 May 2018. The committee is required to report to the Legislative Assembly by 30 September 2018.

There are a few procedural matters before we start. The committee is a statutory committee of the Queensland parliament and as such represents the parliament. It is an all-party committee, which takes a non-partisan approach to inquiries. This hearing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind you that intentionally misleading the committee is a serious offence.

Witnesses have been provided with a copy of the guidelines for witnesses, so we will take those as read. Hansard will record the proceedings and you will be provided with a copy of the transcript in due course. For any media present—and I understand that there will be media here later today—I ask that you adhere to my directions as chair at all times. The media rules endorsed by the committee are available from committee staff, if required.

I remind all those in attendance today that these proceedings are similar to parliament to the extent that the public cannot participate. I remind members of the public that they may be admitted to, or excluded from, the hearing at the committee's discretion. Please also note that this is a public hearing and you may be filmed or photographed.

I would like to clarify a couple of points that we have become aware of over the weekend and this morning. Firstly, the committee is disappointed to hear news of a Supreme Court case between Ramsay and the Pharmacy Guild, lodged on 13 August 2018, around ownership. It is incumbent on all parties who are presenting evidence to this committee that we should be informed, because that potentially puts previous evidence that has been provided at risk of the sub judice rule in the Queensland parliament. I remind those stakeholders to please keep us informed of anything that is happening in other jurisdictions that may affect this hearing. I do not know whether the deputy chair wants to add anything to that.

Mr McARDLE: I will just add that Aaron's comments in no way should be taken as an opinion one way or the other in relation to the matter before the court in New South Wales. It is simply a matter that is of interest to us. If we had known that, we may well have taken different steps in earlier hearings and undertaken a different process given what may be discussed in the court at a future date.

CHAIR: The other thing I wanted to touch on is the media reports on 102.3 Triple M this morning that the Pharmacy Guild is holding a forum today with pharmacists. It is a standing committee of the Queensland parliament that is conducting this inquiry into pharmacy ownership and all other aspects of pharmacy in Queensland. We have clarified that with the media this morning. It is a Monday morning. Let's kick off on a positive note with Mr Milostic.

MILOSTIC, Mr Allan, LiveLife Pharmacy Group

CHAIR: Welcome, Allan. You have travelled from Airlie Beach to be here. We appreciate you being here today to provide your input to this inquiry. Would you like to make an opening statement before we move to questions?

Mr Milostic: Yes. Thank you for the opportunity to appear here before the committee. In terms of putting me at ease, I do not know that those first few comments relieved my nerves too much, but I take all of that on board. Some of those things clearly I have nothing to do with, but it is part of the process.

I do not envy the scope that the committee needs to consider. It is a broad remit, but I applaud the balanced way it has been approached. I have been watching a lot of the televised hearings—very balanced and very considered. Clearly the underlying desire for everyone is the best patient outcome and the best path to get there.

I chose today to turn up in my dispensing coat. It is a bit of a stunt, but I want to reinforce that I am not an academic. I am not a CEO. I am not a lawyer. I am not a director of any big company. I am just a pharmacist first and foremost. I am also a pharmacy owner. I recently went on to the branch committee for Queensland. That is a very new role for me. There are a lot of us out there every day doing what is best for our patients, putting health care before profits. I am the guy who when you walk into the pharmacy you will see. I own that pharmacy. I do care.

I am a North Queenslander now, but I was born and bred in Sydney, so I still have my Blues jersey that I put on every year and cop abuse from the Proserpine people.

CHAIR: We might have to pause already.

Mr Milostic: Love it! Continuing the tradition of difficult to pronounce names, although it is really not that difficult, I am Croatian. Extended family and community means everything to me. It is part of who I am. Following my registration, I worked in a lot of areas. I worked in Sydney. I worked in regional areas. I quickly found that regional areas, communities, tourist areas were where my passion was—that acute contact with patients and the community.

I do own a pharmacy in Airlie Beach. I still work there full-time. I have done a couple of weeks straight now because my pharmacists are at training or on holidays. I still love it. I am part of the LiveLife group of pharmacies who are an independent network. I own pharmacies in partnership in Port Douglas. The partner and his wife live there. They are there full-time. That is the LiveLife model. We look at regional areas. We have partners, with senior partners. We pretty much, without fail, have partners in each area overseeing directly the operation of those pharmacies.

We are pretty progressive. We have consult rooms in all of our stores. We have participated in the QPIP trial. Sleep apnoea, HMRs, residential aged-care facilities—we do the whole lot. Our whole culture is about making a difference to our patients, to our customers, to our staff. Really I think we are representative of the vast majority of community pharmacies. There are a lot of franchise options out there. There are a lot of big-box discounters, but the vast majority are just people like me where the customers and the patients walk in and they call me Al. They know who I am. I am part of their community. To me, pharmacists and trained pharmacy assistants are the key for a robust community healthcare system and the key for getting the best patient care outcomes.

In terms of ownership, one of the things that owners have is an emotional attachment to communities. I am part of my community. I have contact with people every day. I have an emotional involvement and investment in that community that I do not believe corporate entities do. They may have very good staff. They may have very good employees who will go above and beyond, but they do not have that genuine emotional attachment. I am not blowing my own horn but the day after Cyclone Debbie I had my shop open. I was running around between the shops getting injectables for the doctors. I had to climb over trees to get out of my driveway. I do not know that an employee would or would not do that, but I did not think twice. I put the community first. I believe that is where that emotional attachment comes from.

It has been interesting following the hearings—frightening. I also see it as a really good opportunity to cement what I think is a great system. It is world's best practice. It is a good opportunity to prove that the system we have works. I am passionate about this profession. I still love going to work every day—maybe not so many days straight. I do think that this profession has a long way to go and a lot more to offer yet.

In terms of this hearing, there are a few different points but the two main points I see are the formation of the pharmacy council and the scope of practice. In terms of ownership, I really do not think that is in question. I do not know that that was in the terms of reference. The wording I thought was a little bit vague. Fundamentally, I always ask the question: is pharmacy purely retail? I do not

think so. It is a component but it is not purely retail and medicines are not normal items for commerce. So there need to be extra requirements—enforceable codes of conduct to provide the protection for patients.

In terms of the need for the council, the council would oversee the Pharmacy Business Ownership Act—the transfers of ownership—more effectively, I think, than Queensland Health currently does. Queensland Health has a huge job to do. I do not know that in such a specialised field they have enough resources to conduct examinations such as this in sufficient detail. To give a brief example, I had my first inspection in I cannot tell you how long. The Queensland Health inspectors were fantastic. There were a couple of small items that I did not have. I broke a funnel a couple of years ago and I forgot to replace it, but they were not aware that antifungal creams were over the counter. I had them in the shop. When indicated for tinea, they are over the counter. There is a need for a specialised group of people to enforce the Pharmacy Business Ownership Act and the registration of premises.

In terms of scope of practice, I think there has been a bit of a misunderstanding. I do not think anyone is suggesting that pharmacists go out and prescribe open slather. It is not about us initiating therapy or undermining the TGA's ability to schedule medicines. It is about letting us work within our existing capabilities and letting us work to our full scope for the benefit of patients. That is something that this committee can make happen.

In terms of full scope, if I was working in a hospital, when a patient's medication runs out, I can look at their chart, refill it and keep going. In community, if a patient comes in and their prescription has run out or lost or the dog ate it, I have to send them to the doctor. If they cannot get in to see the doctor, technically they go without until they can. There are emergency supply provisions in amongst that that help mitigate that a little bit, but it is only a three-day supply. There definitely needs to be a separation between prescribing and dispensing. We fully agree with the AMA and everyone else on that point.

CHAIR: We only have five minutes for an opening statement, so we might move to questions if that is okay.

Mr Milostic: Absolutely.

CHAIR: Thank you very much for your opening statement. I think you articulated it well when you talked about the linkage to the community. In North Queensland we see cyclones and how they disrupt our communities quite often. I grew up in Bowen and have responded to many in my previous role throughout North Queensland. It is stories like yours that piece together just how important the pharmacist's role is, particularly in relation to responding to natural disasters, so thank you for sharing that with us. They were devastating and particularly Cyclone Debbie to your area. I will have to declare a conflict of interest because I know your pharmacy well. I think you are on the right-hand side as you travel through or are you on the beach side?

Mr Milostic: I am on the beach side.

CHAIR: Yes, I do know it well. My entire family went there last year after visiting Whitehaven Beach, and you probably know why—sunburn.

Mr Milostic: Not sandflies?

CHAIR: We had a fantastic interaction with your pharmacy assistants who treated us. Thank you very much for the work that you do.

Mr Milostic: I am happy to hear that, thank you.

CHAIR: You made a couple of points around scope of practice. Does your pharmacy participate in the immunisation program?

Mr Milostic: Absolutely, yes.

CHAIR: How long have you been doing that?

Mr Milostic: From the beginning and several within our group. We were part of the QPIP trial to begin with. We have continued to do it. Across the group, we will have done thousands of vaccinations by now. Even just within the Whitsundays, we will have done I think over 1,000 influenza vaccines this year. We have consult rooms. We are set up and nearly all of our pharmacists are trained. I have one that is not. We have made a real policy of all of our pharmacists being trained to deliver vaccinations. Whether it is viable or not, we just believe that if somebody walks in on a Sunday afternoon, a Monday evening or a Tuesday morning, they can get that vaccination. It has been an incredibly successful and well received process. We have had zero adverse effects. The collaboration with the doctor surgeries has been terrific to the point where they will regularly send people our way because they have not got stock or cannot fit them in or just cannot see them. I think it is a great example of what is working. That is part of our scope of practice now.

There is a little bit of silliness among the states whereby some states can vaccinate with certain vaccines, but we cannot. There are inconsistencies. I can vaccinate. I should be able to have access to the National Immunisation Program, the NIP. I should be able to vaccinate more than the three that I can in Queensland. My counterparts in Tasmania and Victoria have a much wider scope. There is silliness. In terms of full scope of practice, the example that we are putting forward is that it has already been done in Australia; it is just not being done in Queensland. Why? What is the reasoning? What is the benefit to the consumer by me not being able to do meningitis from 10 years and up, for argument's sake?

CHAIR: A case in point is responding to natural disasters. You could provide a role in regional Queensland where some medicines need to be dispensed more urgently.

Mr Milostic: Correct.

CHAIR: How long have you owned pharmacies?

Mr Milostic: About 20 years.

CHAIR: If you have to turn your mind to it, it has to be a while. Thank you very much. We will turn to other members for questions.

Mr BERKMAN: Allan, yours is not the first evidence we have heard about the lag in inspections being carried out by the department. In your submission you refer to issues around resourcing within the department to properly apply the ownership requirements of the PBOA. Do you think that those are functions that could simply be better performed and adequately performed, in your view, by Queensland Health if there were sufficient resources allocated to those functions within the department?

Mr Milostic: I see no reason why not, but that is another cost. The pharmacy councils in other states are funded by fees from pharmacies. I do not see why taxpayers should fund what I feel is like an internal quality assurance assessment process. I want to know that all the pharmacies in Queensland are doing the right thing. I want to know that they are compliant. I want to know that we are leading Australia in terms of the quality that we have in this state. Yes, the Health Department could, but I do not feel the public should pay for that. If you play sport or anything else, you pay registration fees. Pharmacies should do the same. I am sure they would be willing to do so.

Mr BERKMAN: This is a question I have asked of other witnesses before the committee previously: can you point to particular community health outcomes that suffer as a consequence of the big box discounters; the operation of pharmacies under those franchise models that are really at the centre of this hearing? Specific evidence of community health outcomes, I suppose, is what we are looking to from witnesses.

Mr Milostic: I guess it comes back to the intention of the legislation and making sure it is being adhered to and applied in the way it is meant to be. In terms of specific evidence, I have anecdotal evidence where I work in a forward pharmacy and I talk to every patient I can. I commonly get comments. I had a lady on thyroxin that she had never kept in the fridge. She always goes to the Chemist Warehouse. They are a different model. I do not think there is the pharmacist interaction. In terms of specific evidence, no, I do not have anything specific, personally.

Ms BOYD: My question goes to scope of practice. You have touched on immunisations and the little on-script refills, as well. In your opinion, could private pharmacists add to their scope of practice now to improve health outcomes without further training? Can you elaborate on that?

Mr Milostic: In terms of further opportunities that do not currently exist?

Ms BOYD: That is right.

Mr Milostic: Absolutely. We already participate in lots of health screening activities. I think that could be expanded. Focusing on medicines particularly, I had some examples just in this last week where I think there are currently medications that we could provide with the training that we have right now, safely, which could be of enormous benefit to parents.

A classic example is that travelling is quite stressful on the body, so we see a lot of stress related cases in the Whitsundays. We get a lot of shingles, which is really easy to pick, really easy to diagnose and simple to treat. However, it needs to be treated quickly. On Thursday evening, I had a gentleman who definitely had shingles. He had had it before with the trigeminal nerve. It was Thursday evening. The next doctor's appointment was Wednesday morning. The crazy thing is that if he had had a cold sore I could give him the same medicine that would treat the shingles. I could give him the same medicine for a cold sore, but not for that. I would need to adjust the dosage, et cetera.

I think there are lots of opportunities. Urinary tract infections have been spoken about. Impetigo is not a dangerous thing. It is a skin infection. An antibiotic ointment might be useful. There are lots of medicines that a pharmacy council could appoint a board to consider and see if that could benefit patients and consumers and save the government some money.

Ms BOYD: Was there anything else in your opening statement that was a really key point that you wanted to draw to the attention of the committee? Are you happy to leave that there?

Mr Milostic: I am quite happy. I do have an interesting situation. This goes back to the prescribing and continued dispensing and medication continuance. 'Continued dispensing' is a term that I think Medicare coined. We can already give people PBS quantities of statins for their cholesterol and the oral contraceptive pill. We can already do that.

I had a situation on Friday afternoon. A patient had come up from Melbourne. His medicine was forgotten. I called his pharmacy. His script was on file, except for his blood pressure and his statins. Everything was fine and I could do the continued dispensing medication, continuing on his cholesterol medication, but I could not do his blood pressure tablets. In the end—do no harm—I broke the law and gave him 10 days worth. I am allowed to give three days, but he is on a boat in the Whitsundays for 10 days. They are exceptional circumstances, but those circumstances happen a lot.

It is not beyond my scope to verify what that patient was on and give him a PBS supply of that medication, when I can already do that legally for another medication side by side. There are some inconsistencies that I think could certainly be considered—not open slather, not pain killers and not anything open to abuse, but just a sensible application of the principles that are already in place for some of these medicines.

CHAIR: Following that question, would you suggest that the three-day emergency supply be extended and if so for how long?

Mr Milostic: I think the precedent has been set at PBS quantities, which are generally one month. I definitely think there needs to be checks and balances. Patients need to see their doctors. I know that sometimes seeing a doctor for that bit of paper results in a lifesaving intervention, but that is not the majority of the time. Most of the time, people are seeing their doctor two, three or four times a year. They lose bits of paper. Some medications are for 28 days, some are for 30, some are for 60. It just does not always add up. Those bits of paper are flying around everywhere. It is a hangover from an old system.

CHAIR: We heard similar in Toowoomba. Thank you very much.

Mr McARDLE: Allan, thank you for what I perceive to be genuine enthusiasm for your occupation and also for the care of people who see you on a regular basis. I want to touch upon one point for clarification. Did you indicate to the committee that Chemist Warehouse keeps drugs in a fridge?

Mr Milostic: No. That was just a reference to Chemist Warehouse, because that lady happened to shop there all the time. It was just an isolated incident where somebody had told me they had never been informed of the storage conditions for their thyroxin. When she goes home, she just keeps the thyroxin in the cupboard. She should have been keeping it in the fridge.

Mr McARDLE: It was the actual recipient, not the chemist, who was making the comment?

Mr Milostic: Correct. I was saying that, because I interact more closely, I get feedback like that. That is just anecdotal and I accept that, but it is quite common. The smaller groups and the smaller privately owned pharmacies have more direct interaction.

Mr McARDLE: Let us be very clear: you are saying that there is no allegation that Chemist Warehouse has done the wrong thing; it is more about a client misunderstanding the instructions associated with how to keep the medicine?

Mr Milostic: Correct. Absolutely.

Mr HUNT: Allan, I echo the deputy chair's comments about your genuineness and the work that you do. In your submission you say—

There have been many reviews into the current ownership model and the conclusion is always the same, health outcomes are better ...

It goes on. Can you point me to a review where that is the case in Australia or Queensland?

Mr Milostic: You are putting me on the spot. I cannot. I can take that on notice, if I am allowed.

Mr HUNT: Yes, it is a comment in your submission. You said that 'there are many' and 'the conclusion is always the same, health outcomes are better'. It would be interesting for the committee to see, if there are a number of reviews that we could look at.

Mr Milostic: I will take that on notice.

Mr HUNT: I will leave it at that.

Mr O'ROURKE: In regards to a pharmaceutical council, what would you see the composition of that board being? Which professions?

Mr Milostic: It would have to be key stakeholders: definitely owner pharmacists; there would have to be consumer representation; I think legal and financial, as the pharmacy council would be considering legislation and transfers of ownership; and medical expertise. It would be a cross-section, but I think those stakeholders need to be represented.

CHAIR: Thank you very much, Mr Milostic, for your appearance here this morning. It has been beneficial to the committee. The next witness is Dr Konrad Kangru from Rural Doctors Association of Queensland.

KANGRU, Dr Konrad, Immediate Past President, Rural Doctors Association of Queensland

CHAIR: Good morning, doctor, and thank you very much for appearing today. I see you are the immediate past president of the Rural Doctors Association of Queensland. In my previous role in the Ambulance Service I did quite a bit of work with the Rural Doctors Association. Thank you for appearing today. I ask that you start with an opening statement before we go to questions.

Dr Kangru: Good morning, Mr Chair and honourable committee members. Thank you for bringing your hearings to regional Queensland and for offering RDAQ the opportunity to address you today. The Rural Doctors Association of Queensland represents doctors working in the many regional, rural and remote communities across our entire state. They are a diverse, resourceful and very dedicated group, all of whom are absolutely committed to seeing the best of outcomes for our patients and towns and it is my honour to appear here on their behalf.

Our members are well familiar with the need for all members of the health-care team in a rural setting to be working together, especially including our pharmacist colleagues. We experience daily the well recognised medical workforce shortages facing rural Queensland and are always willing to contribute to initiatives that will aid this cause. However, we consider that extending the scope of practice of pharmacists and pharmacy assistants in Queensland would not be an appropriate step to take. Doctors depend on the professional role of pharmacists every day, especially in smaller communities. We trust them to act in the best interests of patients, to ensure patient safety in the medications we prescribe and to monitor for any adverse effects which may arise.

RDAQ respects the wishes of our pharmacist colleagues to operate and own their own businesses and to be in charge of their own destinies, but we would acknowledge that in smaller communities the costs associated with operating or owning these small businesses may require external capital so we respectfully will not be directly commenting on that particular aspect of the inquiry this morning.

The Pharmacy Guild in its submission has offered that broader utilisation of pharmacists prescribing and pharmacists' skills would aid particularly in rural and remote areas. RDAQ categorically disagrees with this suggestion. This committee has already drawn parallels to the models utilised in the National Health Service of the United Kingdom where non-dispensing pharmacists have worked as members of teams for more than 15 years. This model is not necessarily applicable to rural Queensland. Where the UK models have pharmacists working in particular areas, whether that be in paediatrics, oncology or, indeed, general practice, all of these roles have had patients initially assessed and diagnosed elsewhere. It is this key point of diagnosis which is the key aspect of our concerns.

The responsibility to make a diagnosis lies with an appropriately qualified medical practitioner and is not taken lightly. It depends on a full patient history taken with the assurance of full privacy and confidentiality. It then requires an appropriate physical examination, consideration of prior mental history or genetic risk factors, further refinement with indicator tests and may even require referral to another colleague.

At every one of these important stages the ability of a pharmacist to reach a proper diagnosis is compromised. Yet, as a trusted health professional, especially in rural communities, a patient is unlikely to understand this complexity and see only the perceived convenience of a quick answer to their concerns. In this manner the fragmentation of care through the pharmacist's interaction could potentially become a risk to proper primary care. Delays in proper diagnosis while several well intentioned pharmacist's suggestions are exhausted, a lack of familiarity with prior medical history or known family history or a bias towards prolonged pharmaceutical interventions when other treatment options would be more appropriate, are all examples of this.

Even in so-called low-value consultations where a diagnosis has already been determined previously and continuing treatment is indicated, general practitioners use these opportunities to undertake the preventative health-care interventions patients seldom would make an individual appointment to assess. Cancer screening, targeted assessments, cardiovascular risk modification and mental health monitoring are all obvious examples of the activities general practitioners incorporate into each consultation often with life-saving consequences.

RDAQ, however, does not wish to denigrate the important role rural pharmacists already play. In my own community I enjoy a close professional relationship with each of my local pharmacists. If any one of them were to call my surgery and to communicate to my staff that they were concerned about a patient before them and felt immediate review was required we will always find a place for

that patient to be seen. Similarly, if a patient with acute symptoms of their known asthma was at the pharmacy I would absolutely endorse the decision of the pharmacist to dispense an appropriate reliever pending my appointment. All of these capacities are already enshrined in current legislation and scope of practice and are working well.

This professional respect extends both ways. If our pharmacists note that my patients are on a medication for which a superior alternative is now available or that the blood pressure readings they are checking are suggesting that my suggested medication has been ineffective, I would absolutely welcome their input into further treatment. Pharmacists are experts in medication. Their pharmacological knowledge far exceeds mine and there will be many occasions when once a diagnosis has been made they will have treatment suggestions I may not have considered. Again this is within current scope of practice and may be more reflective of the role prescribing pharmacists in the UK are currently practising under. Our members are well aware that access to pharmacist advice may be more readily available to a patient than a GP appointment, but would be more willing to see the collaboration between the two roles enhanced rather than replaced.

Another key distinction between the overseas prescribing pharmacist model discussed and that which may be being discussed here is the distinction between practising prescribing pharmacists and community pharmacists. While many patients may not be aware of the difference, there is no doubt that the individual recommending a particular pharmaceutical treatment could be influenced by commercial considerations if they were also dispensing that medication. Other submissions have already outlined concerns regarding additional treatments without clinical evidence being suggested to patients presenting for a prescription to be filled. This would be of particular concern if the patient then sees that interaction as being their definitive episode of care rather than being supplementary to the earlier doctor's appointment they have already had.

In closing, RDAQ acknowledges and values the important role community pharmacists play in rural communities. We respect their training, expertise and judgement, as we hope that they respect ours. Although we appreciate the desire of pharmacists to fill medical workforce gaps in rural Queensland, it is the responsibility of the government and medical profession to ensure that rural communities are staffed by doctors properly trained and equipped to assess, diagnose and manage illnesses. It is not the role of the Pharmacy Guild to undertake that task. Our rural communities are already disadvantaged in enough ways. Suggesting that they might not need a doctor looking after their health care should not be another. I thank the committee for its attention and welcome your questions and discussion.

CHAIR: Thank you very much, doctor, for your contribution this morning. Where is your practice?

Dr Kangru: I am in Proserpine in Queensland.

CHAIR: I have retrieved many a patient from Proserpine. It is a good area. I want to discuss a couple of points that you make there, particularly around cardiac patients and the expanded scope of practice which is an issue before us. Currently there is a provision for pharmacists to give a reliever, a nitrate spray, if patients have chest pain or a reliever in terms of an asthmatic acute episode. We have heard to date that when patients present to a pharmacist, albeit in a shopping centre or wherever, with an acute onset that is an entirely good thing that they can do that and then ensure there is some follow-up care.

In your closing comments you say at this stage of health-care reform, any additional clinical provider options for patients will only increase and potentially undermine coordinated team care unless the health service structure facilitates coordinated care demonstrating clinical evidence of health benefits. I draw that to your attention because in some of the previous evidence we have heard where patients may present like this, there was undertakings from the pharmacist that they would immediately contact that patient's GP to get follow-up care. It is converse to what you were saying. It is the flip side of the coin. What do you say to that point?

Dr Kangru: Chronic diseases like ischemic heart disease and asthma, which are the two you have alluded to here, are great examples of where this model needs to be incorporated. Both of those are chronic diseases which should be asymptomatic if they are well managed. If they are actually being properly looked after, in the case of heart disease if blood pressure, if nitrates to open up the arteries, if cholesterol, if aspirin, all of those things are being properly modified, there should not then be the need for reaching for reliever medications in an urgent scenario.

In a similar fashion with asthma, if somebody is using their preventers, if somebody is well educated on their condition and are using their preventative medications and are educated properly they should not need to be grabbing the relievers. In both of those scenarios we would be concerned

that if somebody was needing to repeatedly go along to the pharmacist and ask for relievers and just bounce along from reliever episode to reliever episode they might not actually see that, well, I actually need to be getting this condition properly managed in the first place.

That is the first part of the concern. We do not want to see patients depending just on relievers for the visible symptoms of their condition when the quiet, asymptomatic control of that condition actually is what is desired and what we would be hoping that that patient is seeking even though they might not think of that as an acute priority because it does not actually limit their activity or core symptoms. I am sorry if that is a bit of a confusing answer. I will happily clarify that if anybody requests.

I think the second part is in terms of what is it about the health-care systems that would go with that. No. 1, we probably cannot depend on the goodwill and the altruism of every pharmacist to make that effort to contact the GP. I am in the very fortunate position where I am in a small community, my patients have their regular pharmacist who they will usually go and see. I am very, very privileged that all of my pharmacists recognise my handwriting and my signature so in terms of forgery that is a great asset for us to have, but I cannot necessarily expect that that same scenario would replicate to larger metropolitan centres where patients may have a multitude of pharmacists or even within one pharmacy there may be several pharmacists.

Unless they are actually going off the name and number on the top of the repeat prescription it might be difficult for the pharmacist to actually get in contact with who that patient's regular GP is. I think that unless there was some way that we could ensure that pharmacists were definitely making that contact and that there was ready access available through better communication strategies, I think that it is probably a little bit premature to take that as gospel that the pharmacists will contact the GP if the patient is coming in at that particular time.

CHAIR: That goes to my next point. If there was some kind of a pharmacy council or board that had oversight or clinical governance that ensured that pharmacists were educated in regard to coordinated health-care approaches that would not seem an unreasonable thing in my mind; that you would make sure that the continuum is set from the pharmacists to the GP in relation to ongoing care.

Dr Kangru: I absolutely agree.

CHAIR: Are you aware of the New Zealand study in regard to the warfarin test? I think it was one of the Harper studies that I read—not related—where they simply go in for a pin prick test. We have heard some concerns about warfarin levels. That was a sizeable study in New Zealand. People could come in in the same way as they can with the current practice of cholesterol checks with a pin prick. Are you aware of that study at all?

Dr Kangru: I am not aware of that study.

Mr HUNT: In your opening remarks the very last thing you said was that you do not want to see regional communities disadvantaged by having a pharmacist that is their primary health carer or words to that effect. Do you see any scope for an increased scope of practice in regional areas to improve health outcomes in those areas?

The second part of my question relates to an example given by the previous witness about shingles and feeling as though they were able to, in those circumstances, accurately diagnose a simple condition and provide relief straight away when it needed to be treated urgently as an example of the extended scope of practice. Generally my question is, is there anything that you can see that could be extended to pharmacists that does not create that disadvantage in regional communities or does create an advantage in regional communities' access to better health care?

Dr Kangru: Absolutely, yes. There are certainly opportunities where we could much better utilise the skills and knowledge of pharmacists in rural communities for the betterment of the patients and the communities. Once a diagnosis has been made, we then completely acknowledge that the pharmacist is in a great situation to update and to suggest other medications, to be reviewing current evidence and to be providing monitoring. Although I am not familiar with the New Zealand study, I certainly would acknowledge that warfarin is a great example of a medication where close therapeutic monitoring is appropriate. There may be many settings where the pharmacist is well able to more closely monitor those test results and adjust dosages than the GP in that setting. I would be very keen to see where that goes.

Similarly, we have medication reviews which are already underutilised in the current MBS structure. When patients have chronic diseases—we tend to become very focused on single-disease conditions in our thinking whether we are talking about cardiovascular disease, as we were earlier, or we are talking about shingles. The reality is that with an ageing population more and more patients have multiple significant illnesses and are requiring multiple medications. When a lot of studies and

trials are being done they are focusing on one particular aspect of a patient's illness or conditions. If people have multiple comorbidities, then those other ailments become too complicating and they are excluded from studies. Actually having pharmacists available to better assess the patient as a whole rather than just focusing on one particular condition is a great example of the input they would be able to have.

Our concern does not lie with the time period once a diagnosis has been made; there is plenty of scope for pharmacists to better be providing input into what can be done for that patient from that point in time. Our concern is that we do not want patients to feel as though their interaction with the pharmacist has been their one and only interaction with the healthcare system at that point. That is my concern that we have included in our submission and my opening remarks. We do not want the health system to be leading patients into thinking, 'Well, you have a pharmacist there. You have a prescribing pharmacist in your town. You do not need a GP,' or, 'You only need a GP coming two or three days a week because your pharmacist is going to be able to look after your healthcare needs for the rest of your time.' That is the model that we do not want to see.

Mr BERKMAN: I recognise that Proserpine is not exactly a huge centre, but certainly there are other parts of the state that are far more remote and face additional challenges in terms of accessing any level of health care, whether that be in the form of a local GP or a pharmacy. As a representative of the Rural Doctors Association is there any nuance in the way these issues affect the more remote communities and additional potential for scope of practice changes in those most remote communities?

Dr Kangru: We do have members in those smaller communities. Their response has certainly been that they would still wish to see a doctor being the primary health provider in those areas. There are already fantastic mechanisms for nurses to upskill. Remote area nurses or those who have done their RIPEN endorsement are well trained and have to undergo quite a significant set of competency assessments. Particularly in a lot of our Indigenous communities they really are providing an important backbone of structure. We, of course, realise that we are completely dependent on the mantle of safety which the RFDS supplies as well, which means that no patient in Queensland really is without access to medical advice at a point in time.

There may be some very isolated settings where a pharmacist at a particular point in time is the only healthcare professional in a town. I would certainly hope that that would be the rare exclusion rather than the norm for any communities. Those communities would be where a more sustainable and appropriate model is being vigorously rectified rather than depending on that as being the norm.

There are definitely communities where a pharmacist who has been present for a long period, as happens in a lot of towns, may have the broader knowledge and history of that town, particularly of some families, and would be able to provide a bit more input to the medical or nursing services about that background or what conditions may particularly run in the area. I would be very, very loath to suggest that it is adequate to depend on a permanent pharmacist to be the primary care provider in that area.

Mr BERKMAN: Thank you. That was a very well-made point about the role of nurses as well. I had not really considered the RIPEN as a factor in that mix.

Mr O'ROURKE: Thank you for your submission. In your opening statement you spoke about prescribing medication for patients and having that history to be able to do that work. I am wondering about your thoughts around the My Health Record into the future when there is more information there. Do you think that would then allow a greater scope of practice for our pharmacists?

Dr Kangru: The My Health Record really is a long-term solution, which is far too early in its development for us to really place any emphasis upon. Already if it is being used to the capacity that it has now, it certainly has the capacity to reduce adverse outcomes in that at least any healthcare provider can be assured of reactions—allergies and anaphylactic actions. That on its own immediately means that it has some merit at this point in time.

It is probably decades away from being enough of a snapshot of a patient's medical history to provide any healthcare provider with the ability to look back on that as a reliable record of where that patient has already been and to anticipate where that patient may be heading. Although there is potential, the slow and very, very staggered development process that My Health Record has seen so far means I am quite cynical about whether that is going to reach its potential in the foreseeable future for us to be talking about eventualities like this.

We definitely encourage all stakeholders to be moving forward with it because the more everybody decides that it is too difficult or they want further reviews into My Health Record, sadly the longer and longer its development will take. There is the potential that if everybody is able to upload

information in real time, it certainly would assist with healthcare provision for patients who may not be able to get a doctor's appointment on that day. We are too far from that stage for me to be able to comment on that yet.

Ms BOYD: I refer to an ABC news article from 29 January this year. It stated that around 4.5 per cent of Queenslanders deferred seeing their GP last year due to the price tag, while the national average sat at 4.1 per cent. You are quoted in the article as talking about the competition between bulk-billing prices in cities and how they do a good job of artificially lowering costs, yet that downward pressure trend does not exist in the regions, propping up the cost of visiting a doctor. You also stated that the cost pressures and decentralised doctors in remote areas spelt disaster for health in the region.

My electorate is located about 20 kilometres north of the CBD of Brisbane, yet I know my constituents have a lot of trouble accessing bulk-billing services, and the affordability of that is quite an issue for them. I wonder whether an extended scope of practice for private pharmacies assist in this space? What other federal government measures would you recommend to address this issue?

Dr Kangru: As we identified back in January, it has been the prolonged freeze in the MBS rebates which really did lead to this situation. We also acknowledged at that time that the federal government, through Centrelink, does have mechanisms to assist patients with access to health care. Those who are eligible for healthcare cards and concession arrangements certainly should be approaching Centrelink for that and not be dependent on doctors being the ones to cut their fees to match that. Those same statistics do not just apply to patients attending GP appointments; those same principles also apply to patients refusing to get their prescriptions filled as a matter of a cost barrier.

In that regard I cannot say that just having pharmacists as the ones who are providing the primary care service is going to make that much of a difference. Whether it is the GP who is providing the prescription the patient cannot afford or the pharmacist is providing the prescription that the patient cannot afford I do not think is really going to make a big difference to the outcomes.

What may be a difference is there are certainly lots of occasions when a general practitioner will assess a condition and decide that a medication actually is not what is required at that point in time. Therefore, they may actually be able to provide the definitive input that is necessary without the patient then going to get—not necessarily an unnecessary medication, but a medication which may not actually dramatically alter the outcome of that episode of care at that point in time.

I will try to make sure we separate the issues of the MBS rebates from the scope of practice for the pharmacists, but I think all of these mechanisms—as I said in January, we would like to see the government better reimbursing primary care services so it is more affordable for patients but also that we never want to see patients refusing to get prescriptions filled on the basis of cost.

Mr McARDLE: At the base of page 1 of the submission there is a reference to the course code. What it says in my opinion is that there is now a shift away from the supply of medication to a review role for pharmacists, which is what I think you said here today as well. Are you indicating that there is more scope in the current scope of practice for pharmacists to do more work in that area than they are adopting, or are you indicating that there is potential for the scope of practice to be widened to take into account what is stated in the course code wording?

Dr Kangru: The course code wording which we have included was really to point out that medication remains the focus of pharmacist training. If pharmacy courses were not focusing purely on the medication but on the overall patient picture—we are not just talking about medication interactions or renal function. We are also talking about dexterity; can a patient actually use a device properly? Literacy—is a patient able to understand the instructions for the medication which they are receiving? Cultural influences—does a patient really understand why they are being prescribed a medication, or is there something implicit in what we are prescribing to them that may not actually be culturally appropriate to them at that point in time? What we are implying there is that the focus, as it stands at the moment in undergraduate education, really tends to be on the medication rather than really incorporating what is the patient experience with this medication going to be.

If that was all being amended, you certainly would see pharmacists more understanding of the patient picture and maybe those pharmacists would be in a better situation to better provide input back to the GP, hopefully in communication with the patient as well, because it really is something which as GPs we struggle with.

A clear example is when patients are being given generic medications when they have been prescribed a particular name from their GP. You will frequently have scenarios—and this happens just as much on discharge from public hospitals as it does in the community—where patients will end

up with two or three separate lots of medication which are all doing the same thing. They may all have the same active ingredient, but because they are all branded differently or have different names on them or appear differently the patients are becoming very confused and may take all of them or may take none of them because they are uncertain about what is going on.

We want to see that those baby steps are being incorporated first, that all of those areas are being incorporated proficiently and consistently, before we start talking about moving on to assessing and managing illnesses in the pharmacy context.

Mr McARDLE: I thank you, I think. Doctors are held in very high regard by the public, and rightfully so. It is a lengthy process to become a GP, let alone a specialist beyond that status, but so are pharmacists though. I go to a pharmacy and I expect the person behind the counter as a pharmacist to be well qualified, to understand the script I hand over and for them to give me advice in relation to minor illnesses.

What I am hearing is this: there seems to be a sense that pharmacists themselves do not have the best outcomes for those who walk in their door uppermost in their mind, and that worries me, because the picture I am getting is that pharmacists are seen as not qualified—and there may be some truth in that—but also not caring, and there is no truth in that as far as I am concerned. I am just concerned that we are skewing the argument here to a certain extent. We are forgetting that pharmacists are good people, that they do provide an excellent service to patients. I am yet to find a pharmacist who has overstepped the line and provided deliberately bad advice in relation to a patient. I have been referred back to my doctor by a pharmacist in days gone by. Do you want to comment upon that?

Dr Kangru: Pharmacists are good and caring and trustworthy people and it is quite right that society values them highly—in fact, regularly more highly than doctors and nurses themselves. We acknowledge that. We are not suggesting that pharmacists do not care about their patients. What I am probably missing the point on is that pharmacists do not have the overall picture of what is happening with that patient to make an overall assessment and diagnosis.

Mr McARDLE: That is my point. We are assuming they do not have the rationale to come to a conclusion and that they need more information, and that is what worries me a little bit here. We are jumping to a conclusion and starting with that negative outcome to make commentary, and that is what worries me. We are not going from the earlier point—that is, pharmacists will take the steps to ensure what they do is in the best interests of a patient or the person in front of them, and that is what worries me.

Dr Kangru: As I have remarked earlier, you can have all of the best intentions and you can have great knowledge, but that is actually not enough. That is why I spoke about the need for a proper history when you are assessing an illness. If you are in a busy shopfront scenario, you are not going to be able to get an appropriate patient history. The patient will give you the information that they think they can divulge in that setting, but that is not going to be all of the things that we need to know.

Already we see too many examples of care where a diagnosis is made without an examination—without an appropriate clinical examination—and the importance of that cannot be overstated. Sadly, as we move towards telehealth options of care, we are losing already the role of the physical examination—that is, rather than just glancing at first appearance, actually what an examination involves. We are wary that you may have the push towards an interim diagnosis rather than the time to consider to get test results to consider further information.

All of those concerns that we have about the ability of the pharmacist to make a diagnosis have nothing at all to do with the knowledge or the intentions or the caring nature of the pharmacist. We are merely pointing out that there are real and structural limitations on what that pharmacist is going to be able to provide in proposing a diagnosis and therefore an appropriate management plan for that patient.

Mr McARDLE: I take your point, Doctor. Thank you.

CHAIR: We are nearly out of time, but I just wanted to touch on a point. Conversely in your last response I believe it was the Grattan Institute that provided a submission and spoke on it to us the other day, and that is that 1.3 million people attended GPs across the nation for vaccinations—no treatment, no diagnosis, simply vaccination—which went to overseas travel and a number of other things. What is your current view with pharmacists giving out the flu vaccination for example? Do you consider that a bad thing?

Dr Kangru: We do not consider that a bad thing. I am not going to say that that has been an outcome. We take vaccinations seriously. I know that it is seen that vaccinations are a simple intervention and that it is five minutes in and out nothing to do with it. In doing an immunisation—

whether it be for an influenza vaccination, whether it be for travel immunisations or, more importantly, whether it be for childhood immunisations—as doctors we are considering that patient's need, what their risks are, what is going to be the efficacy or how effective the immunisation will be, what follow-up will be required and then what adverse outcomes are likely. We need to make sure that all of those things are put into what we refer to as informed consent.

If a pharmacist is able to provide all of those steps for something as simple as an influenza immunisation, well and good. In 2018 we most certainly have seen lower incidences of influenza compared to 2017 and that may or may not be due to increased uptake of vaccinations through pharmacy outlets. I am yet to see any statistics regarding that. We would certainly encourage that if pharmacists are able to undertake all of those steps appropriately they do seek endorsement. If that is improving the uptake of immunisations across Australia, then of course that is of benefit.

However, we do not want to see any of these steps being skipped or corners cut in pursuit of a simple quick intervention—get them in and out of the door and back to work as quickly as they can—because all of those things are important. Particularly when you are talking about live vaccinations which may have to be reconstituted and stored properly, you really do have to make sure that you are watching appropriately for adverse events afterwards. We will always have our patients sitting with us in our waiting room for 10 to 15 minutes afterwards. We want to make sure that if that same situation is happening in a pharmacy they have a healthcare professional monitoring them for that all of that time afterwards as well.

CHAIR: Thank you. That was my experience in a pharmacy when I got the flu vaccination. I am sure there will be some academic body out there right now looking at that decreased rate of influenza as we have experienced from 2017 to 2018, so that may well answer or go towards the question that we are after—that is, is there evidence out there in relation to better and improved health outcomes due to pharmacists' expanded scope of practice? Thank you very much for your contribution today. It has been welcomed by the committee.

Mr BERKMAN: Just before this witness finishes, I have a very quick question. I am sorry for interrupting proceedings. I realise that your submission went exclusively to the question of scope of practice. I am just curious though: given your wide medical experience, have you observed or can you point to any differences in health outcomes for patients who are getting their prescriptions filled or seeing a big boss pharmacy as opposed to a smaller, family owned pharmacy for example?

Dr Kangru: Beyond anecdotally I would prefer not to say. Because it would be anecdotal rather than evidence based, I think I would prefer not to skew the committee's hearings in that regard.

Mr BERKMAN: It is interesting though to simply note that you have anecdotal experience of some distinction.

Dr Kangru: Certainly we have growing instances where patients who are coming up to Townsville or going down to Mackay are seeking cheaper medications and therefore they lose that regular contact with their regular pharmacist to ensure that their dosages are maintained properly, that they are keeping up with their doses. We do not want to see dilution of or increased fragmentation of patient care if that means that they are seeing the corporate chains. If a larger pharmacy is able to have a pharmacist who is assessing each patient and is aware of the conditions or medications that patient is having, then it may be that there is no adverse outcomes. I could not comment on that point.

Mr BERKMAN: Thanks, Dr Kangru, and thanks, Chair, for your indulgence.

CHAIR: Thank you again, Doctor.

WHALAN, Ms Catherine, Director, Cate's Chemist

WILLIS, Mr Paul, General Manager, Cate's Chemist

CHAIR: Welcome, Cate and Paul. Good to see you again. I invite you to make an opening statement. Just to clarify, your pharmacy is in Townsville in Garbutt and Hermit Park.

Ms Whalan: Yes. Can I just clarify: do we both get an opening statement, if I keep it really short?

CHAIR: Yes, we can accommodate that. That is fine.

Ms Whalan: Okay. Good morning. I am Cate. I have been a pharmacist for over 20 years. I have worked as a pharmacist here in Townsville for 17 years. Thank you for giving me the opportunity to address you today. I do believe in the need for a pharmacy council in Queensland. I believe they would be able to more accurately interpret the intent of the act, not just the letter of the law, and also enforce it. I hope it would bring transparency to the industry. At the moment it is very difficult to know who owns what pharmacies and whether those owners are actually pharmacists as the law intends.

According to the Queensland Productivity Commission report, it stated in 2017-18 the inspection rate would equate to visiting a pharmacy once every 7.3 years. At my last inspection, which was a number of years ago, they rang me the day before the inspection to say that they were coming. I was shocked. I have never been given notice of an inspection, so that was the first time ever. I queried the staff why. I asked, 'Why would you give me notice that I am being inspected?' Their response to me was that if they gave notice things went a lot more smoothly and there was a lot less paperwork to do. In the Queensland department's annual report for 2016-17—the department report—they maintained confidence in the controls around community pharmacy businesses. I disagree. I do not think they do and, on the balance of the 200-odd submissions to this inquiry, I know I am not alone in thinking this.

I support pharmacists being able to give medication on the PBS when the need arises. I see the potential this has in my pharmacy at Garbutt all the time. We have a lot of patients on pensions and who are registered for CTG, the Closing the Gap scheme, who would benefit by being able to get emergency medicine for a concession price or even for free. For example, if someone does have chest pain and they have left their script at home or they have run out of repeats, then I would be required to dispense that angina spray over the counter and it would cost the patient around $20-odd. Not everyone has that sort of money available at short notice, especially our most vulnerable and concession patients who are otherwise entitled to get it for free.

I have an Indigenous patient who was discharged from hospital with a script for the said angina spray. Hospitals cannot issue CTG scripts, so the patient did not get the script filled because he knew he would have to pay for it. They had an appointment to see the GP the following week when the doctor would have been able to write a CTG script for him. However, prior to that appointment he started getting chest pain and, knowing that he would have to pay for his medication if he came into the pharmacy and did not have any money, he called an ambulance instead. The government trusts that we have the clinical skills to already give out the nitrate sprays, but because I cannot prescribe it per se the patient has to pay for it. This is forcing vulnerable repeat patients to pay or go without or even be supplied a lesser product.

I have listened to other people tell you that we have emergency supply systems in place so there is no need for a pharmacist to prescribe to provide medication continuance. However, the system we have is broken. It costs our patients to access it. Patients who may be entitled to concession priced scripts, or CTG, are forced to pay. I think this contrasts starkly with the desired health outcomes. Our most vulnerable patients should not be left out of pocket or suffer because they cannot afford their medication.

One of my patients—a gentleman in his nineties—could not get an appointment with his GP for a couple of weeks, so he chose to come in and pay us to administer his flu vaccine. His wife resides in a nursing home and he did not want to put her or the other residents at risk as he visits her daily, and he did not want to go a week or two without seeing her. This gentleman was entitled to get his vaccination for free. I am qualified to administer his vaccine but apparently only if I make him pay for it.

Migraine medication such as triptans are another example of where patients are left to suffer unnecessarily. I work in a pharmacy co-located with a GP super clinic. A lady had run out of repeats on her script. She came in to see the doctor. The clinic was busy and not taking walk-ins. There was

nothing I could give her that worked as well, so she was forced to skip work due to her migraine. However, had there been a nurse practitioner around, a nurse practitioner would have been able to prescribe it on the PBS.

Mr Willis: In our business model, I do the corporate governance and Cate does the clinical governance. You can see with our name tags that she is the director and I am the general manager. That adds emphasis to the business model that we want to sustain in Queensland because it puts the clinical outcomes above the business outcomes. I am the guy who is trying to make the business run efficiently, make money and keep it sustainable, and that is balanced by Cate's position as a health professional trying to deliver health outcomes into the Queensland community.

I have a lot to say but I think it would be better to get into questions. Some of the things that you could focus questions on are debunking some of the flawed arguments such as the benevolence of big corporates. I do not think they are as benevolent as they are telling this committee, and I have examples of that. I think examples of pharmacy misconduct are a deflection and they avoid an accurate comparison of the relative consequences of misconduct, and that has not been explored much either.

We have heard other flawed arguments, such as that pharmacists can own medical clinics but doctors cannot own pharmacies. That is a misrepresentation and I think a logical fallacy. We have also heard that doctors lose business to pharmacists and about the fragmentation of care. I do not think that reflects the competencies that they have, and we can explore that further.

I was also involved in the North Queensland trial for the My Health Record. I do not believe My Health Record has been represented to the committee correctly yet, certainly from a North Queensland perspective. I am in support of a pharmacy council and I can cite my own personal experience collecting evidence for disciplinary matters against pharmacists and pharmacies in the Townsville area. We are happy to answer any questions.

CHAIR: We might start with some of those examples and we will go first to some of the disciplinary matters.

Mr Willis: Yes. It is true that at the federal level there are mechanisms in the Australian Health Practitioner Regulation Agency, the Pharmacy Board and the professional association codes of ethics and codes of conduct whereby individual pharmacists can be disciplined. In Queensland, there is no way to discipline the premises or the business at this time. For me, I think that is the significant role for a pharmacy council.

A particular example we had in this town was a case of VPN fraud, or virtual private network fraud. A PBS approved pharmacy had the approval number to dispense the pharmaceutical benefit, which is a Commonwealth subsidy for the medicine to patients who are entitled. There was another pharmacy that did not have the Commonwealth approval, but that second pharmacy started dispensing the pharmaceutical benefit and claiming the subsidy using the number from the other site.

I am not a lawyer, and that is why I want a pharmacy council because I want a pharmacy council to investigate this in a legally correct way. What I understand is that, because it is the criminal law, the burden of proof is quite high and there are essentially three parts of evidence that we needed to collate. One was a PRF sticker which would be able to link the dispensing of that medication to the Commonwealth approval number. The other one was the repeat script, which again would show that it was dispensed and it was dispensed as a repeat and it was dispensed as a PBS subsidised and not private subscription. The third thing was we needed a signed statement by the customer to say they actually got it from site B and not from site A, even though the other two bits of evidence said it came from site A.

In a criminal sense, we secured enough evidence to prove a case of fraud amounting to $6. The problem for the Commonwealth became, 'You've proved one case of $6. Now you have to go and do that all again.' You have to collect all of the evidence to make it significant enough to pursue as a fraud case for prosecutors. I believe the pharmacy council could pursue these matters on a more administrative or civil base. On the balance of probabilities then and based on a jury of peers, you could say, 'If you did it twice, on the balance of probabilities, you're not the type of operator that we think should be running a business in Queensland. Here's a notice to show cause of why you think we're wrong.' They can be kept running concurrently—the fraud matters—but we could have some administrative processes that could police these operators up, because that operator kept going.

CHAIR: Conversely, with both AHPRA and the Pharmacy Board of Australia, some submitters have said this already happens, that they can regulate the industry and take care of disciplinary matters. What is your view on that compared to a Queensland based one?

Mr Willis: They quite specifically discipline people, a health practitioner with a registration number. In this particular case, a pharmacist who had his or her initials attached to the prescription could be censured, temporarily deregistered and stopped from practising in the business, but that business would keep going. If that business is the problem, the federal government and the state government have no way to control it. A key factor in this would be a licence or registration on an annual basis, because that business has something that can be taken away.

CHAIR: That is a fair point. I will move to Cate. There has been some discussion, which you may have heard today, about coordinated care. The AMA and other submitters have talked about the importance of collaboration in care. You have two pharmacies—one in a community based in Garbutt and the other interestingly in a super clinic, where I imagine you would work closely with the doctors and the GPs. What are your experiences in coordinated care in the GP super clinic pharmacy?

Ms Whalan: I think it is great. We have a lot of interaction with the GPs. They quite often will come out to the pharmacy, stand in the middle of the dispenser and say, 'This is my problem. What can I do?' We work together. If we come across a problem with a prescription—an interaction, a contraindication—we are exactly the same. We will go back in and say, 'Did you know this person is also on this?' We can see from My Health Record that they have got medication dispensed from another pharmacy and we can ask the GP whether they know the patient is on that medication already. The pharmacists love it. As far as I know, the GPs love it and the patients are benefiting.

CHAIR: It was interesting that Mr Willis spoke about My Health Record and that you were part of the trial up here. Cate, do you use the My Health Record in your chemists?

Ms Whalan: Yes. Townsville was a trial site, so as soon as it became available we signed up for it.

CHAIR: How have you found that in a coordinated care approach?

Ms Whalan: Fantastic, especially for Indigenous patients. They tend to go walkabout a lot. If they come in from out west and say, 'I need a new medication pack but I don't have my old one because I've run out,' we send them down to TAIHS and TAIHS will say, 'I've got no idea what they're on.' We can pull up a history, print it out and say, 'This is what they have been getting,' and the doctor checks off that and says, 'Yes, I agree they still need to be on everything.' Then we will write the scripts for it.

Likewise, with people being discharged from a hospital, a hospital pharmacist can upload a discharge summary. If you give some of the more high-risk patients the paperwork when they are leaving hospital, they can sometimes become a bit disorientated and they turn up to the pharmacy having lost their discharge summary. If it is on a weekend, the hospital pharmacy is not open so you cannot confirm what changes have been made, so we can jump on to the My Health Record and check. People have care plans, and GPs will put a care plan up for some people.

CHAIR: That flies in the face of a previous person who said it is decades away from a coordinated approach.

Mr Willis: I think the difference is the perspective between pharmacies and the doctors. We are very fortunate in pharmacy to have a smaller range of software providers. Our software providers have made the interface very, very easy. About 75 or 80 per cent of pharmacies in the North Queensland PHN footprint can access the My Health Record. We have 98 per cent of patients, so fewer than two per cent opted out, despite what you see in the southern media. There is a lot of talk about the privacy concerns, but it has not really had the big effect on the ground.

The big effect on the ground is that pharmacists right now have a much better visibility of a My Health Record patient's medication profile than the doctors. It is better than the doctors because of this technology. You are seeing doctors walking into the GP super clinic saying, 'I've got to have a look at your super-duper process. Can I have a look because I have a question about this patient?' They are stepping away from their software, which is lagging, and coming into the pharmacies to get that holistic picture that the doctors do need for their diagnosis, and the pharmacists have it.

CHAIR: That is a really interesting point. Thank you.

Mr O'ROURKE: Good morning and thank you for your submission. My question is in regard to ownership of pharmacies. Are pharmacy ownership restrictions really necessary, given the amount of Commonwealth and state legislation, professional codes, standards and guidelines that regulate pharmacies and pharmacists?

Ms Whalan: Absolutely.

Mr Willis: This goes to some of the bizarre arguments, like the benevolence of a corporate—let us deregulate and let a corporate in because a corporate can absorb some of the costs of a marginal business so they will leave that open. David Jones moved out of the Townsville CBD in 1993 because it was marginal. Coles moved out of Urban Quarter in the Townsville CBD because their Coles was marginal. Corporates do not sustain marginal business units. They just do not. It is not what they are taught to do. When people like me do MBAs, when we go on the AICD courses, we are taught to review the financials and cut away marginal parts of the business.

You definitely need the regulation to protect the Queensland community. In part, if the corporate world, profit motive and laws of supply and demand could deliver equitable outcomes, we would not need Queensland Health, we would not need a public hospital system. They do not provide equitable services very well. That is not what we use capitalism for. We use regulation to protect people, and I think it is important for good medicines for Queenslanders.

Mr O'ROURKE: Are you aware of any specific outcomes that have been improved as a result of the place being managed and owned by a pharmacist in comparison to being owned by somebody other than a pharmacist? I do not agree with Coles or Woolies—that sort of conglomerate—but a fit person to own a pharmacy. Is there any true benefit in having it owned by a pharmacist?

Ms Whalan: I think there is a lot of benefit to having it owned by a pharmacist. I think a pharmacist is the only person who is going to have that level of knowledge to know if I cease this medication or if I recommend this over this. I am not looking at the bottom line. I could give them another medicine which is not going to work quite as well but which I am going to make a hell of a lot more money on rather then what is actually best for them. Somebody who walks into a pharmacy owned by a pharmacist quite often will walk out with just advice and not a product. I cannot imagine a corporate or any other entity doing that.

Mr O'ROURKE: One of the things I have noticed throughout this hearing is that we have some pharmacists who open multiple pharmacies across Australia and I am not sure what that true benefit is. If they have 30 pharmacies across Australia it is not as though they are in each of those shops every day.

Ms Whalan: That is not the norm. I think there are 1,100 pharmacies in Queensland and there are 800 owners. I think each owner does not even have two. The majority of us have one or two. That person who has 30-odd is probably your big box discounter who is sitting in Melbourne and not visiting his pharmacies. There is a flaw in the system but I do not think we should corrupt the rest of Queensland just to let him do what he is doing.

Mr Willis: There is a bit of murky statistics. Eleven hundred and 800 is very different to someone else quoting, 'This guy owns 30 pharmacies.' That is one of the things we want the pharmacy council to do for us—to decrypt that. You would want that, I believe, as a governance organisation and the community and business owners want that too. We want that level playing field.

Mr McARDLE: Thank you both for being here today. Thank you for your submissions as well. Catherine, I think you made the comment in your opening address that you got a telephone call from Queensland Health and they were going to arrive the next day to check the premises. You have been a pharmacist now for 20-odd years I think you said.

Ms Whalan: Twenty-three.

Mr McARDLE: How long have you been an owner of a pharmacy under the Queensland act?

Ms Whalan: Nearly 13.

Mr McARDLE: Over those 13 years how many times has Queensland Health knocked at the door or given you a telephone call to say, 'We're coming around to inspect the premises'?

Ms Whalan: Prior to 2010 I would say every 18 months to two years they would turn up to inspect. Since 2010 I have had one where I got prior notice.

Mr McARDLE: In eight years you have had one inspection?

Ms Whalan: Yes.

Mr McARDLE: And you got a call before that to say, 'We're coming around.'

Ms Whalan: That's correct.

Mr McARDLE: And the reason they made that comment was the paperwork is easy.

Ms Whalan: Yes.

Mr McARDLE: Which I think you would find fairly cynical, and I would agree with you on that point. Since owning a pharmacy, since 2010 have you had a request from Queensland Health to reconfirm your ownership structure?

Ms Whalan: No.

Mr McARDLE: Has anybody from Queensland Health gone out to pose questions to you to say, 'Has there been any change in how you structure your business?'

Ms Whalan: No, not from Queensland Health.

Mr McARDLE: They are not trick questions. There is a reason behind it. Have you changed your structure of ownership between 2010 and now—a new director, new shareholders and things of that nature?

Ms Whalan: What did we change?

Mr Willis: Cate operated the Garbutt pharmacy as a sole trader when we purchased it in 2006 and then the sole trader sold it to its current business structure.

Mr McARDLE: When was that?

Mr Willis: In 2010.

Mr McARDLE: Was that before the new act came into play?

Mr Willis: I am not aware. When did the new act come into—

Ms Whalan: 2010.

Mr Willis: It is the same year. I am not sure whether it was just before or just after.

Mr McARDLE: What I am trying to establish is: has Queensland Health ever come to you post lodgement of the papers to query your ownership structure?

Ms Whalan: No.

Mr McARDLE: Has anybody ever done that?

Ms Whalan: No.

Mr McARDLE: I take it, Catherine, given that the pharmacies you operate are fairly close together compared to other pharmacies across the state you attend them on a regular basis?

Ms Whalan: Yes.

Mr McARDLE: How many days a week per pharmacy would you be on the premises?

Ms Whalan: At the Garbutt one I would be in the store four to five days a week. At the Hyde Park store I have a partner who has an ownership stake in it as well. She is there five days a week and I do a weekend a month there.

Mr McARDLE: And the third one?

Mr Willis: The third one opens in October.

Ms Whalan: It opens next month.

Mr McARDLE: It is yet to open, my apologies. What will the arrangements be there regarding your presence or perhaps your partner?

Ms Whalan: I will be there one to two days a week.

Mr McARDLE: Paul, you are the CEO, if I can use that word, of the two pharmacies and the third one coming online. What will be your arrangement to be on the premises to coincide either with Catherine or to at least supplement her not being there?

Mr Willis: I usually go where Cate is not to one of the pharmacies where she is not. We are fortunate to have some office space in all three, but I try to stay out of the way intentionally of the day-to-day operations. I am in pharmacies twice a week.

Mr McARDLE: For 24 hours or seven hours or what?

Mr Willis: About 16 hours a week.

Mr McARDLE: Catherine, you are still clearly—and rightfully should be—the front person and, Paul, you are the heavy-handed gun behind the doors?

Mr Willis: That is a nice way of looking at it. I like the way you are looking at it.

Mr McARDLE: What you would say to the committee is that the way you conduct the pharmacies that you operate is very professional.

Ms Whalan: I would like to believe so.

Mr McARDLE: And you have a very strong hand in the delivery of services?

Ms Whalan: Yes.

Mr McARDLE: You heard me put to Dr Kangru my concern that what we are missing in all this is the starting point seems to be that we are not acknowledging the qualifications of the pharmacist nor are we acknowledging the role the pharmacist has and we are assuming that they will not be doing the right thing. My belief is that pharmacists do the right thing and make an assessment based upon the knowledge of the patient, and if there is any doubt they will make relevant contact with a qualified person to assess that. Would you like to comment upon that?

Ms Whalan: Yes. It is engrained into us throughout our degree when to refer. We are all aware of the red flags for all illnesses—circumstances which arise that, if you see this, then you need to refer, whether you ring triple 0, whether you refer to the hospital or refer to their GP. That is what we do. I believe it is exactly the same as what the doctors do with specialists. They see their patients and they, I am assuming, would refer to specialists when it comes outside their scope. I am comfortable that all the pharmacists I know are aware of what our scope is.

Mr McARDLE: You made the comment that there are red flags in your training et cetera. Does the guild assist you in ongoing training post your degree being obtained? How do you upskill in relation to your skills to ensure that you are ahead of the curve regarding medication, disease et cetera?

Ms Whalan: The guild is one of the organisations that provide education. There is the Pharmaceutical Society, which I am also a member of, which provides opportunities for education. There is a minimum standard of 40 hours or 40 points per year that we need to do.

Mr Willis: That is regulated by the Pharmacy Board. They stipulate the continuing professional development and then providers such as the guild, the PSA or the hospital association will develop training packages that meet the national requirement.

Ms Whalan: And they need to be accredited.

CHAIR: That is for the credentialing.

Ms Whalan: Yes.

Mr BERKMAN: Thank you both for being here. You heard my questions earlier about differential health outcomes in different circumstances. I am interested in any insight you can give the committee into different or worse health outcomes when we compare the situation of Queensland with other states that have a pharmacy council and the comparison between the big box discounters and smaller pharmacies. Any insight you can offer in those two spaces would be helpful.

Ms Whalan: Because we do not have a pharmacy council in Queensland it is really hard to know what the ill effects have been. I note there was an article in the *Australian Journal of Pharmacy* today with the Victorian council pulling up I think five pharmacies within six months. We have no idea for the last eight years how many pharmacies are not up to standard. I would like to think there are not any, but I do not know.

Mr BERKMAN: Before you go on, can I probe a little more on that? What were the issues that the Victorian council uncovered?

Ms Whalan: Some pharmacies were reprimanded and others had increased inspections based on their storage of schedule 8 medications and their signage being accurate as to who the pharmacist on duty was at any given time. They are things that a lay person would think are quite minor but they still need to be policed. I think if you are not getting inspected then people will start doing that. It is really difficult to draw a line with the health outcome if all your S8s are not in the safe where they are meant to be. It proves bad practice as opposed to a specific detrimental health outcome.

Mr BERKMAN: Is there anything more you can add, whether anecdotally or specific evidence, about differential health outcomes for patients who are dealing with the big box discounters or the smaller pharmacies? That was the other aspect of the question.

Mr Willis: We differentiate ourselves specifically with our Garbutt pharmacy. There is a Chemist Warehouse in the same suburb, and our business model deliberately tries to differentiate itself from the Chemist Warehouse model. If you want cheap perfume or cheap shampoo, knock your socks off and go to Chemist Warehouse. If you want health advice, come to Cate's Chemist because we will assess your medical condition over time, simplify it and provide the health solutions that you need. That business model has been quite successful 700 metres away from a Chemist Warehouse. Customers are telling that us we are doing the right thing

Ms BOYD: We have heard a lot today about global structures making their way into the pharmacy sphere, and your submissions talk about the risk that you foresee associated with that as well in terms of putting downward pressure on your margins and not making business sustainable.

The previous submitter who appeared before us talked about getting incentives from pharmaceutical companies. Is that something that you think would be more prevalent in a scenario where you had these large global hospital groups and so forth in the mix?

Mr Willis: Right now, it cannot be. The PBS price disclosure system prevents that or prevents any benefit from it. If you do get something from a supplier, it has to be declared and then the subsidy you receive from the government will be adjusted accordingly, so the benefit becomes moot. We would see that being sustained into the future. The advantage the corporates have is probably not from the suppliers; it is in economies of scale, personnel and buying power.

Ms BOYD: In your submission you spoke about 'tendering for a molecule', which is a term I am not familiar with. Can you talk me through what that is all about in the pharmacy world?

Ms Whalan: My experience with it is from defence, because I used to be an Army pharmacist. I believe that is a New Zealand model, as well. You identify your need. It might be that I need an analgesic, a pain killer, for my people. I put it out to tender. Everybody who makes a Panadol-like paracetamol product would put in a tender saying, 'I would be able to supply you this many at this price'. The most competitive one wins. You do not get a choice with brands.

Mr Willis: The risk there is that all the competitors drop away, so if there is a supply interruption with the one successful tender the community is without medicine. Sustaining the Australian system increases the scope for redundancy in the supply of medicine. If there is a supply interruption from one person, you can get two other companies to provide the same generic.

Ms BOYD: In a place such as North Queensland that is particularly susceptible to natural disasters, for instance, is this something that is very important to you?

Ms Whalan: Absolutely, yes.

Ms BOYD: Do you support a pharmacy council in Queensland?

Ms Whalan: Yes.

Ms BOYD: How do you think it would be best funded?

Ms Whalan: By the pharmacy owners.

Ms BOYD: You would be happy with your two and soon to be three small businesses actually paying a levy?

Ms Whalan: Yes. At the moment, we pay—what were the statistics with the wholesaling licence?

Mr Willis: One of the inconsistencies is we also wholesale to aged care facilities, private and Queensland Health. Sometimes we need to stock their imprest. Queensland Health especially usually looks after themselves. Queensland Health makes us pay $600 for a wholesale licence, so that we can have the privilege of providing a $30 medicine to them maybe once every three months. We are losing money on that straightaway. Queensland Health does not require us to pay $600 a year for the 127,000 prescriptions that we supply to the community. That is completely unlicensed and unregulated. I would quite happily pay $700 or a reasonable fee annually, so that the community could be protected from misconduct.

Ms Whalan: Just so that we all know that we are all playing on the same even field. If I am going to all the effort of keeping my standards high, I want to know that everybody else is as well. I am prepared to pay to have it policed.

Ms BOYD: Wonderful, thank you.

Mr HUNT: Most of my questions have been asked and answered. I want to explore the business of a pharmacy. We received a lot of submissions from pharmacists about ownership regulation and the intent of that. The general theme was that a pharmacist cares more about the health outcomes than they do the profit, whereas a corporate entity would care more about profit than health outcomes. In terms of the business that you run, and I guess I direct this to you, Paul, as the business manager, I assume that as part of your business planning process profit is still something that is looked at. You also mentioned the cheap perfumes at Chemist Warehouse. Is it a fair comment that you would sell a lot of retail items, as well?

Mr Willis: No. We have a very different prescription-to-front-shop or prescription-to-retail balance. It is very different. We are quite high. Even by guild standards, we are shifted towards the dispensary at about 85 to 90 per cent.

Mr HUNT: Your talked about how well you compete against a nearby Chemist Warehouse because of that business model that is aimed primarily at health care. Is that the difference that you are looking for in terms of being able to be a sustainable and successful business next to them?

Mr Willis: Sadly, we are targeting, in a business sense, people with chronic health conditions that need to be managed over time. For example, I tell a lot of my friends my age that if they have an acute condition, they have a one-off script of antibiotics, they are really good patients for Chemist Warehouse. They are going to save $1, $2 or $3 if they go to Chemist Warehouse. However, if you have diabetes and a cardiovascular disease, come to us because our pharmacists will remember you. The same pharmacist who is there today will be there next week. They will be able to help you manage your condition over time. Also, you are probably going to need dose administration aids. We supply that. We will charge that $1, $2 or $3 extra, but you will get dose administration aids and you will get free delivery. We are going to make this part of your life easier.

Mr HUNT: Throughout the hearing process, we have heard examples of pharmacists who own multiple pharmacies around Queensland and Australia. Why is a pharmacist investor more caring, I suppose, than a non-pharmacist investor?

Mr Willis: Because of AHPRA, the pharmacy board and, we hope, pharmacy council oversight. As a director of a company, I look at the relative consequences for someone like a director of AMP in the recent banking royal commission. Those directors are still working. Even the ones who left AMP are still working as directors. If a pharmacist loses their registration, they lose the ability to own the business. They have to sell the business. The house is mortgaged to that business. The scale of consequence is much larger for someone who is regulated at the federal and the state level.

Mr HUNT: I do not know whether this is a fair question to ask you and whether you would have any knowledge of it, but do you know of any pharmacists in that situation, who have been investigated and deregulated?

Mr Willis: Yes.

Mr HUNT: Do you know if it is widespread?

Mr Willis: It is not widely employed. It is employed in other states that have pharmacy councils to discipline people. It is a very real deterrent that does not exist here in Queensland.

Mr HUNT: In Queensland, do you know of any examples?

Mr Willis: Yes, I have evidence of unsavoury business practices in Queensland pharmacies. The case I cited before about virtual private network or VPN practices is illegal. It also sets the consumer up for not being able to manage their repeat prescriptions properly. There is no level playing field for the business owners. There is a poor health outcome for the patient. At the moment, there are very limited ways we can deal with it in Queensland.

Mr McARDLE: You have used the word 'benevolent' on a number of occasions during your submission here. You refer to the model of a traditional one-owner pharmacy as being benevolent, but the corporate structure of a multinational being non-benevolent by definition. Do you think it is automatic, that because you are a multinational you cannot be benevolent?

Ms Whalan: No, I do not think it is automatic, because I am sure some of the corporations have their own charities and the like that they give to. I think that was in response to Mr Giannopoulos from Ramsay saying that, as a corporation, they would be likely to keep their smaller rural pharmacies open if they had control of them, even if they were not making as much money, because they would be making money elsewhere.

Mr McARDLE: That is a little bit soft, Kate; sorry.

Ms Whalan: I do not think that is benevolence as such.

Mr Willis: A corporation might have a corporate social responsibility feature in their business, that is true. In that sense, they would be benevolent. However, they will not be benevolent by sustaining marginal business practices like Coles at Urban Quarter or David Jones. If something is not making money, a company will shut it down. It was specifically related to that claim, that assertion.

Mr McARDLE: On the issue of the council, let us go forward to 1 July 2019. We have leapt ahead in a time machine. The act has been changed. The council is in place. All is right with the world. At 1 July 2019, if you were part of the council, would you require every pharmacist to establish at that point in time that they complied with the act? Would you then, every year thereafter, at 12 months registration, require that confirmation to be undertaken?

Ms Whalan: Yes.

Mr McARDLE: You would not accept that, for the 1,100 pharmacies in Queensland, registration or at least licensing or compliance with the act is sufficient? You would start from scratch and then every year they would have to prove that again?

Ms Whalan: I do not think it would be hard to prove.

Mr McARDLE: Why every year?

Ms Whalan: Why not?

Mr Willis: We have to do it for wholesale licences already. You have to do it for a rifle licence. Where there is a health risk, where something needs to be controlled, it would be prudent to recheck the circumstances. That might be asking, 'Have your circumstances changed?', which is roughly what we have to do.

Mr McARDLE: The answer might be no.

Mr Willis: Yes. So you say 'no', sign the form, here is my fee and you get your licence back.

Mr McARDLE: That is what I am getting at. I am concerned that you are actually producing all documentation every 12 months. That has been mooted in the past as being what should happen. That worries me, because I would have thought as a legal practitioner and a paramedic you would tick the relevant box to say, 'Things have not changed, I have done my relevant CPD points', et cetera. Then it goes on from there. Wouldn't that be sufficient?

Ms Whalan: Yes.

CHAIR: Thank you very much, Cate and Paul. We have quite deliberately kept you up here giving a little extra evidence. Not every person in the Townsville area who made submissions was willing to come before a parliamentary committee and unpack everything that you have managed to do today. As the local member, I thank you very much. Obviously, you are embedded within the community and have been for a long time. Thank you for the work that you do. Finally, where is the third chemist opening?

Mr Willis: It is really exciting. It is going in to the Townsville Aboriginal and Islander Health Service. Again, the pharmacists especially like that clinical interaction with the Aboriginal health workers. We have traditionally done a lot of business with TAIHS and now we are actually going to get a footprint in their medical centre, so it is exciting.

CHAIR: That is outstanding. I congratulate you on your business model. Obviously it is well established in the Townsville community. Thank you for the work that you do. Thank you for your attendance today. It has been very beneficial.

Our next witness is giving evidence via telephone. For the benefit of those in the audience, this is not our preferred way to take evidence. However, that is the way we will finish today's hearing, with Mr Matthew Brosnan, pharmacist.

BROSNAN, Mr Matthew, Private capacity (via teleconference)

CHAIR: Good morning, Matt. We would much prefer you to be in sunny Townsville than where you might be right now in the state, but we welcome you to the inquiry that is before our committee regarding pharmacy ownership and scope of practice. Would you like to make an opening statement before we move to some questions?

Mr Brosnan: Certainly. Firstly, I would like to thank you for the opportunity. I know that there are a lot of young pharmacists out there who would echo my sentiments but they would never get the opportunity to express them in a forum like this, so for that I am very grateful.

Pharmacy is my career and it has provided me opportunities and scope to influence others to follow. Both my father and brother are pharmacists and we are strong advocates for rural pharmacies in maintaining opportunities for a younger generation of pharmacists coming through. It is my opinion that the pharmacy industry needs a system that levels the playing field between the larger pharmacy corporations benefiting from economies of scale and the many small pharmacies that have lost out. In a word, we need a new ownership system that pursues health and social wellbeing rather than growth.

The quest for growth by these large pharmacy groups has destroyed informal health care provided by many community pharmacies which provide a safety net to numerous patients in our community. In our obsession of following globalised rhetoric in reducing citizens to mere consumers, do we ever stop and wonder at what cost to the health and wellbeing of our patients, our grandmothers, our fathers and our children?

When I look at productivity stars such as Professor King, I wonder what price do they put on pharmacies to bring morphine to a dying patient and sitting for hours with a soon-to-be widow comforting and reassuring her that there is support? What price do you put on Karen Brown's work in organising playgroups and activities for isolated mothers in order to address postnatal depression or Lucy Walker's work in fundraising for farmers who may not be able to afford medication and treatment for mental health disorders? What is the price of that goodwill and is it all driven by sheer greed and profit as some would have us believe?

When these enlightened economists talk of individual competitors and more efficient owners, are they referring to the unregulated supermarkets that dominate food, fuel, alcohol and office supplies? The subsequent destruction of communities, small businesses and employment over decades should be sufficient evidence to hold any thought of a deregulated pharmacy industry. Unbridled deregulation has proven to create more problems than it solves.

This inquiry was established to look at the transfer of ownership in the last two years, I believe. Apart from the obvious ACCC concerns, we cannot scrutinise one transaction—that is, the purchase of the Malouf chain by Ramsay—without looking at the overall ownership legislation. We are at a crossroads in terms of ownership legislation in this state. It may have been one transaction that has brought this inquiry to a head, but it has been many transactions that have led pharmacists to really question what is the spirit of the act and what does it purport to achieve.

It is too important not to act. There is a feeling of disenchantment and cynicism amongst our young pharmacists coming through in relation to ownership. I personally believe that the opportunity that many others have had in this profession to attain ownership provides an incentive to stay in the profession. The disillusionment of our young towards attaining ownership and the angst of those who have taken the leap have led to an exodus of good people from our profession, and it is a waste of a health resource. We cannot afford to maintain the status quo. If we do, three things will happen: the likes of Chemist Warehouse will continue to grow, other corporates like Ramsay will enter the market and existing groups will continue to acquire independence using existing loopholes.

This inertia in pharmacy regulation is a strategy for those who argue that we have reached a critical point which is too difficult to wind back. I often hear the comment that we should be deregulated, corporates are already at play, no-one abides by the rules anyway. There are groups that are currently buying pharmacies with the intention of selling them if and when deregulation occurs. This is a defeatist view and community pharmacy is worth fighting for. It just needs resolve and leadership, and we can do it only with your help.

In Queensland the term 'ownership' revolves around enforcing proprietary interest provisions, when pecuniary interest provisions should be given more attention. It is my opinion that the act should be tightened to include these provisions in order to broaden the scope of what constitutes ownership. 'Proprietary interest' means ownership interest as a sole proprietor, as a partner, as a director,

member or shareholder of a company or as the trustee or beneficiary of a trust. 'Pecuniary interest' is defined as a direct or indirect financial or legal interest. In other states it also includes the definition of proprietary interest, as does AHPRA. It should also be the case here in Queensland.

There was a case a few years ago in New South Wales involving Coles Myer, a subsidiary of Wesfarmers, purchasing and transferring the ownership of Sydney Drug Stores owned by Mr Brown. The case was the Attorney-General v Now.com.au. The judge concluded that, although Mr Brown was in charge of the administration and professional aspects of the pharmacy, Coles Myer had financial control of the company. He stated that Coles Myer were more than a mere shareholder; they were an active controller of the business and hence had a pecuniary interest in the business. He concluded that pecuniary interest had to be more than a proprietary interest and involved a degree of active control in the business of pharmacy. As such, they had to divest. I fear that if that business had been in Queensland, the situation may have been reversed.

In Queensland, the corporates and larger pharmacy groups have circumvented legislation by assigning a proprietary interest—the approval level or what have you—to a willing participant whilst hiding their corporate pecuniary interest in the form of security over the business. That security should be counted as both a proprietary and pecuniary interest because by its very nature it assumes control.

In summary, the ownership rules have always been about protecting Queensland patients and the health of communities. If we invite large conglomerates to operate in this industry then the patients and communities become shareholders and boards, and that is not healthy for anyone.

CHAIR: Thank you very much, Mr Brosnan, for your opening statement. For the benefit of the people in the audience, can you tell us where you are located and how long you have been in pharmacy? I heard you touch on the fact that you have a family history of being in pharmacy.

Mr Brosnan: I grew up in Western Queensland at Moranbah and south of Mackay at Sarina. My father went to Moranbah in 1969 and then moved to Sarina. I subsequently did pharmacy late. I was 27 when I went into pharmacy. I have a pharmacy in Biloela, Agnes Water and Sarina. I have partners. I have a couple of young female partners from the bush. I have been involved in pharmacy for 25 years and am very passionate about it.

CHAIR: I can hear the passion, Mr Brosnan. They are all good parts of the world. You did touch on Lucy Walker. We met her in Toowoomba and she made a very similar passionate contribution. You have four pharmacies by the sounds of it. Is that correct?

Mr Brosnan: That is correct—an interest in four.

CHAIR: Did you happen to read the Queensland Productivity Commission's report on establishing a pharmacy council? It looked at the cost benefit of it, saying that it was not in our interests. Can you comment on that at all?

Mr Brosnan: I read the summary points, yes. I was at the second hearing when I heard Trent say that the costs should be met by the pharmacists of Queensland—that they would look after the costs. I was in two minds, to be honest. I thought that you could run this out of Queensland Health with a committee, with tightened legislation. Then I thought if we are going to do this properly you do need an independent statutory body, one that is funded by the industry or otherwise. If we do this, it will be rough for the first two years. We are looking forwards from when this new legislation is in place. I think it has to be remain apolitical.

In my view, we cannot afford not to do this. Victoria has one. WA has one. The resources are there. My point is that we are registered federally. The location rules are administered federally. The funding comes from federally. Yet all the ownership provisions are state based. It is ridiculous in my view. There should be a lot more cohesion between states regarding ownership legislation. My point is that there are a lot of resources out there at the moment. It should not cost that much.

CHAIR: What are your thoughts on expanded scope of practice? If you have been following the contributions to date—

Mr Brosnan: I know that this has been well covered, but I would like to make two points. I think both screening and recording provide a future for pharmacists. There is so much that we do in pharmacy in contributing to the health of the nation that is not noted. It cannot be monitored. Pharmacists cannot be renumerated for it. That is why My Health Record is very important.

The other thing is screening. As Professor King said, the greatest asset that pharmacies have or that community pharmacies have is a network. I think that the federal government and state governments could better use that network to promote health initiatives. We are only a few years away from somebody walking into a pharmacy and obtaining a blood test and screening for diabetes,

cardio—I mean without thinning blood—and certain other chronic contributions. At-point-of-sale technology should be utilised in pharmacy. We have a real place for screening. I listened to the doctors, the AMA. We do not want to diagnose or prescribe, but there is certainly a place for us to continue and enhance medication adherence by continuing supply. That is all I have to say on that.

CHAIR: We will move to a question from the deputy chair.

Mr McARDLE: In your opening comments, you referred to a case where a corporation had to divest.

Mr Brosnan: That is correct. That was a New South Wales case. It was the Attorney-General (NSW) v Now.com.au. Why they called it Now.com.au I am not sure. It was Coles Myer/Wesfarmers.

Mr McARDLE: Do you have a citation for that that we could look at? You seem to know the case quite well.

Mr Brosnan: I will have to take that on notice.

Mr McARDLE: How long ago was that case decided?

Mr Brosnan: It was a few years back—2006, from memory. I would have to look.

Mr McARDLE: It deals with the same issue of pecuniary interest—how that is defined and how the law has changed in that regard. Is that right?

Mr Brosnan: Absolutely.

Mr HUNT: In your submission you mention that the Swedish government has gone back to regulation after a period of deregulation. Can you unpack that a bit for us in terms of what happened there and why that occurred, if you are aware?

Mr Brosnan: Certainly. It was only last year, 2017, that the Swedish government commissioned a report. The report is called *The quality and safety of the Swedish pharmacy market*. It is a thousand pages long. It was state run, just like the liquor shops. In 2009 they opened it up. They deregulated. There may have been some pressure from the European Union, I am not sure. Initially there was a spike in pharmacies in urban areas—98 per cent of all new pharmacies were within six kilometres of existing ones. There was no growth in the rural pharmacies.

The Swedish government implemented a strategy whereby if a corporate bought an urban pharmacy they had to take on a rural one. There was no provision that they had to keep the urban one open, so a few of them closed. Although they may have argued that access improved initially, what has happened over the last couple of years is that the major groups in Europe have moved in. I think there are now maybe four major players which is a great shame. They have mentioned reregulating now, meaning they want pharmacies or rural pharmacies to operate more efficiently. I think they have provisions in place for that to occur, meaning they are making them more viable.

Ms BOYD: Mr Brosnan, I was just doing some googling here. Your pharmacy has been operational for 50 years?

Mr Brosnan: Have I been a pharmacist for 50 years?

Ms BOYD: No, is it Brosnan's Haven Pharmacy, or is that a different organisation?

Mr Brosnan: It is a different organisation.

Ms BOYD: You have been a pharmacist for 25 years?

Mr Brosnan: I am involved, yes.

Ms BOYD: In your submission you talk about dealing with pharmacists who are new to the profession. You cite one pharmacist who goes to WA because he believes there are better prospects there in terms of being able to become an owner in the industry through relocation. Are you meeting these pharmacists through professional means? Are they pharmacists who are doing internships? How is it that you are interacting with other pharmacists in the industry?

Mr Brosnan: Through industry events and friends I know who have taken on interns. Obviously it is a very small network.

Ms BOYD: It is indeed.

Mr Brosnan: It is, yes, that is right.

Ms BOYD: In your evidence today and in your written submission you have given us a bit of an indication in terms of where you want to see us going, but where do you think the pitfalls currently are in the system as it stands?

Mr Brosnan: I think the legislation needs to be tightened up. To be honest, because of inaction I think a dangerous precedent has been set. It is very hard to wind back. It is very hard to curtail the rights of Chemist Warehouse or Ramsay or whoever, for that matter. We have a couple of options. If that does not take place, then the New Zealand model needs to be looked at. They just opened it up and allow 50 per cent corporate ownership. The banks were happy; they got their money. The wholesalers were happy; it enabled them to get very full integration. The industry welcomed an injection of funds. It enabled a lot of young players to survive and pay back their debts and what have you. Once you open the door and let them in, it is very hard to get them out. The door was left slightly ajar. It is too important not to do something about it. I think I have made that point on a few occasions.

Ms BOYD: One of the things that you say in your submission is that you have held the view for a long time that community pharmacy is the most underutilised health resource in the country. Can you elaborate on that for us a little more, please?

Mr Brosnan: When I was first engaged in the pharmacy I can remember the TE score being around 975 or 980 and then obviously it drifted from an OP 3 or 4 down to 18, as I told you on Friday. I see that as a brain drain. I see it as a lost opportunity. I think there have been demarcation disputes for many, many years. I think there are enough bright people in this industry to assume a lot of those roles that, say, nurse practitioners who can prescribe have. I think the reality is that commercial pressures prevent that from happening. We would all love to put on interns and initiate a lot of these programs, but a lot of pharmacists cannot afford it and I think that is really a missed opportunity.

Mr O'ROURKE: Given that some proprietor pharmacists own multiple pharmacies and some live away from where the pharmacies are located or they are interstate or overseas, can you explain how the ownership of a pharmacy delivers a demonstrable health benefit or better quality patient care above what is provided by the dispensing pharmacist?

Mr Brosnan: True. This point has been raised on a few occasions. How many are absentee owners, I sat there last time and wondered, of all the pharmacies in Queensland? What you will find is there is usually a junior partner or they do obey the rules. There are very few, I believe, who actually have absentee owners without that shareholder—that pharmacist who has skin in the game. That is the first point I would like to make. I have heard this argument for many years, but if you own your own business then you have an incentive to look after patients. If you do not look after a patient, they will walk. As a corporate, you are still going to be paid regardless of whether you look after that patient. I know that small businesspeople put 100 per cent into their business because if they do not, they go broke. Corporates cannot touch that. They cannot come anywhere near that level of care. That is my strong belief and I am sticking with it.

CHAIR: Thank you very much, Mr Brosnan. If you have any closing statements we will give you a few minutes. I also understand you had a citation you were going to provide, so can we have that by next Wednesday?

Mr Brosnan: No problem. Look, this may be a once-in-a-lifetime opportunity to do something. Do not waste it, because the health of our community is too important. Thanks for your time. I really appreciate the opportunity, and I look forward to hearing from you.

CHAIR: I thank everyone who has attended today for their contribution to this inquiry. I declare this hearing closed.

The committee adjourned at 11.21 am.