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

TUESDAY, 11 SEPTEMBER 2018

Cairns

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The committee met at 9.00 am.

CHAIR: Good morning, ladies and gentlemen. I now declare open this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's committee in Cairns. I would like to start by acknowledging the traditional owners of the land on which we are meeting today. I am Aaron Harper, the chair of the committee and member for Thuringowa. The other members with us today are Mark McArdle, the deputy chair and member for Caloundra; Marty Hunt, member for Nicklin; Michael Berkman, member for Maiwar; and Barry O'Rourke, member for Rockhampton. We are missing one of our members, Nikki Boyd, the member for Pine Rivers, who will be joining us very shortly.

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 on 30 September 2018.

There are a couple of procedural matters. This committee is a statutory committee of the Queensland parliament and as such represents the parliament. It is an all-party committee which takes a nonpartisan approach to its 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 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.

I ask any media present to adhere to my directions as chair at all times. The media rules are endorsed by the committee and available if required. I remind all those in attendance today that these proceedings are similar to the 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 note that you may also be filmed or photographed.

KELLY, Mr William, Chair, Pharmacy Board of Australia (via teleconference)

CHAIR: Welcome, Bill. I have read your submission and I think it will be quite beneficial for the committee to hear from you, especially on aspects of ownership and scope of practice. I was quite interested in point No. 12 where you recommended that a council be established. I invite you to make an opening statement before we move to questions.

Mr Kelly: Thank you, Chair. Good morning to everyone else on the committee. It is nice that it is in Cairns. Unfortunately I, cannot be in Cairns myself. I am a Cairns boy. I was born just down the road from where you are meeting, in the Cairns Base Hospital many years ago. I am not only an ex-Queenslander; I am an ex-North Queenslander.

CHAIR: A true local.

Mr Kelly: A true local, yes. Thank you for the opportunity to address the committee. I am the chair of the Pharmacy Board. I have been in that role for the last three years or so and have been on the board for nine years. We are fast approaching the end of our term. We are due to change over to a new board very shortly, once we get the COAG Health Council to sign off on it which I believe is happening very soon.

I note that the committee has received our submission on the establishment of a pharmacy council and pharmacy ownership in Queensland. I will go through a brief overview of the board's functions and address two main points in the statement—the regulation of pharmacy premises and the opportunities to broaden the range of pharmacy services to meet the healthcare needs of the public.

The board has been a participant in the National Registration and Accreditation Scheme since its commencement in July 2010. The role of the board essentially is to register pharmacists to practise in Australia. The national scheme, which you are probably aware, is one part of a complex regulatory framework in which pharmacists practise. This complexity is demonstrated in a pharmacy regulator

and stakeholder diagram that the board has produced. I seek leave to provide this for you following this meeting if the committee does not have access to it at this point. It is on our website. It demonstrates the players in the regulatory environment that pharmacies are involved in.

CHAIR: There being no objection, leave is granted.

Mr Kelly: I will forward that to the secretariat. Workforce mobility, which was one of the aims of the scheme, has certainly improved under the national scheme. Pharmacists register with the board, pay a single registration fee and practise anywhere in Australia, thus reducing administrative burden. There is a national register which is maintained and accessible online. Anyone can seek the registration status and related information about pharmacists in real time online.

The board has registration standards, codes and guidelines for all registered pharmacists practising in Australia that have public protection at their core. The registration standards set the minimum requirements for registration of pharmacists. They support the board to ensure that only suitably trained and qualified individuals are registered to practise as pharmacists.

Codes and guidelines provide practice guidance to support the safe delivery of services to the public. Some examples of these include guidelines for the compounding of medicines, minimum standards for practice and addressing the risks associated with compounding of some medicines, guidelines for the dispensing of medicines, supporting safe dispensing, and guidance on the role of dispensary assistants and pharmacy technicians assisting pharmacists, and guidelines for proprietor pharmacists which focus on the professional responsibilities of proprietor pharmacists and impact the safe and effective delivery of services to the public.

In relation to the regulation of pharmacy premises, despite national registration of pharmacists some inconsistencies in healthcare delivery exist due to the lack of harmonisation of other legislation relevant to pharmacy practice such as in state and territory drugs and poisons legislation and pharmacy premises and ownership legislation.

Prior to the national scheme, most state and territory pharmacy boards regulated both pharmacists and pharmacy premises. Since the commencement of the national scheme, the regulation of pharmacy premises has remained under state and territory control under respective legislation administered by a form of authorised body in each jurisdiction.

The variation in powers of the current state and territory premises regulators creates varying levels of public protection across jurisdictions due to factors such as differing jurisdictional powers to set minimum requirements for establishing and operating pharmacy premises and setting fees to cover the costs of regulating premises to protect the public. There are inconsistencies in inspectorial powers to ensure that standards establishing pharmacy premises are maintained, and there are differences in actions that can be taken by the authorised body to ensure deficiencies in practice are remedied.

The board may be asked to consider complaints about the conduct of individual pharmacist owners which may vary according to the regulatory outcomes that could be achieved by the regulator of each premises. This means the board may have less information about the risks to the public posed by particular pharmacists in different jurisdictions. It also means that owners of pharmacies in more than one jurisdiction may be able to operate premises to different minimum standards which I believe is not in the public interest.

In relation to the delivery of a broader range of pharmacy services, stakeholders and governments have explored opportunities for pharmacists to deliver additional services in the interests of the public. Developments such as the authority granted by states and territories to pharmacists to deliver vaccines is a recent example. With additional training to complement their existing skills, knowledge and experience, pharmacists are now administering vaccines against the influenza virus. They can also administer additional vaccines. However, the range varies across jurisdictions according to the authorities conferred by the states and territories. The training that pharmacists are required to complete for vaccine administration also varies by jurisdiction and therefore may impede workforce mobility which has been achieved through national registration under the national scheme.

Other opportunities for the delivery by pharmacists of additional healthcare services in the public interest are currently being explored. The board held a recent forum with stakeholders including government representatives where it explored the potential role of pharmacists in prescribing in order to support improved access to medicines by the public. This proposal aligns with the objective of the national scheme which are to enable the continuous development of a flexible, responsive,

sustainable health workforce and to enable innovation in the education of, and service delivery by, health practitioners. A report outlining discussions of the day and the next steps will be published by the board in the coming week—hopefully this week—and a copy will be provided on its release.

For prescribing by pharmacists to evolve, there will need to be legislative reform—relevant state, territory and Commonwealth legislation. There will need to be further development of the professional framework that pharmacists must practise within including practice standards as well as any regulatory action by the board under the national law including setting registration standards for approval by ministerial council and any codes and guidelines. Successful implementation of such reforms will depend on the effective collaboration of health practitioners responsible for the care of individual patients and effect an efficient service delivery framework.

Through this inquiry the committee is also exploring the scope of practice of pharmacy assistants. The board addressed this in its submission outlining a range of considerations such as the range of competencies required, the training required to address these, accountability, the risk to the public, how the public would be protected and whether additional regulation would be required. As we outline in our submission, the board does not regulate pharmacy assistants or other ancillary staff. I would be happy to provide further details on any of those matters or any questions that you or members of the committee have.

CHAIR: Thank you very much, Bill. That was very informative and a good way to start the day. Because of the blurring of different standards between jurisdictions, there is a lack of harmonisation and I think that is something we need to consider. There are inconsistencies amongst the different jurisdictions, no doubt. In terms of establishing a pharmacy council, I have no doubt that the Pharmacy Board would be talking with the relevant ministers of each state to ensure harmonisation between the states. Do you think establishing a council would help in moving that way with some kind of coordinated approach?

Mr Kelly: In relation to establishing a pharmacy council—a premises authority of some ilk—it would start to bring it in line with other jurisdictions where, as you are aware, there are different types of authority involved in this whole process which the board deals with at different levels. For example, we have a memorandum of understanding with the Victorian Pharmacy Authority. We deal closely with the South Australian registering authority et cetera. The board deals with each of these authorities, but we deal at different levels because of the different requirements and the different legislation involved. Anything towards harmonisation is certainly welcomed. Nonharmonisation just leads to complexity, which is what we should probably try to avoid.

I would like to very briefly mention the harmonisation of drugs and poisons legislation. I know from my Queensland connection that my father was a former chief health inspector of drugs and poisons in Queensland many years ago, and he was working on harmonisation of drugs and poisons legislation 50 years ago, so we have a long way to go yet, I think.

CHAIR: I agree. On point 12 which I mentioned earlier, that was in relation to what functions a pharmacy council might perform in Queensland and how those functions would differ from current functions performed by Queensland Health. You have gone on to state—

Other than a national regulator of pharmacy which could not be established under the national Scheme, it would be desirable and in the public interest to establish a premises regulator in Queensland that has similar powers to some existing jurisdictional premises regulators ...

I think that is the point right there.

Mr Kelly: It is certainly the case. It varies between jurisdictions. In some you need to grant/revoke licences that establish a business; grant/revoke approval of premises; different powers to inspect premises to ensure minimum standards; power to take action; and power to audit premises. That is the harmonisation of the types of activities that need to be consistent across this part of the regulatory framework.

CHAIR: With your current established councils in other jurisdictions, I imagine you would have a very good close working relationship or better understanding of ownership issues in those states, given that the councils have some remit there?

Mr Kelly: That is certainly the case. The model that we always look to is the Victorian pharmacy model. We have an agreement with them. We get involved from an inspection point of view. If they do an inspection that reveals inconsistencies or practice issues, they will refer them to the board. If we do other investigations or other notifications that show issues around premises, for example, we refer back to them. There is a close working relationship with that. While I am not saying that it does

not exist with other jurisdictions, it exists at different levels because of the different structures. I do not think there is any noncooperation at all. There are just different levels of cooperation due to the different legislation.

CHAIR: Yes. There has been some criticism under the Queensland model that pharmacy inspections are happening on average every seven years. We are hearing differently from established councils that they are quite regular.

Mr Kelly: Yes. Again, that is the resourcing that is applied to the regulator as such and models that are in existence and the size of the jurisdiction. For example, in the ACT it is very easy to do inspections, with 60-odd pharmacies in a very small area. There are differences in demographics as well which contribute.

Mr McARDLE: Bill, thank you for your submission and for your presentation here this morning. As the federal president, are you able to give a report card on Queensland Health's stewardship of the act in relation to enforcing its terms—for example, inspections and making certain that those who seek not registration but approval are in conformity with the terms of the act regarding ownership?

Mr Kelly: That is not in our area of responsibility at all. We would only be involved in any issues around that if the proprietor had been referred to us for some breach of professional standards. The board is not involved in any relation with ownership at all. We have guidance for proprietor pharmacists to give them some guidance of what they need to do as proprietors, but that is nothing to do with the business models or anything like that.

Mr McARDLE: The board has not been approached by any body—I mean 'body' as in a corporate body—to bring concerns to your attention regarding ownership models?

Mr Kelly: No, nothing has come to the attention of the board at all. The board receives correspondence from time to time, but nothing like that has been brought to my attention or that of the board about different corporate models. The board receives complaints in various methods, either through formal notifications or through letters that come through to the board which will outline issues that people might have. Some of these may involve individual pharmacists' professional responsibilities and failing in that regard. Others might revolve around advertising. The advertising issues are referred to a statutory offences unit within AHPRA which deals with advertising offences under the national act. That is where the board's involvement in the ownership side of things is. It is at a level of interest but we do not have any specific legislation around ownership.

Mr McARDLE: You would not be aware of the determination in Western Australia in September this year?

Mr Kelly: Only what I read yesterday in a press release.

Mr McARDLE: That is not an issue that you could comment upon in relation to the facts of that case?

Mr Kelly: No, I cannot at this stage. I read it yesterday for the first time on a pharmacy newsfeed. That is through the Pharmacy Registration Board of Western Australia, which is the premises authority over there. That split up when the national scheme came in. Those elements were reconstructed into a pharmacy premises authority which they called a board.

Mr McARDLE: You made a comment to the chair in relation to what you would probably call a coordinated approach to pharmacy regulation, ownership requirements and the like. Would you see going through COAG as the best way to go?

Mr Kelly: Yes, I believe that is the way to go. The way we are going to get the best bang for your buck and protection for the public is to have a uniform approach to all of this, and obviously through the COAG system is the way this would be progressed.

Mr McARDLE: Let's just look at that for a second and unpack it. One of the issues in this inquiry is to deal with whether or not entities have a pecuniary interest in the business or whether they are controlled by a more senior corporate entity. That is one of the core points that has been raised before this committee. Would a body that you are talking about deal with that and would it need harmonisation of laws across the nation to do that?

Mr Kelly: You could do that if you had some form of national regulation of pharmacy premises. That would to me indicate that that would be a model that could work in that particular way. While there are different ownership models around corporate ownership and various degrees, it certainly is complex when there are differences by jurisdiction. Again, that is not in the area of interest of the board other than to comment that something like a national regulator of pharmacy premises would probably be of assistance in that area.

Mr McARDLE: What would that board look like?

Mr Kelly: I have not given that a great deal of thought at this stage. It has not come up until now what that would be. When the pharmacy boards of old were disbanded when the new scheme was started, the premises aspects were left with the states. The rationale for that I think was to do with consistency of the national scheme rather than any other issue. It showed up the advantages of a national scheme where you have increased workforce mobility, better access to services et cetera. You would think that some form of consistency around the pharmacy premises regulation would also achieve that. Whether that is a national regulation model or greater consistency around the states, both would achieve that. I have not gone any further in examining what a national regulator of premises would do. As I said, it is outside our area of responsibility.

Mr McARDLE: There are two points that have often been made that are interrelated. One is that the community based pharmacy is more benevolent—and that is the word that has been used—than the corporate structure and that the former is going to provide better health outcomes than the latter. Can you comment on that?

Mr Kelly: I can only comment to the effect that from the board's point of view there is no difference in what comes to the attention of the board in terms of what the ownership model of a pharmacy is. Whether it is a single owner pharmacist, whether it is a multiple owner proprietor pharmacy, whether it is a model involving some sort of corporate arrangement with pharmacists, there appears to be no difference in any of the notifications or complaints that come to the attention of the board. We see complaints from pharmacists across all spheres of levels of ownership from the single operator to the multiple proprietor to the corporate bodies as well, but there is no stand-out in any one of them.

Mr McARDLE: There is no distinction between the type of ownership model in relation to the number of or percentage of complaints that come forward?

Mr Kelly: There is no significant difference in any of those that come to the board. Each type of ownership model is represented in the level of complaints, which surprisingly is still low. There is no one stand-out ownership model that we look at. Where the board gets involved if a complaint comes in in relation to who is responsible for it, there are guidelines as proprietors that we fall back on to indicate what a proprietor pharmacist acting as a proprietor should do. That is where the board comes in. In getting back to your original question, no, there is no distinction between the different models.

Mr McARDLE: The professionalism of the pharmacist is not better or worse based upon their corporate structure?

Mr Kelly: Not in relation to the notifications coming to the attention of the board.

CHAIR: You spoke briefly on minimum standards of qualifications. Do they differ greatly throughout the nation in regard to education standards for pharmacists?

Mr Kelly: No. A pharmacy has competency standards which all pharmacists meet upon their initial qualification from university and then on their registration of pharmacists. There are standard competency standards. There are accreditation standards in place. The board is involved with the Australian Pharmacy Council. No, everyone comes out, in effect, with the same standard qualification.

CHAIR: You said your dad had been advocating for national harmonisation or a national approach on the drugs and poisons issue 50 years ago.

Mr Kelly: That is in relation to the practice in the individual states. One particular state may have a different requirement to record or whatever how a particular drug is handled. That might be different in another state, particularly in relation to schedule 8 drugs, where there could be different rules in each state. Rather than different standards of practice, I was referring to different degrees of legislation.

CHAIR: Fair enough. In my previous career in ambulance it took us 25 years, but last year we got national standards for education, so we did get there. Your dad has some hope yet if you are on the case, Bill.

Mr O'ROURKE: My question relates to different ownership set-ups. Where you have received complaints, how many of the complaints would be against the actual owner of the pharmacy or their employee?

Mr Kelly: I would not have the exact figures to analyse our notifications down to that detail. I am not quite sure. I could find out. I can certainly take the question on notice. The initial complaint may well be against a pharmacist. It could be against the managing pharmacist who may well be the

owner as such. The complaint could then involve the owner being involved in the complaint by virtue of the fact that they are in breach of the board's guidelines in consideration of adequate resourcing, not assuring levels of practice et cetera. There could be different levels. A complaint could involve either one or several pharmacists, depending on what it was. I do not believe I would have analysis of those figures at this time.

Mr O'ROURKE: Where an employee is the pharmacist, are there occasions when the actual owner of the premises ends up being brought to task on issues as well?

Mr Kelly: That is correct; yes, that does happen. I would not say it happens frequently, but it does happen. Several cases recently have involved the initial complaint against the pharmacist being extended to a complaint against the manager and a complaint against the owner for not providing sufficient resources or not managing the standards of practice in the pharmacy. It happens that the owners can be involved under the national law.

Mr O'ROURKE: What would be the implications if it was managed through a corporation?

Mr Kelly: I think that becomes a little bit more complex. There is the ability for corporations to be brought to terms under the national law if they are unduly influencing the practice of a profession. It is not just pharmacy; it is a general thing in the national law. There are those sorts of clauses. I cannot think of the legal term for them. It is not quite 'inciting wrong behaviour', but it is along those lines. If a corporate entity is going down a particular path that is creating problems, under the national law there is provision for that to be dealt with.

CHAIR: Bill, breaking down the inquiry in front of us, there are two key parts: pharmacy ownership and regulation, and scope of practice. Are you aware of any evidence that an expanded scope of practice or role results in improved health outcomes for consumers?

Mr Kelly: When you say 'evidence'—and I am not a pharmacy researcher—that seems to be the type of evidence that is put forward by people, organisations or bodies that believe that that is the case. Certainly there is overseas evidence to say that a better health service for the public can be achieved by a wider scope of practice for pharmacists in particular areas. There seems to be enough international evidence for that in various areas.

The whole issue about scope of practice is that it is really a time-sensitive, dynamic thing. It indicates the sorts of activities that a pharmacist is educated to do, competent to do, authorised to perform and held accountable for, and that can vary from time to time. Pharmacists should work to their full scope of practice; otherwise, it is a waste of a highly trained health professional. There are reasons that cannot always be the case, which could be because of the level of training or authorisation to perform those roles.

Ms BOYD: Bill, my question also goes to scope of practice. I see that one of the roles of the Pharmacy Board is to assess overseas trained practitioners who wish to practise in Australia. Also, you look to the registering of pharmacists and students, developing standards and codes, and things such as that. In terms of Queensland, the committee has heard that pharmacists in other jurisdictions actually work to a higher scope. Can you fill us in around what that would be in other jurisdictions and the advantages that the community would take from that?

Mr Kelly: I am sorry, but I do not quite understand what that means. Pharmacists work to a particular level of practice and what they are legislated for. Basically, they are all trained to the same level coming out of university. Some will do additional training. If by that you mean that some pharmacists are involved in other activities, that would be because there is a legislative ability to do that and is not anything that the board gets involved with as such.

Ms BOYD: You do not advocate in different jurisdictions for, say, continuity for pharmacists across-the-board, being a national body?

Mr Kelly: No, we do not as such. The board considers any issues in relation to scope of practice changes. We look at it in relation to the safety of the public, the relevant competencies, if they exist or if they are needed, any legislation aspects, any additional training requirements, including continuing professional development, whether there is any other registration standard needed. If the legislation allows that and all those other boxes are ticked, the pharmacists are able to do that. They are meeting their scope of practice, because they are meeting those requirements.

Ms BOYD: How are members appointed to the Pharmacy Board?

Mr Kelly: It is a very lengthy appointment process that started, this year, in January and is to reach its completion around about now. The initial Pharmacy Board was set up with a national scheme in 2009. There was a call for applications against certain criteria. Pharmacists applied to that. A selection process is run essentially through AHMAC and the COAG Health Council. Those are the people who make the final decision on the members of the board.

It is similar to all other boards within AHPRA for the other 14 health professionals. They called for applications in January of this year, for example. Pharmacists had a closing date of four or six weeks to put in their application against a criteria. They then go into an assessment process. That assessment process eventually ends up at a jurisdictional level. For example, I am the ACT practitioner member. I was appointed as the ACT practitioner member and then also as the chair. Involvement in that would come through the ACT and be signed off by AHMAC and the COAG Health Council.

The Pharmacy Board has eight pharmacy practitioner members—one from each of the jurisdictions—and we have four community members, ranging from lawyers and health educators to ex-bureaucrats. They are community members. It is an application process that goes through a selection consideration at jurisdictional level and then is signed off through AHMAC.

Ms BOYD: How are members appointed to your Finance, Risk and Governance Committee; your Policies, Codes and Guidelines Committee; your Notifications Committee; and your Registration and Examinations Committee?

Mr Kelly: They are appointed from within the board, based on the skill levels of the practitioners and community members who come to the board. They are initially selected by the chair in conjunction with the members. It is to give a fair share of the workload to people on the board in accordance with their particular skill levels or interests. Those members are rotated over the period. It is a three-year term. Generally, they are rotated through one or two of the committees to give them experience across the different committees.

Ms BOYD: Let us say I am a Queensland pharmacist who is really passionate about extending scope for the community. One of the roles of the board is to develop those standards, codes and guidelines for the profession overall. Would I lobby you and make approaches to you? As a board, do you find that professionals lobby you or make representations to you around scope of practice or any of the issues that we are examining within this bill?

Mr Kelly: We certainly do get approaches from individuals and organisations as to the board's views on things. That is why we recently conducted the forum into the role of pharmacists in prescribing. We see that as an area of opportunity for increased workforce development, increased effectiveness for meeting the emerging healthcare needs of the community. That was the result of probably the profession maturing at the same time and saying, 'What's going on with prescribing? Why cannot pharmacists do it?' The board takes a lead role in that by facilitating how it happens rather than laying down the particular laws, because they vary in relation to what people can do in relation to the scope of practice, for instance.

In the forum we looked at the types of models that pharmacists could be involved with, who could be involved, what sort of training was needed. For example, the board had funded some mapping of competencies, to map them against the prescribing competencies to see where pharmacy fitted in this particular area. As I said, the outcomes of the forum will be available hopefully later this week or early next week when we release that. It is looking at where we believe pharmacy is in relation to prescribing. Generally speaking, it appears to be fairly well set up to be involved in the collaborative prescribing models, but anything involving independent prescribing needs some more work. That is basically where we are up to on that. That is how the board would get involved.

The profession would come to the board, asking in a number of ways. That is how the vaccination one started some time ago. The board's opinion was sought on what was needed. Queensland took the lead in that and ran the initial trial programs et cetera. It comes from organisations, but the profession can approach the board in relation to where we can extend scope of practice and how.

CHAIR: When the outcomes of the forum are released, we would dearly like to get a copy of that.

Mr Kelly: Certainly we can make that available to you. Hopefully, it will be available later this week or early next week. Certainly it can be made available to you, no problems at all.

Ms BOYD: If pharmacy professionals wanted to make an approach to you to lobby for, let's say, an extended scope of practice, would they be doing that in an ad hoc way? Is there a particular avenue though which they approach the board? Is it simply that when the board facilitates an opportunity people make approaches to the board?

Mr Kelly: I think it is a bit of everything. It does not mean to say we do not get individuals writing to the board from time to time and saying, 'Am I allowed to do this under the scope of practice?' Generally, significant changes to scope of practice come through in some coordinated fashion, either through one of the professional bodies or associations such as the guild or the PSA. It becomes a profession type approach, but there are individuals who come forward.

CHAIR: I imagine that if a council was established it could do that work for the pharmacists in Queensland.

Mr Kelly: It certainly would have a role in the particular area of looking at scope of practice changes, what it means from a Queensland point of view and whether it applies to the rest of Australia. We would get other regulatory authorities involved, as well as the board. A lot of this is based on the legislative background. Generally, the competency side of it is the board's bailiwick to make sure that pharmacists are competent and have sufficient training or identify training requirements. Then it is whether there is appropriate legislation to make it happen, and that is the regulatory model from the jurisdiction side.

Mr BERKMAN: I want to go back to your evidence around a premises regulator, which has been very helpful so far. All but one of my questions has already been answered. You have identified quite explicitly the sorts of powers that that regulator should exercise. I am interested more broadly in how the regulator might look. If we start with an assumption that that kind of regulation is maybe not being done as well in Queensland as it could be, is there any particular barrier to the department, if properly resourced, performing that role? Beyond that, what specific expertise would you suggest a regulator needs in order to do the job properly?

Mr Kelly: My personal view is that anything like that needs to be independent of government. The reason is that it is more like a public interest test, to see that the people who are enforcing the law are not necessarily regulating, for want of a better word—if you get the distinction there. There are different models around the country that do that. The Victorian Pharmacy Authority is sort of independent within a government sphere. The Pharmacy Council of New South Wales is similar. They can exist within the government field, but I think the key to it all is that they need to be adequately resourced and are able to do the functions that I highlighted: inspection approvals, audits, and so on. If that can be achieved adequately within a government model, that is fine. The partly independent model such as the Victorian Pharmacy Authority seems to me to be a nicer fit.

Mr BERKMAN: In terms of specific expertise, we have had evidence from others about how a regulator or a pharmacy council might be composed. Do you have any views on that which you could share?

Mr Kelly: As to its actual construction, I have not given that a great deal of thought.

Mr BERKMAN: That is fine.

Mr Kelly: Basically, I think the key to all of this is a strong inspectorial team to carry out a range of the duties in addition to the administrative side of things. There is a balance there on what is required, depending on the size of the task.

Mr HUNT: In relation to your disciplinary processes, is it true that the highest level of disciplinary sanction that you could impose is the deregistration of a pharmacist?

Mr Kelly: The board cannot impose that. That is done at a higher level. It is not even AHPRA. It is beyond that. It goes to a tribunal.

CHAIR: Bill, thank you very much. It has been incredibly beneficial to hear from you on behalf of the Pharmacy Board of Australia in relation to our inquiry. Any answers to questions taken on notice need to be returned by next Wednesday, 19 September.

McCORMICK, Professor Khory, Bartley Cohen Litigation Lawyers (via teleconference)

SACCASAN, Mr Peter, RSM Australia (via teleconference)

TWOMEY, Mr Trent, Queensland Branch President, Pharmacy Guild of Australia

CHAIR: Good morning, Professor McCormick. My name is Aaron Harper, the chair of the health committee. I invite Mr Trent Twomey from the Pharmacy Guild to the table. Professor McCormick, I understand that you will be joining him as the legal representative. We also have Mr Peter Saccasan from RSM Australia as the accounting representative. Good morning, gentlemen, and welcome. Trent, we will start with an opening statement in regard to the inquiry before us, which looks at pharmacy regulation, ownership and the extended scope of practice.

Mr Twomey: Good morning, Deputy Chair, and members of the panel. Firstly, I would like to personally acknowledge the traditional owners of the land on which we meet, the Gimuy Walubara Yidinji people and the Yirrganydji nations, and pay my respects and the respects of the Pharmacy Guild to their elders, past and present.

I would like to seek leave to table a few documents. Firstly, as outlined previously, the guild commissioned Ernst & Young to conduct an economic analysis of the benefits to not only the Queensland economy but also the health system in Queensland and to Queenslanders of pharmacists practising to their full scope of practice. I have copies for all members of the committee here today and for the secretariat. We were only in receipt of that this Monday.

CHAIR: Is leave granted?

Mr McARDLE: Mr Twomey, with respect, that will be a complicated document, I suspect.

Mr Twomey: Yes.

Mr McARDLE: You had it yesterday. It is now Tuesday morning. Why were we not availed of it before this? You did not have it before now?

Mr Twomey: I sent it to Kwik Kopy yesterday at lunchtime and I picked it up at a quarter to five yesterday afternoon. They are newly minted. I can forward them electronically if you wish, but I have only just seen them myself.

CHAIR: That might be the default position. If they could be sent to the secretariat, we could consider them over the weekend and I think deliberate in our next meeting to accept them.

Mr McARDLE: I think it is also important that equitably they be shared across all the people involved in this matter and have them have the right to reply—

Mr Twomey: They will be released publicly at two o'clock this afternoon anyway. The guild is releasing them publicly as public documents.

Mr McARDLE: Mr Chair, I agree with you. We can take them on board and then make an assessment of the content.

CHAIR: Okay, thank you.

Mr Twomey: The other document I have in front of me, as outlined to the secretariat and the chair previously, is an article that appeared yesterday in the *Australian Journal of Pharmacy* regarding sanctions and warnings from the Victorian Pharmacy Authority in the first quarter of this year. Another document is the composition—and this is just going to questions from various members of the committee regarding a possible composition of a pharmacy council of the Medical Board of Queensland, which is a subcommittee of the Medical Board of Australia. The final document is in relation to a question that was asked of somebody who appeared to give evidence previously, Ms Fiona Watson, you may remember, in Brisbane. She was asked a question regarding any evidence that she may have—I think that was from the member for Maiwar—internationally or domestically, on health outcomes. She has provided me with a full list of references that I can provide to you today as well.

CHAIR: With those other documents, apart from that, is leave granted? Leave is granted.

Mr Twomey: Thank you. Before I introduce the two subject matter experts that the committee was good enough to allow the guild to include in our submission today, I would like to thank the committee. As you know, I have joined you on all five days of these hearings—not just in Brisbane but in regional Queensland. It has been rewarding for me personally and for the Pharmacy Guild of Australia to see not just members present but non-members, as we had yesterday, dial in—and that particular pharmacist who dialled in yesterday was not a member of the Pharmacy Guild, but I have

to say that we agreed with everything he was saying—medical practitioners and non-community pharmacists as well. In saying that, I will introduce our two guest speakers. Firstly, our subject matter legal expert is Professor Khory McCormick from Barton Deakin and our accounting expert is Mr Peter Saccasan from RSM Australia. We might go to our legal representative first. I know that he is due in court later today.

CHAIR: That is fine.

Prof. McCormick: Thank you, Chair and committee members. I am with Bartley Cohen, which is the firm that represents the Pharmacy Guild of Australia in various matters. I thank the committee for fitting me in early because I have other commitments. Could you also tell me if I am audible, because we are having trouble hearing the dialogue? Please let me know if you cannot hear me.

CHAIR: We can hear you fine, Professor McCormick. Thank you.

Prof. McCormick: I will to some degree augment the short section 2 of the guild's submission to the inquiry dated 13 July 2018. Could I flag two other qualifying statements. One is that nothing I say should be taken either expressly or by implication or inference to waive the legal professional privilege attaching to anything between the guild and my firm. The second thing is that, to the extent that I may comment on any other matter related to proceedings, whether admissible in court, I make reference only to public documents and nothing in any respect that would enter upon the question of being sub judice. I mention them lightly by way of example or simply to point to matters of public record.

In relation to my comments, I thought the committee would like if I addressed them under four very short points and then, after I have identified them, I could ask if there are any questions about them and do you ask them at each interval or whether you could contain them to the end. The first point that I propose to address is the present situation with pharmacy ownership in Queensland and then, secondly, the question of whether that would be considered to be an adequate regime and if it is being enforced adequately. Thirdly, I will give some degree of comparison around the ownership position in other places to the extent that I had not covered it when talking about the Queensland position at the beginning. Finally, I will make some comments about arrangements in respect of the ownership of pharmacies that recent events have suggested were quite clear in the adoption of the ownership regime.

Of particular note, I am intending, unless otherwise directed, to simply move through those topics. I propose to do so relatively briefly out of respect for the fact that I know that the committee is au fait with the subject matter and also in the interests of time, given that I know that there is a limited allocated period provided to the three speakers that you need to hear from. If you are happy, I will begin.

CHAIR: Yes, I am happy to continue through those four points.

Prof. McCormick: The first thing to understand in terms of speaking about the Queensland regime, which I propose to begin with, is that it is a statutory requirement that the objects of the application of the act are to promote and maintain confidence in the pharmacy profession as well as professional safety and the competent provision of pharmacy services. We know that from section 8. We also know from section 8(2) of the Pharmacy Business Ownership Act that an object is to be achieved mainly by 'limiting who may own a pharmacy business'. The scheme of the act is to give effect to a community pharmacy—in other words, the ownership of pharmacies by a pharmacist model.

This is entrenched in the law of Queensland by a series of provisions that appear in that act, the first of which is in section 139B, which provides restrictions on who may own a pharmacy. It provides that a person must not own a pharmacy business unless they come within a series of specific categories, the first of which is a pharmacist. The act seeks to define what constitutes ownership of a pharmacy by section 139A. It is important to note several things about it. The provision reads as follows—

Own, a pharmacy business, includes having a proprietary interest in the pharmacy business, but does not include having an interest in the pharmacy business arising under a bill of sale, mortgage, or other form of security, for the pharmacy business.

The definition is inclusive—that is the first point—and not exhaustive. In accordance with the purpose of the act, the true intention is that pharmacists alone own pharmacies.

The second thing is that the term 'proprietary interest' is not defined, but we find myriad of that language in Victoria and Western Australia. In the case of Victoria, in section 3 of the relevant legislation, propriety interest exists to mean a legal or beneficial interest and includes a proprietary

interest as a sole proprietor, as a partner, as a director, member or shareholder of a company and as the trustee or beneficiary of a trust. In section 3 of the Western Australian act, proprietary interest in respect of a pharmacy means a legal or beneficial interest and includes an interest as a sole proprietor et cetera. The Western Australia act then goes on expressly to define in section 3(2) some particular other characteristics, including a share of franchise income by reference to turnover and the like.

The key point there is that under the Queensland act the first distinctive prohibition is that pharmacy ownership prohibition excludes the ownership of a proprietary interest, which has a broad and unrestricted meaning, by any other person other than a pharmacist. An analogy would show that that interest can be legal or beneficial, direct or indirect. In fact, the New South Wales act, which uses the term 'financial interest' rather than 'proprietary interest', is even more exhaustive in its prohibition against non-pharmacy ownership of pharmacies.

The second thing to remember is that, where the ownership provision permits in Queensland the existence of a financial funding instrument, it goes on in section 139I to prescribe that such instruments are void to the extent that they do certain things. In fact, section 139I provides that the prohibition against instruments doing certain things captures franchises. It says—

A bill of sale, mortgage, lease, franchise, agency or other service or commercial arrangement for a pharmacy business is void to the extent it—

and it then goes on to say—

(a) gives to a person, other than the owner of the business—

(i) the right to control in whole or part the way in which the business is carried on; or

(ii) the right to receive any consideration that varies according to the profits or takings of the business.

What one sees in those provisions, also supplemented by section 141, which makes it an offence for certain aspects of personal supervision of the pharmacy not to occur in the required way, is that the Queensland act is very comprehensive to ensure there be no corporate ownership of pharmacies in the state of Queensland. In terms of whether that provision is adequate for its purpose, it is, of course, adequate.

I turn now to my second point, if the act is enforced in a purposeful way. The question is: can the act be enforced in a purposeful way or is it optimal to enforce it through a position which uniquely in the country resides that capacity within a department of the government, within the executive arm of the government, and not an independent body? There must be a strong case that as presently constituted it cannot be.

If we look at the models in other places across the country where there are variously pharmacy councils or boards—and I do not think I need to recite them, unless you wish to me; in each state there is such a situation ranging from authorities to councils to boards to committees—we see the concept that it needs to be independently, properly resourced and adequately financed. I mean 'resourced' in terms of capacities, competencies and skills and 'financed' in terms of the wherewithal to undertake the task. That would enable the proper and rigorous enforcement of the legislation. It would be a given that you understand that the guild considers nothing approaching a rigorous enforcement of the law is presently occurring because, as the guild says at section 2 of its submission, this requires a forensic examination of what occurs.

The other matter, apart from the resourcing and competencies and the desirability of independence, is that it must be the case that if the person with whom they are being discussed is the same person who is undertaking this regulatory role then conflicts must arise. I do not mean improper conflicts, but technical conflicts must arise. The other problem is that, of course, if the matter is administered within the public sector, in the Public Service, then, because of the application of general conduct provisions, it must be the case that bureaucrats or public servants will be, by definition, defensive of errors of judgement because of the fear that they might be otherwise seen to maladminister acts, which no-one would suggest they have but the technicality of the structure would put them in a challenging position in terms of being transparent to review, whereas under councils and committees and the like, which are amenable to general review processes, no such sensitivity should exist or, in fact, it appears has existed historically across the country where other regimes are in place.

If we go then to the question of the comparative examples of ownership, the committee is aware that as recently as 5 September in Western Australia, where the board had rejected certain franchise pharmacy proposals put to it, you see the true value of a forensic examination approach rather than the tick and flick or reference to external advisers for the purpose of simply passing a view

on documents reviewed in the abstract. The Western Australian decision that you are aware of—in fact at paragraphs 20 and following and then 29, which annexes annexure 1 to that particular case—is the example where the proper forensic examination of the transaction shows its true nature and whether that transaction in substance conforms to the requirements or otherwise of the prohibitions in the relevant legislation.

There are other examples of that occurring in New South Wales in what is called the now.com case. Although each of these cases turns on provisions in their own jurisdiction, they have alluded to a purposeful and sensible reading of all provisions across the country that reflects a common setting in terms of policy and there are simply variations in language, all of which are expressed in such a way as to ensure by proper vigorous application non-pharmacist ownership of pharmacies is not permissible in any form or structure that might be designed. The ultimate question is, when those documents are looked at as a whole, whether they produce a position where someone achieves a benefit from being associated with pharmacies in some proprietary financial or beneficial role which they ought not to possess.

It is the case, too, that in those examples one deduces that it is not a case that one should depend upon the person seeking to have a transfer or acquisition approved but should vigorously interrogate them. For example, they ought be asked to provide all the lease documents, partnership documents and so forth and so on that could be listed.

Mr Twomey: It is a shame we could not have you here in person. You cannot see the non-verbal cues we are getting from the committee. I know they would like the opportunity to ask you a few questions.

Prof. McCormick: I am happy to finish because I think what I would go on to say is simply that there is a miscellany of documents that the cases, when read as a whole, show you that the regulators should ask for and should simply not take the standard documentation and tick and flick it. The other thing is that the Western Australian case, but all cases, show that you need to read all of the clauses within the documents together to understand the full purpose and effect of the transaction. The question they must be asked at the front end is: why would entities fund acquisitions if ultimately they do not receive benefits, whether they be listed entities or large proprietary entities that are unlisted too?

Mr Twomey: Chair, would you like to have questions for the legal subject matter before we go to the accounting?

CHAIR: Professor McCormick, thank you very much for your opening statement. Are you of the view that the current enforcement of the act is not being effectively managed by the department in Queensland?

Prof. McCormick: Without intending personal criticism of anyone, the answer is that it is not being properly administered effectively.

CHAIR: Do you think with the establishment of a pharmacy council, board or committee in Queensland that could be more effectively managed and is that because of your observations of other jurisdictions that have established councils?

Prof. McCormick: Unequivocally, for three reasons: the first is with the proper skills, competencies and resourcing to do the proper analysis, which the guild feels is not being done; the second is it would remove these conflict issues which means that the challenge of dealing with any error in the process would be removed and proper transparency and public benefit and accountability would occur; thirdly, within the state of Queensland to align it with best practice.

Mr McARDLE: Professor, good morning. Can I clarify how much time you have left with the committee before you have to scoot away to the court?

Prof. McCormick: The committee would take precedence, as you would expect. I am in a court case but I will stay as long as you require. I do not wish to occupy a disproportionate amount of time. I can only comment on public matters. There is enough on the public record to indicate that something has to change in the way Queensland approaches its enforcement.

Mr McARDLE: One of the things that has been brought to our attention is that in Queensland there seem to have been no enforcement proceedings, no proper investigations post compliance with the act being approved since 2010 by Queensland Health. Does that concern you?

Prof. McCormick: I do not know the statistics so I cannot comment. I am not suggesting it is not accurate, but I do not comment on it because I do not know it, but if that was the case that would not surprise me but that would concern me. It is a product of the way the system is set up in Queensland.

Mr McARDLE: There is also a particular clause in the act—I just cannot locate it—that there is some dispute about the meaning of the term—it is something like 'enforce and monitor' or words of that nature. There is dispute as to what it really means. What I am saying is: there seems to be no follow-up action to ensure that ownership post the initial compliance check is further complied with in the forward years. Is that your understanding as well?

Prof. McCormick: Yes, it is. I think what the guild would say is that the object of the act is providing for compliance and monitoring and enforcement. That is section 8(2) (c). There is no question that, if you read this act properly, with the power that there is for investigations to be launched, there should be a program, even under the current act, of vigorous monitoring and enforcement of compliance in the years forward. In some states where there is a need to renew or annually account, you have that. One element that would have to be introduced under any scheme, even if the legislation was not to be improved, which it definitely could be, is a situation where the owners of pharmacies would be obliged to update their regulator.

Let us talk about franchises. The franchisor might enter into a series of documents and might judiciously go around the place signing them in one state or not in another and might structure the deal and tweak the deal, but that might be at the point when the document is approved. Ultimately, they might alter that or might sign a document which was previously unsigned which changes the position. In the state of Queensland absent vigilance, which you are telling me—I am taking your statistics—has not occurred, the party would immediately and consciously go into nonconformity. I am not saying that that has happened anywhere; I am just answering your generic question. Of course that is a gap in the scheme.

Mr McARDLE: You also referred to a body being set up outside of the government.

Prof. McCormick: A body that is independent of the department. Nothing I am saying is a criticism of anyone for anything past or current or even future, but it is just common sense that, in the current regime of transparency and public accountability, if the person who has made the decision sits in a department and is challenged that they have made an error they are going to get very concerned about whether they have maladministered the act and somebody is going to say that is misconduct or they are going to get very defensive of their position, particularly if there is not clarity around the policy setting and how the act has been enforced. I think it is not fair on them, to be honest, but legally, technically, it puts them in a conflict because they are human and because it is a challenge for them how to perform the role, where an accountable independent body is transparently open to review and has no property in the outcome. What I am saying is that it is a problem that does not arise under other models.

Mr McARDLE: If we had to look at a model, would you point to Victoria as being the pick of what we have?

Prof. McCormick: The Victorian model seems to be moving in the right direction, definitely. It has a composition of both pharmacists and lawyers. What you really need on that model is forensic accounting and legal skills as well as the pharmacy experience, based on people who are dispassionate in terms of pharmacy representatives as much as they can be, but you need the skill set. What you can see in the west is when you bring a forensic lens to these transactions they get looked at in a totally different light.

Mr McARDLE: If we accept that there have been failings in the Queensland model, should there then be a full-scale review of all pharmacies?

Prof. McCormick: That is a question I could not comment on because that is not a legal question; that is a policy question. What I will say to you is: your terms of reference are a two-year retrospective review of acquisition, and that should be done in a proper forensic way and not done in simply a compliance tick and flick: 'What were we given, when we read it in the abstract, does it look all right?' What needs to be looked at is how the pharmacy business that is being acquired is being transacted on a day-to-day basis.

Mr McARDLE: If we accept and if it is found that there have been major shortcomings in Queensland Health's stewardship of the terms of the act, would that raise in your mind a concern that there may be myriad transactions or arrangements in place that need to be looked at from a legal perspective?

Prof. McCormick: All I can say is that I would not for a moment argue or suggest that the matter should not be dealt with on a transparent and equal basis. I am not answering your questions by reference to any particular individual action.

Mr McARDLE: Neither am I in posing that question.

Prof. McCormick: I am not seeking to move on to a political question, but if you are asking whether it should be done on a transparent and fair basis, then of course it ought.

Mr McARDLE: Professor, you missed your calling. You should have been in parliament.

Prof. McCormick: That is the one place I am not going.

Mr McARDLE: They say 'never say never', Professor. One can never tell. Is this a matter that needs to be dealt with on a national basis because, at the end of day, we have pharmacies right across Australia? Is it better to have it legally dealt with on that basis or should we maintain the current state-by-state and territory-by-territory jurisdiction?

Prof. McCormick: Once again, not being cute, I will not traverse the policy, but what I can say to you is: regardless of whether you do it federally or whether you do it at a state level, the answer is that you need the legislation to be structured in the right way and you have raised some questions about the Queensland legislation. The other thing is that you need competencies around its enforcement to give effect to it purposefully.

The answer is that I am not commenting on whether it should be federal or state. What I am saying is that, at either level, the legislation needs to be well drawn and the legislation at present of course could be improved. There might be more use of common language and things like that. Is the legislation adequate? Yes, it is because it is purposeful legislation. It gives effect to what I understand to be a nonpartisan supportive policy setting in an act that expresses the policy and gives the mechanisms within it to give effect to it. Therefore, when circumstances arise which do not appear to conform, the question is: what has gone wrong with the application of the act?

Mr McARDLE: Thank you very kindly for your time.

CHAIR: Thank you very much, Professor McCormick. I will take those as some closing comments on ownership and regulation.

Prof. McCormick: Can I be excused?

CHAIR: Absolutely. There are a couple of points we want to look at in terms of scope of practice which we will leave to discuss with Mr Twomey. We also have Mr Saccasan on the line.

Mr Twomey: I do have on the phone our final subject matter expert, Mr Peter Saccasan from RSM. He did make a submission in his own right, which I am sure the committee has had the opportunity to read. We have asked Peter to come here today to speak specifically on two issues. The first is, in his capacity as a managing partner of RSM, how he sees the difference in filing for changes in ownership between jurisdictions. Is it easier or harder in Queensland to get something through versus another jurisdiction? The second is what structures people are able to use to obscure the true pecuniary and/or proprietary interest of the business using accounting mechanisms.

CHAIR: Mr Saccasan, would you like to start with a brief opening statement on your submission?

Mr Saccasan: Thank you, Mr Chair. Just to correct the record, I am not the managing partner of RSM. I am the national director of pharmacy services at RSM and also the national head of the business advisory division at RSM. I am not the managing partner or chairman.

I have worked in the pharmacy industry for over 20 years and in my role as an accountant have advised pharmacists in many aspects of their businesses, including acquisition and the structuring of their pharmacies. I am resident in Sydney so my experience is predominantly with the New South Wales council. I have on occasion dealt with transactions interstate, including in Queensland. Given the nature of the inquiry, I was asked by the guild to comment in that respect around the different experience and, further to that, to talk about the structures that go with the ownership of pharmacies. I am certainly not as eloquent as our former speaker, the professor, but I will do my very best.

In my submission I referred particularly to being able to deal with subject matter experts, if you like, or dealing with council members who are familiar with pharmacy. I note, for example, that the guidelines to submit an application for change of ownership in New South Wales is a document of some 34 pages. It gives detailed requirements and detailed guidelines as to what is expected to come before council in New South Wales. As opposed to a form which simply asks for details of statutory positions held in a structure that is being proposed, they ask for documents that surround the transaction—that is, anything that looks like a management agreement or a service agreement, where the finances come from, who is providing the finance—if the pharmacist is providing their own funds then they have to provide a statutory declaration that it is their own funds—and a host of documents in that sort of form.

I preface all of my comments by saying that it is not my intention to make any commentary on any particular group or pharmacy owner. I deal with a whole range of different pharmacy owners and pharmacy transactions. I am more speaking to my experience with the council with regard to these transactions.

I find in dealing with the council in New South Wales that, because their role is pharmacy specific, the questions we get from time to time are certainly well directed, because of the experience of the council. They actually have in-house legal counsel as well. They review the plethora of documents that are provided to them and do actually engage directly by email and telephone prior to any submission going to what is the Pharmacy Council of New South Wales for a change of ownership to be approved.

I see that as addressing a lot of the aspects that Professor Khory outlined in his presentation. I felt by outlining the way the New South Wales council works—and I know there was a mention just then of Victoria—it shows that it does apply itself in very much the manner that the professor would be recommending. Given their experience, their questions are very pointed and very efficient. They get to the matter at hand and they invite clarification where required.

Having those detailed guidelines available, and certainly requesting the documents that they do, does, in my observation, certainly—I will not say ensures—directs the council to apply the legislation as it is written and intended. Again, I just compare that to the Queensland position, where it is a document containing the ownership details and that is all that does. I find the list required by New South Wales more exhaustive and specifically addresses the points raised by the professor in his presentation.

The range of documents that are submitted include, obviously, the direct ownership documents, such as company structures, who the directors and shareholders are and, if there is a trust involved, a copy of the trust deed. The deed itself is required to comply with the act to ensure that beneficiaries cannot be appointed who are not pharmacists, which is the requirement here in New South Wales. You are required to submit details of all finance documents, security arrangements and any agreement that meets the definition of what is called a management agreement. If there is a lease and sublease, obviously both of those documents are required to be submitted as well. A copy of the franchise agreement is required as well. All of those documents are required to be submitted and to be held by the council. I know there was a discussion at the end around annual confirmation of financial interests held in a pharmacy. That is also required in New South Wales.

Mr Twomey: Mr Saccasan, thank you very much.

CHAIR: We might go to a couple of questions. Are you aware of the Queensland Productivity Commission paper on establishing a pharmacy council in Queensland?

Mr Saccasan: No, I am not.

CHAIR: I will not ask you any questions on that. Fundamentally, they said that there would be an incurred cost to set one up. I can see through your submission that having an independent, transparent council would support the safety of all Queenslanders, ensuring medicines are available to all Queenslanders and are dispensed by a pharmacy accountable to a pharmacist owner who derives the full beneficial and financial outcomes of the business.

Mr Saccasan: Can I talk to the point of cost. When you submit to New South Wales there is a range of fees required to be made with each application. There is an application fee and also a fee for each financial interest that is held. If you have, for example, four partners there are four fees paid plus an application fee. That cost goes towards dealing with the submission. The council is made up of pharmacists, community members and a legal representative. That goes to the professor's point about having a council which is independent from the government but obviously accountable too.

CHAIR: I want to get you to unpack the statement in the third paragraph of your submission: 'I've seen firsthand how the pharmacy council has protected the safety of consumers in New South Wales.'

Mr Saccasan: They provide a register of pharmacies which is publicly available. That enables anyone to, firstly, identify all of the pharmacies in New South Wales and, secondly, identify who owns a particular pharmacy in New South Wales. That is a level of public accountability which I believe goes to the safety of consumers.

CHAIR: I think you have identified through your five points on the back of your submission the benefits of establishing a council in Queensland. I will open to other members on the committee to ask any questions in relation to your particular points.

Mr HUNT: The evidence I have listened to this morning could broadly be summarised as that the act is complex enough to require more forensic examination of applications for ownership and that this would best be achieved by an independent pharmacy council rather than a government department. Speaking as a former police officer, is it not the case that there are many government departments that administer acts that are properly resourced and properly trained? Would you suggest that a properly trained and resourced department with investigators could properly enforce the act or is there another reason for it being independent of government?

Mr Saccasan: I think the professor touched on that a little in terms of removing the checker from the supervisor, if you like. I would probably have to agree with that as a matter of principle. I do see the wisdom in the New South Wales council where they actually have on the council pharmacists and community members as well as legal people. I see the benefit of that structure in having those sorts of people on the council. I note your use of the words 'properly trained'. I cannot really argue with that. It is a matter of what 'properly trained' means, but I certainly could not argue with that proposition. I see the wisdom in having pharmacists who are a bit perhaps savvy about the industry and what is in front of them in terms of the documentation, as well as the legal counsel of course.

Mr HUNT: What expertise would a pharmacist have over a trained investigator, for example, around the ownership laws—proprietary interests and things like that? Pharmacists are not really trained in that aspect of corporate structures and business ownership, are they?

Mr Saccasan: I could not argue with you on that, not at all.

CHAIR: If there are no other questions, in our remaining time we will go back to Mr Twomey to ask about some other aspects of the issue. Do you have any closing remarks before we move to Mr Twomey?

Mr Saccasan: No, I think I have talked to the matters which I have presented on, which the professor raised and which I am experienced. I will leave it at that.

CHAIR: Thank you very much. To clarify, we have a bill before us this afternoon; this is an inquiry.

Mr Saccasan: Am I able to drop off at this stage?

CHAIR: Yes. Thank you very much for your time and contribution this morning.

Mr Saccasan: Thank you for having me.

CHAIR: Mr Twomey, thank you very much for being here today. You have been following us now for a period of time.

Mr Twomey: I have.

CHAIR: Would you like to make an opening statement?

Mr Twomey: Sure. In my mind the points the guild made in our original submission have been reinforced by the evidence that you have heard over the past five days—that is, to ensure a level playing field amongst all the different state and territory jurisdictions, the establishment of a pharmacy council is needed for the protection of Queenslanders. I think the independence of that council as a check and balance to make sure that the recourse of a potential or perceived breach does not go directly towards a question of maladministration of the act by a delegate in the department is an extremely important one, as I think the member for Nicklin was just asking.

This is about Queenslanders. This is about ensuring that medicines which are not normal items of commerce are provided in a safe and efficacious way to all Queenslanders regardless of where they live. We need two things to ensure that. We need to ensure that the professionals who are conducting this service—me as a pharmacist professional—are properly trained and are held to the highest of standards and if I breach those standards there are appropriate mechanisms in place to hold me personally accountable. We heard the Chair of the Pharmacy Board of Australia, Bill Kelly, talk about that this morning.

The second aspect is the premises and the systems, processes and infrastructure that go to the creation and maintenance of a safe premises for not only the storage of medicines. I can point you towards the *Australian Journal of Pharmacy* article which goes to the breaches of the first quarter alone of this year. In the first quarter of 2018 there were five pharmacy owners who were either sanctioned or cautioned by the Victorian Pharmacy Authority for breaches—for anything ranging from failure to store a temperature sensitive medication in a proper facility, failure to ensure that proper records were kept around dangerous drugs or controlled drugs, being those that are opioid based, and failure to ensure appropriate infrastructure and signage so the consumer was aware of who owned the premises and who was accountable for the service they were receiving.

We have not had five notifications of breaches or sanctions in eight years since 2010 when the current structure came in. The Victorian Pharmacy Authority, with proper resourcing, found five incidents in the state of Victoria in the first quarter of this year. I am exceptionally proud of the 1,140 pharmacies I represent in this state, but I would hazard a guess that there has been at least one in each quarter of this year that could have done something better. The Queensland Productivity Commission's report which said that it went from an average visit of one every 18 months to one every 7.2 years shows that the current process is not up to scratch, is not robust enough and does not ensure the quality provision of essential medicines to Queenslanders.

CHAIR: What are your views on the other important part of this inquiry, which is scope of practice and particularly—as you have probably picked up over the last few days—the health benefits to Queensland consumers for affordable health care?

Mr Twomey: Until January this year I had the absolute pleasure of being the chairman of the North Queensland Primary Health Network, a role which I stood down from to do this new role as the head of the Queensland guild. One of the things the PHN was struggling with is how, together with the four hospital and healthcare services that make up Northern Queensland, being Mackay, Townsville, Cairns, Torres and Cape, we move from a measurement of occasion of service—for example, so many ED admissions or the dispensing of so many prescriptions or so many MBS item numbers—to how we measure outcomes. I know that the member for Maiwar has asked questions about this issue.

Quite frankly, this is something that all professions, AHPRA regulated or not—even the newest member of AHPRA, being the paramedic profession—public, private and otherwise are struggling with in Australia. It is a real struggle to go from a system that sets minimum standards—and we measure minimum standards—to a system that measures health outcomes. Not one health profession has been able to take the step yet where we can say we have a system that just measures outcomes.

To ensure that we get the best possible health outcomes for Australians and the best possible health outcomes for Queenslanders we use proxies for health outcomes. Every profession does that: the medical profession, the nursing profession, the pharmacy profession—whether it is the Cairns Base Hospital; whether it is my pharmacy in Westcourt. The proxies for health outcomes that are used in a clinical governance sense in the state of Queensland are around minimum standards—standards for the practitioner and standards for the infrastructure. There is a really big gap in terms of the enforcement of minimum standards in community pharmacies in Queensland because of the absence of a council.

CHAIR: That was going to be my question to you. Will establishing a pharmacy council deliver better outcomes? I think you have tabled some evidence that we can look at at some point. Health care is derived from evidence based research for better outcomes.

Mr Twomey: With respect, I think the current system we have is not and it should be. The system of health care we need in Australia moving forward is one that allocates finite public resources to the best bang for dollar, whether that is in the MBS, PBS, state health or community controlled health organisations. We are struggling—and most OECD countries are struggling with this—with going from measuring widgets or occasions of service to measuring health outcomes but it is something we all aspire to. The point I am making is that in the absence of measuring health outcomes—and there is no system to measure health outcomes, whether it be in Queensland Health, Queensland general practice surgeries or Queensland pharmacies—we have a default proxy system which measures minimum standards, and at the moment we are not doing half of that job in Queensland.

CHAIR: I will open it up to questions.

Mr BERKMAN: Let me get right to the nub of these issues around the entry of the big box chemists—Ramsay Health Care into community pharmacy ownership, for example. If Ramsay Health Care is fit and proper to own pharmacies to dispense medicines in hospitals, why is Ramsay not fit and proper to own pharmacies and dispense medicines in the general community?

Mr Twomey: Firstly, as I think every pharmacist who has presented before you has said, the concept of whether or not a pharmacist or a corporate entity should own a pharmacy is not in the terms of reference. However, to go specifically to it: of all the people whom I have heard speak before you, the ones who I think resonated with me the most were the husband and wife team who presented yesterday in Townsville—Catherine and Paul. My mind goes to two specific definitions—one is a fit and proper test which is something that I think the Chemist Warehouse guy put forward to all of you. There should simply be a fit and proper test and that person should be able to own a pharmacy. The

primary responsibility—I think they used the word 'primary'—of a director according to the Australian Securities & Investments Commission is to operate in the best interests of the shareholder. That is the primary responsibility of a director of a company.

Governance, as defined by the Australian Institute of Company Directors, is the systems and processes through which authority is managed. Clinical governance is the systems and processes through which clinical authority is measured, and those are the two things here that we need to balance—one, the responsibility of a director to act in the best interests of a shareholder, which is the primary responsibility of a director of a company, public, private or otherwise; and, two, the clinical governance obligations of a pharmacist. Which should be subordinate to which? I can only reinforce the comments Paul made that the responsibilities to achieve a commercial return to the shareholder should always be subordinate to the responsibilities of clinical governance to ensure the quality use of medicines. Only pharmacist owned pharmacies can ensure that that is the right way around.

Mr McARDLE: Mr Twomey, it is good to see you yet again.

Mr Twomey: Stalker!

Mr McARDLE: No, I did not say that. You made the comment that a council is 'needed for the protection of Queenslanders'—

Mr Twomey: I did.

Mr McARDLE:—and my colleague made a comment in relation to that. My understanding from the last time we spoke in Brisbane at a hearing was that we would hear today evidence from an accountant or somebody qualified who would make a statement showing statistically—my wording—that corporations of the type that you are against produced worse outcomes for clients or patients or residents. Am I mistaken in that belief or not?

Mr Twomey: My understanding was today the guild sought leave to present two subject matter experts, both legal and accounting, to show how the intent and spirit of the Pharmacy Business Ownership Act were being circumvented in the state of Queensland. In terms of comparing one model with another, we have addressed that in two sections of our inquiry and there is not much more I can add to the two sections in the guild submission about the comparative nature of one model versus another. What I draw your attention to is the fact that at the moment there is virtually zero check and balance in the state of Queensland that any pharmacies in the state of Queensland are providing any minimum service levels or have any minimum standards of infrastructure required to ensure that any of them have delivered the quality use of medicines that they are required under National Medicines Policy.

Mr McARDLE: Isn't it part of your case that the community based model delivers a better outcome?

Mr Twomey: Yes, it is but the guild's position firmly is that we are being asked to contend to the reverse onus of proof. Pharmacist owned pharmacies are a long-entrenched norm at every level of government—

Mr McARDLE: Mr Twomey, with respect, I have to disagree with this claim about reverse onus of proof because it was the guild's contention that community based pharmacy produces better outcomes. It was not our contention. We would not put that up. It is illogical for us to argue from that perspective. It was your argument. What I am simply saying is that if we accept that is the argument—and I think you agree that is your argument—there seems to be, following from the member for Maiwar's comments, consecutively throughout the days little direct evidence. There may be anecdotal evidence—I accept that—but little direct evidence.

Mr Twomey: I suppose I can refer you directly to the evidence that was given by Stephen Duckett from the Grattan Institute. This is all theoretical. Pharmacist owned pharmacies are the widely entrenched norm both at a state and Commonwealth level in Australia. We are being asked to prove whether or not the theoretical deregulation of an industry which would allow corporate ownership in the state of Queensland would provide either better, worse or parity healthcare delivery. As Professor Duckett said when he gave evidence, he used words like 'may', he used words like 'might' and he could not attest the Grattan Institute—

Mr McARDLE: I think that is my point. No-one can substantiate that one is better than the other.

Mr Twomey: That comes down to my point about reverse onus of proof. For the better part of a century we have had pharmacist owned pharmacies which have served Queenslanders well, and based on theory and a lack of evidence we want to unshackle a system that has served Queenslanders well. That, to the Pharmacy Guild, is extremely risky.

Mr McARDLE: We will leave that issue for the report potentially. The other problem is this: when we spoke to Mr Kelly he seemed to indicate that from the board's perspective there were no differences in the number of complaints—percentage wise, I suspect, not in strict numbers—deriving from the corporate structure as opposed to the community structure. That implies to me that there is a very high degree of professional status and professional action in regard to both types of pharmacies, again deriving from his comment, not mine—nor reverse onus of proof—that there is no distinction in regard percentage wise complaints coming through to the board at least. Can you comment upon that?

Mr Twomey: Yes, I would love to. Firstly, the Pharmacy Board of Australia has jurisdictions over some 30,000 registered pharmacists in the Commonwealth of Australia who practise in a variety of areas from Queensland Health to industry to academia, the majority of which, some three-quarters, practise in community pharmacy. What Bill also said in his remarks is that the board does not investigate premise. The board does not investigate breaches that relate specifically to being an owner. They have a code of conduct for pharmacists as pharmacist proprietors, and I should note as well that one of the anomalies that I am sure has come to the board's attention is that in other jurisdictions you are required to be registered as a practising pharmacist to own. In Queensland you can be nonpractising, which I would say is a fair anomaly. If you are present in your business, you should be a practising pharmacist. The point is that Bill's comments in context were that the board did not look at breaches of state government rules regarding the execution of duties and responsibilities of pharmacist proprietors.

Mr McARDLE: Would you agree, though, that it goes to my first point about the outcomes? He does not see any distinction—

Mr Twomey: No, I would not.

Mr McARDLE: He does not see any distinction between the number of complaints between the corporate structure and the community structure.

Mr Twomey: You would have to ask him what a corporate structure was or was not.

Mr McARDLE: Thank you, Mr Twomey.

CHAIR: As there are no further questions, do you have any closing remarks?

Mr Twomey: There are a couple of points that I did not get the opportunity to be asked but I thought I might like to pass comment on. With regard to the pharmacy assistant one, which I know, Chair, when the terms of reference were being drafted was one that was specifically close to your heart, two-thirds of the pharmacist workforce in the state of Queensland are pharmacy assistants. They are our family, though the majority of people that work in my personal business and in fact in the majority of the people that are in the room here today are members of the Pharmacy Guild of Australia.

My mother was a pharmacy assistant. She was a single mum with four children that raised me and put me through a Catholic school. I think it is a risk that there is no minimum mandatory training for pharmacy assistants in Queensland. I think consumers who walk into pharmacies would expect that, regardless of whether a pharmacy assistant is working in the front shop providing advice on wound dressing or infant formula and breastfeeding or whether they are behind the counter dispensing a prescription, there would be some form of minimum training.

CHAIR: On that point, do you think with the establishment of a council—and we asked the professor from QUT whether—

Mr Twomey: Lisa?

CHAIR: Yes, whether that would benefit.

Mr Twomey: Lisa is, as you know, a professor of a tertiary institution, so she does not have jurisdiction over the professional training workforce or the vocational workforce. I should note that at the moment the only minimum training requirement is part of the QCPP standard, which is a module on S2 and S3 training. The guild's view is it should be at a certificate II or III level and that should be mandatory, so I think we should just put our comments forward there.

CHAIR: With the establishment of a council though, do you think having some control over educational standards would be part of the—

Mr Twomey: Yes, so specifically to the Queensland Productivity Commission where they assess the three models—status quo, one just doing the PBOA, one having the further wider scope of practice covering education and research to make it consistent with New South Wales—we would go with option 3.

CHAIR: Okay; thank you.

Mr Twomey: The other point I would make is around scope, and there are two points that I want to make here. The first is around vaccinations. Part of the further information that the guild made available to the committee Friday of last week was around the national immunisation protocol and we gave comparisons to other state and territory jurisdictions. I am sure the committee is aware that under the National Immunisation Program community pharmacies do not have access to that essential stockpile which is putting an unfair accessibility burden on Queenslanders because they can only access the government funded program from their GP; they cannot access it from their community pharmacy. Even though that is federally funded, that is an anomaly in the administration by the state in the National Immunisation Program and that should be removed so consumers can have a choice of where they access that program.

Furthermore, what vaccinations and who could get vaccinations from community pharmacy I know, Chair, is something you have raised several times. Under the National Immunisation Program, adolescent vaccinations and teenage vaccinations are from 10 years of age and over. We note that since the commencement of this inquiry Tasmania has now ensured that 10 years of age and over are able to go and access those programs through their local community pharmacy. Our desire is that a recommendation of this committee is that all impediments to pharmacists practising to their full scope of practice be immediately removed.

CHAIR: And your views on the AMA and their opposition to—

Mr Twomey: This is all about ensuring that in a patient centred system we do not fracture patient care. I should note that since the beginning of this inquiry only 10 days ago GuildCare, which is the electronic professional platform that we record our vaccinations on, automatically integrates with the Australian Immunisation Register, so all of the 600 pharmacies in Queensland out of the 1,140 that are providing vaccinations automatically upload every one of those vaccinations to the Australian Immunisation Register. The notion of fractured care, I think, is a bit of a furphy.

The last thing I would like to touch on with your indulgence, Chair—and I will be brief—is around pharmacists prescribing. This is also a confusing point because I do not think it means the same thing to all people. What is prescribing? Prescribing by its quintessential definition is a medical professional, whether it be a pharmacist or a GP or a nurse, making a diagnosis and recommending a particular treatment which usually involves a drug. Pharmacists already prescribe. We already prescribe. We prescribe unscheduled medications, we prescribe Schedule 2 medications, we prescribe Schedule 3 medicines and in fact under the continuing dispensing protocols in the emergency supply provisions we already prescribe Schedule 4s. The difficulty is at the moment there are restrictions under the Health (Drugs and Poisons) Regulation and the Medicines Act and the Health Act 1953 which prevent pharmacists from practising to our full scope of practice.

There is a big difference between independently and autonomously initiating treatment of an S4 medication as in, 'We're going to diagnose schizophrenia and provide a drug,' which we heard from the Royal Australasian College of Physicians, to somebody who is already on a chronic medicine, they have run out and we need to ensure a continuity of care. That is why in the documentation we provided to you on Friday we referred specifically to those six points in the Alberta model. I met a pharmacist. His name is Mike McIntyre, who went to James Cook University, did the guild's intern training program and he is practising over there now doing all of these things. He has the same training I have and he is practising to his full scope of practice.

All we want, as I said, regarding vaccinations is for this committee to recommend to Queensland Health that all barriers to pharmacists practising within their current scope of practice be removed. We are not asking for an expansion. We are not asking for anything new. If we can do it in another state and territory, if we can do it in another comparable health system, if we can do it working in a nursing home or working in a Queensland hospital, why can we not do it when we are working in our local community pharmacy? Thank you for your patience. I know we went a little over time today. It has been a pleasure of mine to follow you, as I said at the outset, around this great state. I am very proud to be not only the union representative for these people behind me here in Far North Queensland but their state president as well and I look forward to the committee's report.

CHAIR: Thank you very much, Mr Twomey, for appearing before us today. Obviously you are content expert in this area, and we are about to hear from your wife.

TWOMEY, Ms Georgina, Owner, Alive Pharmacy, Innisfail

CHAIR: Welcome. I invite you to make an opening statement and then we might go to some questions.

Ms Twomey: Thank you very much for the opportunity to appear before this committee today and thank you to my local pharmacy owner colleagues that are here today behind me, hopefully in support of what I am about to say. They have taken time out of their businesses, just like I have today, to be here to see all of you. I own three community pharmacies in Far North Queensland. Like many pharmacy owners who operate in regional Queensland, I do a lot more for my patients than dispensing medicines alone. I regard my pharmacies as important health infrastructure for local residents providing advice, screening and a range of other health services. I strongly believe in the merit of pharmacist ownership of pharmacies because of the clinical governance, accountability, ethics and care pharmacists are required to provide as part of their professional responsibilities.

I strongly believe that pharmacists will put their patients first ahead of profits. One example I can give is my Innisfail pharmacy which is open seven days a week, eight till eight Monday to Friday and eight till six on weekends and public holidays. A profit-only approach to my business would see me reduce those extended hours substantially because they are just not profitable, but as a pharmacist I am concerned about the lack of availability of health services in that community after-hours, so I have decided to continue opening beyond normal business hours as a service to my patients.

In Innisfail, which is one hour south if you do not know where it is, we also provided space for a GP practice to establish a surgery to try and address the lack of GPs in the area because we found patients were missing out on basic health checks and repeat prescriptions. We had a great uptake when we were able to do flu vaccinations as patients in the area just could not see their GP in a timely manner. Allowing pharmacists to access the National Immunisation Program vaccines for at-risk groups such as the other state governments have done in Victoria and WA will be very beneficial to my patients.

I am here today to support the need for a pharmacy council in Queensland. I believe a pharmacy council will provide certainty for pharmacy owners and for patients who are entitled to know that their local pharmacy complies with the law and with the highest standards they expect from a health destination. As a pharmacist who has complied with the Pharmacy Business Ownership Act, I want to be able to be confident that other pharmacy businesses have also complied. A level playing field is fair and in the interests of all consumers. Patients are also entitled to feel confident that through a pharmacy council their local pharmacy premises meet all the relevant clinical standards and requirements. In short, I believe it would serve pharmacists, patients and the health system to have an independent body which can ensure the current laws are being enforced.

In terms of scope of practice, I believe pharmacists are highly trained health professionals with expertise in medicines but their role is more limited in some respects in Queensland than in some other states and certainly some other countries around the world. I believe we in Queensland should be able to perform to our full scope of practice to maximise the benefit for our patients. I also believe this full scope of practice is definitely something we approach collaboratively with doctors and other health professionals.

I am a big supporter of the My Health Record. We were a trial site for the system and I am committed to the electronic health records because of their obvious benefits for my patients but also their potential to streamline collaboration with all other health professionals. Whatever I am able to do in terms of scope of practice it will always be in cooperation with other health professionals and for the benefit of the patient.

Finally, as a pharmacist in regional Queensland I want to mention the workforce difficulties we face attracting young pharmacists to work in our area and keeping them here. This is where pharmacist ownership of pharmacies plays an important role in terms of mentoring and guiding young pharmacists who serve these communities. Thanks very much.

CHAIR: Thank you very much for that. I do know Innisfail very well. I have family down there and I have probably shopped in your pharmacy. In fact, my wife hates me going to pharmacies because I spend way too much money in them. I cannot seem to walk past one without spending money. I wanted to get an idea of the difference you experience in Innisfail compared to a larger urban centre such as Cairns, where you have another pharmacy. Are you called upon to do more in the acute space when people come into that pharmacy?

Ms Twomey: In my opinion, yes. Definitely medication continuance is a big problem, so people who have run out of their prescriptions and just cannot see a doctor for quite a number of weeks. Probably four weeks is the norm there whereas my Smithfield pharmacy to the north of here has 10 doctors right next door, so to get a script there is far easier.

CHAIR: No doubt if you are working in that Smithfield pharmacy your collaboration with the medical fraternity is probably well developed and a lot closer.

Ms Twomey: Very well developed. For all of my pharmacies I am lucky to have doctors next door. The problem in Innisfail is that they do not have enough doctors to be open all of the time.

CHAIR: I think as a case in point, regardless of where you are in rural or western or remote Queensland, it is difficult to retain health professionals. I saw that in my own previous career. We see it in nursing and medicine and obviously pharmacy makes up a big part of that, so I note that as well—that is, retention and incentivising people to stay is quite difficult.

Ms Twomey: Yes.

CHAIR: I think we heard that from Lucy at Toowoomba who is out at Goondiwindi.

Ms Twomey: Yes, Lucy is like me. She employs a lot of young pharmacists to try to mentor them through at the start of their profession, and those pharmacists do need extra help. They do one intern year after finishing their degree and that is just not enough to prepare them to be on their own and deal with the patient that has come in who has run out of blood pressure medication, has no scripts left and asks, 'What do I do? I can't see my doctor for four weeks.' It is just not ingrained in them to make those decisions. They need mentorship.

CHAIR: Did you experience any negative aspects in performing the flu vaccination? Obviously, in Innisfail there is probably a bigger uptake, particularly versus your urban centre.

Ms Twomey: No. In my opinion it has taken the pressure off the doctors. We see most of our vaccinations after hours or on the weekend.

CHAIR: How many years have you been vaccinating in Innisfail?

Ms Twomey: I cannot personally vaccinate. Being a pharmacist owner, I have done what is best for the patient and actually allowed my pharmacists who are on the ground every day to go and do the courses. We have limited access to the courses up here. They book out every time, so I send every other pharmacist before me. We have been vaccinating in Innisfail for two years.

Mr HUNT: During this inquiry we have met a lot of pharmacists with a passion for what they do and they are hardworking. There is a lot of angst around the ownership laws and the enforcement of those laws and what that might hold for them in the future. In your submission you used the words 'I believe'—

I believe that a corporate-run pharmacy would not prioritise the health needs of my community ...

... I believe the outcomes for patients would be a lot worse under a corporate model.

As a committee we have asked what evidence you have to base those comments on, and I note the comments of Mr Twomey earlier about the unfairness of the reverse onus of proof in that regard. Do you have any anecdotal—have you spoken to pharmacists who have operated under a corporate model or about bad experiences? Where does this belief come from?

Ms Twomey: I agree with what Trent said in terms of—I will not say it as eloquently—AICD companies, corporate structures having to answer to a shareholder, whereas my focus is always the patient. It has to always be the patient that is at the centre of the care. I can call upon my example of the extended hours. If I look at my reports it is unviable to open after about 6.30 on a weekday. I would definitely reduce straight away to 9 til 5 on a weekend. That is not in the interests of the community. They do not have a proper emergency department. They cannot get in and see a doctor. I might be the first aid for an emergency on the weekend that they can see. If I just look at my figures I would make a completely different decision.

Mr HUNT: I am more interested in pharmacists talking to each other. Have you ever spoken to someone who is a pharmacist who has worked in a corporate model that has had a bad experience or felt pressure to compromise their professional standards in a corporate structure?

Ms Twomey: Not in Australia. In Canada I have seen a pharmacy in the back of a supermarket between the deli and the milk. I believe that the back of the supermarket is not really the environment to provide proper health care or vaccinations. That to me does not seem clean or appropriate.

CHAIR: Just to clarify for the committee, we talk about ownership. You are not a pharmacist yourself?

Ms Twomey: Yes.

CHAIR: You are a pharmacist?

Ms Twomey: Yes.

CHAIR: I thought you said you were not and you could not give me—

Ms Twomey: I cannot vaccinate, but I am a pharmacist.

Mr BERKMAN: Thank you for being here. We very much appreciate all the evidence we have heard and you taking time out of your day. Very similar to the questions that the member for Nicklin has asked, I am interested in your experience before you were a pharmacist owner. I am assuming, like most pharmacists, you had a spell where you were employed as a pharmacist and not working in that role as a proprietor. In terms of the application, the exercise of your professional obligations, how do you feel that actually differs in circumstances where you are working as an employee or as a proprietor of a pharmacy?

Ms Twomey: As a proprietor of a pharmacy I feel like I have an extra responsibility over the pharmacists who work in my pharmacy to ensure that they have the resources, the required ethics and the environment to be able to practise within their full scope. I do not make professional ethical decisions on behalf of my pharmacists; I would never ask them to do that because that is under their registration as a pharmacist. However, my responsibility is over the environment, so providing a fridge that does hold things to the right temperature, and making sure my safe locks and making sure the DDs are audited on a regular basis. I cannot think of any other examples.

Mr BERKMAN: That is fine.

Ms Twomey: I take pride in being an owner and having the responsibility. I guess it comes back to clinical governance. That is the difference in being an owner and the pharmacist manager or the pharmacist in charge. I have an extra level of responsibility to make sure that I have clinical governance over my businesses and all of the staff in them, including the pharmacy assistants as well, ultimately for the benefit of the patient.

Mr BERKMAN: Whether we are considering your staff or yourself before you were a proprietor or any other employee pharmacist—I guess I am trying to better understand the basis of the apparent concern, not just yours but broadly that we are seeing throughout this inquiry, that employee pharmacists will not be able to exercise their professional obligations as effectively. Sorry, I should clarify. We have to assume I suppose—and this is perhaps a question for proprietary regulators regardless of what might come out the other end of this. Assuming that all of those requirements for the operation of a pharmacy are met—those things you mentioned like the locks are functioning, the storage is at the right temperature—are there other impediments to the full and proper exercise of professional obligations by pharmacist employees?

Ms Twomey: I guess unless someone is holding you responsible how would you ensure that the things were being done? Have we established that the pharmacy council in auditing pharmacies every 7.2 years is not responsible? Perhaps that is why you need a pharmacist owner to step in. If Queensland Health is auditing every 7.2 years how do you know that the managing pharmacist has audited the DDs and they are correct and there is no breach there?

Mr BERKMAN: Essentially, this is the case for better oversight by someone, whether the department was doing its job more effectively or a council or some other proprietary oversight—a regulator?

Ms Twomey: Yes.

CHAIR: Under the Health (Drugs and Poisons) Regulation in relation to schedule 8 drugs and the DDs you are talking about, regular auditing has to occur. You conduct that yourself?

Ms Twomey: Not always. I do if I am in the pharmacy. I would ensure that it has been audited or I would go in and do a spot check. If I am working that day I would do it myself. It just depends on what is happening and what day I am working.

CHAIR: When was the last time you had Queensland Health through any of your pharmacies to do an audit or a check, particularly around the DDs, first?

Ms Twomey: I probably had a check—Smithfield was a new pharmacy. It was a greenfield site. It was opened in 2015. Usually new sites are first on the hit list. That would have been the last audit, probably two or three years ago. Every time they come in they will check the DDs. That is pretty well guaranteed.

CHAIR: That is a standard requirement, yes. Three years seems a long time. Seven years seems even longer.

Ms Twomey: In relation to the other two I do not remember whether they have ever been in.

CHAIR: My experience in the previous role is our DDs had to be checked regularly. As a statutory authority we had our own frameworks to operate under. It is interesting.

Mr O'ROURKE: In relation to training what are the key areas where pharmacists' scope of practice could be extended to improve health outcomes for patients or consumers?

Ms Twomey: In terms of what I mentioned about allowing pharmacists to access the National Immunisation Program, at the moment we are really limited to flu vaccinations. We were one of the piloting states in the country, so I see it as a no-brainer to extend that out. It is within your control to do that. I really see that as an easy win. I think that medication continuance—we are already doing some of that, just extending the medications that are allowed. Then probably looking at—

CHAIR: What about the continuance of prescribing?

Ms Twomey: That is what I consider to be medication continuance. That is extending a prescription for something that is a chronic medication that has already been diagnosed, but also looking at decreasing the burden on emergency departments, so looking at some things like Trimethoprim for a UTI. I am not sure—and you might have statistics on how many people present to an emergency department for a simple antibiotic. That is within our scope of practice and it is not a medication with many adverse effects, so I see that as a really easy way to decrease the burden on the state healthcare system.

Ms BOYD: In relation to a pharmacy council, as an owner, would you be happy to absorb the costs or fees of establishing and running that council?

Ms Twomey: As an owner I would be hesitant to absorb any further fee. I see that the council already is being funded at the moment through the state government. If it were to move, then surely some of those resources could move with it. Perhaps I could be cheeky and mention—my husband might not like me mentioning it—

CHAIR: It could be an interesting dinner conversation tonight!

Mr McARDLE: I am supporting you, Georgina.

Ms Twomey: This is not specifically related to this inquiry. This is a bit on the edge. In rural and regional areas we pay the same payroll tax rate as those in South-East Queensland and I really think we should look at the Victorian model for that and have a regional decreased payroll tax rate to stimulate employment. I am just going to go on the edge and say that. Then I would be happy to pay a fee.

Mr McARDLE: That was a very brave statement you have just made. It would be very brave, in Sir Humphrey's terminology, for a politician to make a similar comment, although there may be a lot of truth around what you did say. You made this comment before about the scope of practice linking into Queensland Health and how we could assist them. We know as a state that chronic disease is out of control, we know that obesity is out of control and we know that taking no action is simply not an option. I would have thought that your scope of practice in relation to chronic disease would be a true perfect set in terms of your capacity in relation to a situation with an outcome in mind. Can you comment upon that?

Ms Twomey: I could comment on a specific chronic disease, say diabetes. We have diabetes educators that work within Queensland Health, is that correct?

Mr McARDLE: Correct.

Ms Twomey: Why could they not be in the pharmacy? Why could there not be staff employed through the pharmacy, then Queensland Health do not have to employ them? Having more people who come into pharmacies—Trent might know the average number of visits to a pharmacy per year, but it is at least once a month. They are coming anyway. It saves you rent and resources within Queensland Health and it all can be done within the infrastructure that is already provided.

Mr McARDLE: What you are doing then is using your scope of practice to take from the acute into the community where they can be looked after by a qualified person—

Ms Twomey: Absolutely.

Mr McARDLE:—who can make the call in relation to ongoing treatment with referral back to their doctor as well on a relevant diagnosis.

Ms Twomey: Absolutely.

Mr McARDLE: Is that done enough do you think?

Ms Twomey: No.

Mr McARDLE: Is that a gap you do see?

Ms Twomey: Absolutely. We have this current bricks and mortar model of 1,140 community pharmacies in Queensland. Why not utilise it to its full scope?

CHAIR: Ms Twomey, thank you for appearing before us today as our final witness before the pharmacy inquiry. I will make a couple of observations from our travels. Regardless of where we have been there is not a pharmacist—and I note we have Mr Giannopoulos from Ramsay here—we have met, whether it is corporate ownership or under the guild, who is not dedicated and professional towards their community and their profession. That is the first thing.

I think there has been some agreement between scope of practice—whether it is a corporate governance structure or a community ownership structure, my observations are there has been support broadly for expanded scope of practice for the betterment of health outcomes in Queensland. Whilst the ownership issue remains for us to grapple with, in our deliberations and in forming our views on the report we have taken note of everyone's contributions.

We do thank all submitters for coming before us today. There seems screaming agreement in one area and opposition in the other. That is the issue for us to resolve. We do thank everyone who has contributed to the discussion. It has been informative, it has been welcomed. You will have the tabled report at some point in the next few weeks.

Mr McARDLE: Once the report is tabled it passes from our control into the minister's hands. He must reply within three months, at least on a preliminary basis, but we have no further control over that document nor the outcome of our recommendations. Please, if there are any complaints, go the chair!

CHAIR: No pressure. Again, thank you all very much for your contributions. It has been very good. I declare this hearing closed.

The committee adjourned at 11.17 am.