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

Members present:

Mr AD Harper MP (Chair)
Mr MC Berkman MP
Mr MA Hunt MP
Mr MF McArdle MP
Mr BL O'Rourke MP
Ms JE Pease MP

Staff present:

Mr R Hansen (Committee Secretary)
Mr R Bogaards (Inquiry Secretary)

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

TRANSCRIPT OF PROCEEDINGS

MONDAY, 3 SEPTEMBER 2018

Brisbane

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The committee met at 9.12 am.

CHAIR: Good morning everybody and welcome. Before we start, I request that mobile phones be switched off or to silent. I now declare open this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee. 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 of the committee are Mark McArdle, the member for Caloundra and deputy chair; Michael Berkman, the member for Maiwar; Marty Hunt, the member for Nicklin; Barry O'Rourke, the member for Rockhampton; and Joan Pease, the member for Lytton.

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

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

Witnesses have been provided with a copy of the guidelines for witnesses, so we will take those as read. Hansard will record the proceedings and you will be provided with a copy of the transcript in due course. This hearing will also be broadcast live on the parliament's website. For any media present, I ask that you adhere to my directions as chair at all times. The media rules are endorsed by the committee and are available from committee staff if required.

I remind all of 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 this is a public hearing and you may be filmed or photographed.

I would like to advise that the deputy chair and I met privately this morning with representatives from the Pharmacy Guild of Australia at the guild's request to clarify procedural issues about the inquiry. We did not take documentation or evidence in relation to this inquiry.

DHUPELIA, Dr Dilip, President, Australian Medical Association Queensland

CHAIR: Welcome. Thank you very much for your very detailed submission to this inquiry. We would ask you to make a brief opening statement before we unpack your detailed submission and ask questions.

Dr Dhupelia: Thank you for providing me with the opportunity to appear before you today. From the outset I wish to inform you that the AMA Queensland does not support the establishment of a pharmacy council in Queensland. In the written submission that the AMA Queensland has made and which you have received we outlined issues such as broader ownership of pharmacies briefly but concentrated largely on factors affecting quality and safety for the public of Queensland. We outlined issues such as conflict of interest regarding prescribing and dispensing by pharmacists. The Pharmacy Guild themselves have said—

> The separation of prescribing and dispensing of medicines provides a safety mechanism as it ensures independent review of a prescription occurs prior to the commencement of treatment.

AMA Queensland agrees with this statement. We also made reference to the code of conduct and the code of ethics that doctors operate under regarding conflict of interest and how pharmacists may find this extremely difficult to manage if they were the prescriber and dispenser. We outlined a number of examples of why a request at a GP for 'just a script' of perceived low-value care request encounters have led to life-saving interventions by highly trained GPs. Finally, we outlined issues of prescribing safety and how the AMA lobbied the federal government to allow for pharmacists in general practice in residential aged-care facilities and in Aboriginal medical services via the recent

federal budget announcement of the workforce incentive payments and where pharmacists will now work collaboratively with GPs rather than competing with doctors. This would occur if community pharmacists' and pharmacy assistants' scope of practice were to be extended. Many general practices, especially in rural and remote communities, are marginal businesses and verging on non-viability as they attempt to recover from adverse federal policies such as years of MBS indexation freezes. We outlined how we already have the TGA and the Pharmacy Board of Australia being charged with schedules and standards and conclude with the risks to the community by Queensland not having real-time prescription monitoring. I am happy to take questions on all of these issues later.

We note in the Queensland Productivity Commission's report, which aligns with AMA Queensland's position, that a pharmacy council would not deliver better outcomes to industry or consumers in Queensland, is unlikely to produce a material benefit, would cost Queensland taxpayers money that does not need to be spent and will dampen innovation and competition. The report goes on to say that it seems redundant and short-sighted to establish a new body. We already have a system in Queensland that works—a system that AMA Queensland believes can be further improved by greater transparency and reporting but one that does not require the establishment of a new body.

To the best of our knowledge there is no publicly available information from the department on how they are administering the Pharmacy Business Ownership Act. Greater transparency in this regard could help improve enforcement of the act and improve compliance where there are requirements without establishing a pharmacy council. We believe that the government should identify gaps such as these and incorporate them into updated and amended legislation.

Further underlining the redundancy of a proposed pharmacy council is the fact that it would also replicate functions that are currently being undertaken by the Therapeutic Goods Administration, the TGA, and the Pharmacy Board of Australia. As we have noted in our written submission, we have schedules which classify medicines and poisons according to the level of regulated control over the availability of medicines or poisons required to protect public health and safety. These schedules are set by the TGA, and involvement or interference by the state of Queensland is not necessary.

A vital point that I would like to make is that if Queensland were to go it alone and make any changes to the pharmacists' scope of practice it would be in contravention of the COAG agreement developed in 2016. The AHPRA prescribing working group developed a clear national pathway for other health practitioners to prescribe which requires clear steps in determining community need, a comprehensive survey of training standards and accreditation, and a requirement to gain approval at various levels including the AHPRA Scheduled Medicines Expert Committee and then AHMAC before looking at state level approvals. The Pharmacy Board of Australia recently began this process by holding a prescribing forum in Melbourne just a few months ago. In effect, if pharmacists were given approval to prescribe in Queensland this would fly totally in the face of nationally agreed and developed processes which took into account fundamental issues of patient safety and would be more akin to the optometrists who in 2015 just decided that they could prescribe by changing their policies with no regard to patient safety or proper processes.

Finally, earlier this year the members of the federal AMA passed a motion at the national conference which was 'doctors should not dispense pharmaceuticals or other therapeutic products unless there is no reasonable alternative and where dispensing does occur it should not be undertaken for material gain'. If it is good enough for the doctors to separate prescribing and dispensing due to concerns about conflicts of interest and material gain, how are pharmacists any different? I am now happy to take questions from the committee.

CHAIR: Thank you very much for your opening statement. Page 7 of your submission talks about prescribing safety. Obviously there are two aspects to the inquiry that is before us. One is around ownership and one is around the scope of practice. I will take you to the latter part. You say that there is no convincing evidence to demonstrate the safety of non-medical prescribing, or NMP, yet in contrast the experience in the UK has been, for some 25 years—as you have put in your submission, since 1992—that non-medical prescribing has been part of that health system. Is there any evidence around what they have established in the UK that is contrary to patient safety? We are talking about—you unpacked this; it is quite detailed—putting patients at risk with certain medications. We will get into some of the depth of that later, but it is a bold statement to make. If the UK has had this for 25 years, is there any evidence to support the contrary—that patients are dying? We saw in media reporting that Queenslanders will die if this happens. We cannot control what is in the media, but the UK has had it for 25 years. I put to the AMA that it seems to fly in the face of what the guild is suggesting in expanding a scope of practice. Can you talk to that point?

Dr Dhupelia: Sure. There is no convincing evidence that demonstrates the safety. We are not saying that it is unsafe, but we do not have evidence based literature that shows that. Most of the studies that have been done in the UK since 1992 have related to job satisfaction of non-medical prescribers, other health professionals and patients. There is some evidence that shows that doctors who work with non-medical prescribers felt improved teamwork. That is something I wanted to talk to you about, if I may have the opportunity, and what the federal government is doing regarding this collaborative teamwork. Others have said that working with non-medical prescribers as part of the teamwork is good. However, it does take a bit more effort and a bit more time and increases their workload in working in this collaborative arrangement. We have no evidence that there is no safety, but we are saying that we have more evidence where pharmacists working with general practice have been shown to be much more beneficial to the community and the patients that we look after.

CHAIR: What are your views on current practices in Queensland around vaccination for things like the flu? This has been around for some time. What are your views on that?

Dr Dhupelia: Members have clearly said to me that we as doctors do not know which pharmacists immunise. There is no transparency that we have seen about which pharmacies immunise. There has been a recent push to move towards live vaccinations, like the measles, mumps, rubella vaccination. As we know, there are very stringent procedures that we put in place in general practice where we have to be fully mindful of allergic and anaphylactic reactions, have all those contingency measures, and we believe that push for live vaccines is possibly a risk to the community of Queensland.

CHAIR: I am sure that the guild will respond to that, because it has been happening for some time and I believe I have seen some data that shows that not a great deal of anaphylaxis or allergic reactions have occurred. We will look to that data, I think, going forward.

Under scheduling you talk about S4s. I do not think it is the view of the guild to be pushing for pharmacists to look to prescribing S4 medication, so it sits well within the remit of the AMA. I might be incorrect on that, but we can ask them about that. What are your thoughts on prescribing some medications such as the contraceptive pill or to treat a UTI?

Dr Dhupelia: There are a couple of things there. Members have given us many examples where a patient has come in saying, 'I just need the pill prescription, Doctor.' I have quoted in my paper where a 19-year-old girl recently went for a pill prescription, the GP checked the blood pressure, which is a normal process, and noticed a melanoma on the arm and saved that girl's life. It turned out to be a level 2 melanoma. There are many examples. There are changes in long-acting reversible contraceptives that we discuss with our patients where that would not be an opportunity to do over the counter.

Regarding the UTI, a very senior gynaecologist member of the Australian Medical Association has shown the number of people that he sees because of irritable bladder or sensitive bladders where they go to the doctor and say, 'I think I've got a UTI,' yet the urine cultures are always negative and catheter specimens are negative. If these patients just said to the pharmacist, 'I think I've got a UTI,' and have prescribed antibiotics, I think that is wrong, especially where we are now being charged with antimicrobial stewardship. Antibiotics are being abused and the AMA is urging general practitioners to be the keepers of antimicrobial stewardship and show leadership. Without evidence of a UTI, to be prescribing antibiotics I think is fraught.

CHAIR: There is a current study on unnecessary emergency department admissions. I will declare my previous career as a paramedic for some 25 years. To turn out a truck with staff costs money. To take people to the emergency department has an impact on the Queensland health system. Some of my experience—I think you mentioned it—in terms of relievers for asthmatics has been where someone had an acute onset, be it from smoke or pollen, in a shopping centre and simply needed a relieving medication. Do you think it is a step too far for someone having an acute asthma episode to be able to go to a pharmacist and say, 'I need a reliever now,' without having to go to a GP? I am just giving you my experience on that. I get what you were saying about proper asthma management in terms of preventers, but in my experience these could have been avoided. We now have to take you to hospital to give you some salbutamol and more treatment. Do you think it is a step too far? What is your opinion on that?

Dr Dhupelia: You have asked me three questions so I will take them one at a time, if I may. First of all, AMA Queensland is pushing for a collaborative partnership with pharmacists, not a competitive arrangement. For some time we have been lobbying the federal government, which is responsible for that, that we would like general practices to receive practice incentive payments for allowing non-dispensing pharmacists to work collaboratively in general practice. For some years now

we have shown the success and the evidence where the Commonwealth has given a practice incentive payment of $25,000 for a nurse who works in a general practice. That is indexed at a 50 per cent loading for rurality. A practice in Cunnamulla, for example, will receive $37,500 on a 50 per cent indexation for having a practice nurse. That is not a lot of money. The rest of the money for that wage has to be brought up by the general practitioner.

We have asked, besides the practice nurse, to allow pharmacists to work collaboratively in general practice, and for several reasons. The budget announcements in May 2018 by the federal government have now changed the Practice Nurse Incentive Program to the Workforce Incentive Program. We now have a $25,000 subsidy if we employ a pharmacist within our practice. That is what we are pushing for.

At the start, when the allowance came for practice nurses, I think there was great resistance from practices to say, '$25,000 is not enough and we will not be employing nurses,' yet that phenomenon has successfully grown because of the value that those practice nurses bring to those general practices. We will see the same sort of resistance in the start, or the slow uptake, but our prediction is that, with AMA support, as our patients are getting older and chronic diseases are getting worse, it makes sense that we work collaboratively in a team in a medical home. We believe that a non-dispensing pharmacist is a very critical part of that. I think we will see a larger and larger uptake of that.

Regarding the Remain Home study, I have only preliminary information, because the studies are very early. From what I have heard—and this study is happening in north Brisbane currently, right in our own backyard—at the moment the state is spending thousands of dollars in outpatient avoidance and outpatient diversion. We are funding GP liaison officers to make sure that the referrals to outpatients are valid, necessary or cannot be done in primary care and then diverted back to primary care or alternative service models that are in the community. The Remain Home study is showing that, by having pharmacists working in general practice—these are very preliminary findings and I will declare that straight-up—there is going to be a significant cost saving to the state government in terms of the readmission of patients for various reasons. Here is a federal intervention—a federal policy of workforce incentive payments—where the federal government is allowing a collaborative arrangement of non-dispensing pharmacists to work in general practice that is going to save the state of Queensland large amounts of money.

As for your third question regarding the reliever, that already exists. Ventolin is available. Salbutamol is available. I have no qualms in an emergency situation about what needs to be done to save that patient's life. I have no problems. I will support that.

Mr HUNT: I have a couple of questions about the possibly increased scope of practice. You give examples in your report of people attending a GP for just a prescription and other diagnoses being made. It seems that most of them are a by-product of the purpose of the visit, the purpose of the visit being a repeat prescription. Would it be fair to say that it is not really related to the repeat prescription but related to frequent visits to a GP being a good outcome?

Dr Dhupelia: There are two parts to that. The evidence is showing that if you have a regular GP and you attend regularly then that is the best model. That saves lives and saves misdiagnosis et cetera. Currently, GPs work in a highly computerised world with their medical software. In that software we have a number of recalls and checks and measures for you to say that, 'In September of this year, you are due a repeat colonoscopy referral. In November of this year, you are due to have a repeat cholesterol test. In January of next year, you require a prostate examination.' When you come in for just a prescription for whatever reason, one of the first things that we would do as a general practitioner is say, 'How are you?' solve your current problem and then say, 'Let's look at where we are in your recall and what is coming up for you.' Those measures will be lost if the patients are not coming back for their routine visits to the doctor.

We have said that when people have come for just a prescription other measures have been taken during that visit. Sometimes these have been fortuitously life saving for the patients as well. I think having that continual relationship following the recall protocol that we follow—the health pathways that we usually follow, the guidelines that we follow for our patients—makes a difference.

There are many times personally when I, as a GP, have seen a patient for just a prescription for a pill and that is all they wanted and there is nothing in the recall system. As I am saying goodbye to them I ask the simple question, 'And how's the family?' just to see that patient break down in tears, sit down and then we have a mental health issue about things that are happening at home. It is an opportunity for us to build that longitudinal relationship—a trust relationship—where other things happen, even though the initial visit may be a low-value visit, or perceived to be a low-value visit.

Mr HUNT: In your opinion, are there any activities that could be added to the pharmacist's scope of practice without further training?

Dr Dhupelia: Training is an important thing. I said in my opening speech that there has been the COAG agreement where they asked the AHPRA prescribing group—this is regulated federally—to have developed clear national pathways. We support those clear national pathways where they look at community need, a comprehensive survey of training, standards and accreditation, which the PSA is responsible for. We support that.

Currently, we in the AMA have in front of us also a push by nurses and midwives to extend the scope of practice. We are looking at this positively. We are looking at models that underpin principles such as non-medical prescribing that occurs in a medically led and delegated team environment. Non-medical prescribing occurs only in the context of role delegation to the non-medical person, not a task substitution. There is a difference between role delegation and task substitution. We at the AMA believe, for example, that there must be formally documented collaborative arrangements that ensure the diagnosis, ongoing monitoring and an evaluation of adverse events by a medical practitioner, that there are clear lines of accountability and responsibility and the separation of prescribing and dispensing.

We need to make sure that any non-medical practitioners must have the core skills and appropriate competencies for safe prescribing and complete high-quality, accredited education and training courses. We are not averse to that at the AMA. We know that what comes with our ageing population is more chronic disease. We need pharmacists to work with us collaboratively in this sense.

The course curriculums must include core competencies in determining when to prescribe and when to refer patients to a medical practitioner and, as occurs for us as medical practitioners, any non-medical practitioner should be closely supervised during the first year of prescribing practice. AHPRA and the prescribing group are looking at that. The AMA is working with them federally. There is still work to be done. For the state to reverse or take an alternative position to what is happening nationally as far as the standards are concerned I think is wrong at the present time and probably premature.

Ms PEASE: Thank you very much for coming in today. You were talking about the federal government introducing an incentive for you to take on pharmacists in practices. How will that work?

Dr Dhupelia: The pharmacists will work in our team. As I said to you, at the moment many general practitioners have practice nurses. We have chronic disease. At the moment, if you have a chronic disease, general practitioners formulate a team care arrangement. It is a coordinated arrangement for that chronic disease. The general practitioner sets out a team plan: 'These are your chronic diseases, these are the targets, these are the goals and these are the allied health practitioners who will be responsible, together with me as the leading general practitioner, for your care who will assist me in taking care of this.' That is called a team care arrangement. Items 721 and 723 under the MBS schedule and GPs schedule are renumerated to take time with chronic disease patients to formulate a team care arrangement. Pharmacists can be one of those team members and currently are one of those team members. Having them in the practice will make it much easier for them to access those records and have a dialogue with the general practitioner about the necessary roles that pharmacist will play in this coordinated care as far as medication safety, regularly taking it, compliance, monitoring for side effects et cetera.

With this team care arrangement currently, the MBS allows for five visits to an allied health practitioner, including a pharmacist, and that visit attracts a Medicare schedule. We do not believe that five is enough, but that is not your issue; it is a federal government issue and we will take it up with the federal government. As we are getting older, we are requiring more allied health and pharmacy intervention. We will be working with that. We think that pharmacists working in general practice will improve that.

The second answer to your question is home medication reviews. Currently we have a system where doctors defer to pharmacists where they do home medication reviews to make sure that the medications that they have at home are not clashing with other vitamins or natural health products that they are taking. A review is done and a recommendation is made to the pharmacist regarding a number of things that they are observing in their home medication review. Currently the Commonwealth limits that, because pharmacists get paid to do this. Currently the Commonwealth limits it to 20 per month.

Ms PEASE: When you are talking about pharmacists, are you talking about an in-practice pharmacist or a community pharmacist?

Dr Dhupelia: Currently, a non-practice pharmacist does the home medication review. When they do that, they are limited to 20 per month because they get paid for that service. There is a federal regulation. We have more than 20 patients a month who require regular review. We believe that, by having a pharmacist in the practice, we would be able to do that in a much broader and expanded sense.

Ms PEASE: Would community pharmacists not undertake many of those tasks that a practice based pharmacist would do?

Dr Dhupelia: Currently yes, but at the moment they are restricted to only 20 of those home medication reviews per month under the legislation. We require them to do more than that. I think by having them in our practice we would be able to facilitate that for our growing burden of chronic disease in our practices.

Ms PEASE: It is not just about the home assessments but about further medications that people are on. I go to the pharmacist and they can look up my file and say, 'This is what you are on. You shouldn't be taking that.' You are saying that an in-practice pharmacist will provide that service, but community pharmacists will already be providing that service, won't they?

Dr Dhupelia: We have heard varying reports of how this occurs—some good, some indifferent. The medical record that is in the doctor's surgery is the most complete record. I am not sure what record the pharmacist utilises to crosscheck that reference. I am not sure that there is a mechanism of checking the record system that pharmacists have for that patient's medication.

The other thing is that patients do not usually go to the same pharmacist, just like they do not usually go to the same GP. That is why we are trying to introduce things like the My Health Record, so that it is safer for the doctors. I think there is a while to go before we can say with certainty that the record that is up there in front of us is the accurate record.

CHAIR: That takes me to real-time prescription monitoring. I point out that I am a creature of habit, so I go to the same pharmacy.

Ms PEASE: Me too.

CHAIR: On page 9 of your submission you state—

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

I do not disagree. Your submission states further—

Everyday there are four Australians who die from misuse of drugs, and half of them are from prescription medications.

Did you unpack that number that you put in your submission? In my experience there are medications that are taken accidentally—say, a child taking his grandmother's beta-blocker—but my experience is that many of those deaths from overdoses of benzodiazepines and opioids are suicides. People deliberately take overdoses of medications. I am just scrutinising that statement a little bit further and asking whether you looked at the causes of those deaths.

Dr Dhupelia: No, I do not have the subsets of suicides versus accidental deaths or overdose deaths. I am sorry, I do not have that data.

CHAIR: It was just a point in my mind. I do not disagree with the statement. I think it needs to be unpacked a little further as to the actual causes.

Mr McARDLE: I start by looking at the UK studies that you refer to for non-medical prescribing. That paragraph of your submission does not say there were adverse outcomes in the UK.

Dr Dhupelia: Exactly.

Mr McARDLE: There are no adverse outcomes that I can see in having a pharmacist prescribe; is that right?

Dr Dhupelia: There is no evidence. We do not have evidence or any statistical data at the present stage, as far as I am concerned. We have referred to that particular reference in our list of references.

Mr McARDLE: I appreciate that, but my concern is this: if it had been a problem, I would have thought that would become an issue and subject to a study of some sort. However, your submission does not raise that as a concern.

Dr Dhupelia: I guess where you are coming from—and forgive me if I am wrong in what I am suggesting—is the convenience factor.

Mr McARDLE: No. The health outcomes in the UK do not seem to have become worse by this process. It is not convenience; it is the health outcomes.

Dr Dhupelia: I would agree with that, but we do not have well-established studies that look into this in great detail. Yes, we have not seen adverse reports, but we have seen—as we have seen in the BEACH and the OECD studies—that regular visits to the GP are where the benefit lies.

Mr McARDLE: I accept that regular GP visits are very good. Why could a pharmacist not be entitled to prescribe for one month or two scripts, unless notified on the script by the doctor that that should not happen? Why could the pharmacist not phone the doctor and say, 'I have Mrs Jones here and I want to issue her with medication. What do you think about that?'

Dr Dhupelia: It is the same argument that Marty Hunt MP put to me in the sense that we have, at every visit to the doctor, usually some other intervention that we used to have to do. It is not necessarily at every visit, but we do have a recall system and a management plan for that patient. Regarding the prescriptions, at the moment the federal government makes the laws that you have 30 with five repeats. We are not averse to the idea, for somebody who has a chronic disease for example, of saying, 'Let's make it 90 with two repeats.' The federal government could easily do that if it wished to, rather than extending a prescription and preventing a recall visit to the doctor.

Mr McARDLE: The issue of My Health Record is now topical. Leaving aside those who opt out for the time being, My Health Record, as I understand it, may not be a complete record; it may be a summation of the record of the patient. Could the My Health Record, which a pharmacist can access, contain when this patient is required to undertake blood tests—or anything at all—and that could be brought to the attention of the pharmacist, who would then be fully informed when the patient comes in? They could ring your office, talk to your practice manager and get advice. Isn't that a way around it that does not compromise the health of the patient?

Dr Dhupelia: First of all, My Health Record is not designed to replace the clinical notes of the doctors. Minister Hunt has actually said that. My Health Record is a health summary and is not a communication tool. It will not contain the extent of information that makes it safe for prescribing. Secondly, it is very premature, as we have seen, in that the rollout has been challenging and legislation has been rushed through federal parliament to try to appease the community and the medical profession that it is going to be something that is good for the patients.

I think it will be many years before My Health Record can be reliable, as far as that is concerned. At the moment, the consumer will be controlling the My Health Record. The consumer can delete pieces of information that may be vital to the pharmacist. The consumer can put a pin on anything that they do not want the pharmacist to see. I think it is risky. I think it is premature. I think it is early and we cannot hang our hat on that at the present time.

Mr McARDLE: You would eliminate My Health Record as any sort of source that a pharmacist or allied health professional could go to, to get a proper assessment of a patient?

Dr Dhupelia: Right now, yes. In the future, I do not know how this will develop.

Mr McARDLE: You indicate that that would take years to roll out before the AMAQ, or the AMA for that matter, would come on board and say that you can rely upon it?

Dr Dhupelia: The AMAQ totally supports the rollout of My Health Record, provided that we have the four conditions that the federal council actually asked of Minister Hunt last week, and he has accepted all those points. He is rolling out those four points. Those four points are on the privacy legislation by court order to satisfy that the records will not be going; increasing the opt-out period, so that we have more chance to sell it to our consumers, by one month; a communication strategy; and the provision that a consumer can completely delete the record at any stage they wish to. All four of those have currently been granted by Minister Hunt and we are working very closely with that. Once those four things are in place, we support the rollout of My Health Record, but it is still very early days, very premature and cannot be relied upon.

Mr McARDLE: In their submission, the Royal Australian and New Zealand College of Psychiatrists referred to the National Prescribing Service's Prescribing Competencies Framework, developed in 2012, as a training tool or learning tool for pharmacists to upskill. Would you support that as a model so that, if scope of practice is enlarged, pharmacists should follow that particular set of requirements?

Dr Dhupelia: I am not aware of that particular standard that the psychiatrists have done, but I outlined to you a bit earlier the conditions under which the AMA is working with other non-medical prescribers and how we are working with the Pharmacy Board of Australia, through AHPRA as well, to make sure that there are training standards and there is a curriculum. At the moment, the PSA is the holder of those standards and regulations and the accreditation. We are working closely with that. Provided it goes through what COAG has suggested, AMA federal will work with AHPRA on that, yes.

Mr McARDLE: If this committee recommended that there was an enlarged scope of practice, would the AMA endorse that, provided there was an upskilling requirement through AHPRA or via AHPRA's terms and conditions?

Dr Dhupelia: We agree to work very closely with COAG and what has been put through the AHPRA prescribing working group, that there should be a clear national pathway for health practitioners to prescribe. It has to be based on community need, a comprehensive survey of training, a comprehensive survey of standards, accreditation and a requirement to gain approval, including the AHPRA Scheduled Medicines Expert Committee and then to AMAQ, before the state should do it.

Mr McARDLE: I find it quite hard to divine whether you said yes or no to my question.

Dr Dhupelia: As long as it goes through this process, we are happy to work with it.

Mr McARDLE: I take it that if there were put in place a series of KPIs the AMAQ may say that that is satisfactory, but you will put a caveat on that: 'We will make certain that the terms and conditions are of such rigour that we can confirm them'?

Dr Dhupelia: It is all to do with patient safety.

Mr McARDLE: Correct, absolutely.

Dr Dhupelia: I outlined earlier what we are working with the nurses and midwives at the moment and the conditions under which we will work very closely with them. The same conditions, as far as I am concerned, will apply to pharmacists.

Mr McARDLE: You refer to upselling. Of course, we know you can walk into a pharmacy today and buy a kitchen fridge, just about. You talked about the coordinated approach where a doctor, a pharmacist and an allied health professionals work together. Wouldn't the upselling still take place with the pharmacist in those circumstances? They are independent bodies.

Dr Dhupelia: Under the team care arrangement, we visit the team care arrangement in the doctor's practice and the in-practice pharmacist would be questioning and reviewing the medications that the patient is taking. If the patient comes in with medications that are not prescribed but that were sold at the pharmacy or purchased on the shelves by the patient in the pharmacy, that may or may not clash with or contravene the medications that they are currently taking, that will be easier to pick up if it is done within a community pharmacy.

Mr McARDLE: So the pharmacist would not be an employer; they would be an employee of the doctor and the AMAQ would say that no upselling could take place in those circumstances?

Dr Dhupelia: The pharmacist we employ in general practice will be a non-dispensing pharmacist.

Mr O'ROURKE: Dr Dhupelia, I note that you do not support any changes in pharmacists, particularly in rural and remote areas, being able to be prescribers. Do you think there is an option around the scope of practice for our pharmacists in those tiny towns where there may be only one doctor or no doctor?

Dr Dhupelia: Absolutely. It is not as far as scope; it is vital. I travel all over Queensland in my substantive position. I know that it is vital that the lonely rural general practitioner or practitioners in a one- or two-doctor town have that collegiate agreement with the pharmacist—absolutely. They should work together in that team care arrangement in the small rural communities.

One of the things that I want to mention is that most of the practices in rural and remote Australia are very marginally viable. They are just coming out of the MBS indexation freeze that you have heard about. Again, that was a federal policy issue that had adverse effects on rural Queensland. More and more practices in rural Queensland are folding, with the result that Queensland Health is becoming the default provider of services for those patients. Therefore, a federal policy on making practices non-viable is costing the state of Queensland large amounts of money, for which they do not get money from the national health agreement.

I think we have to protect rural practitioners. We have to make it attractive for rural retention so that they go to practices where there is viability or hopeful viability and not the hopeless state that currently exists at the moment in rural and regional Queensland.

Mr O'ROURKE: Further to that, there would be nothing stopping the pharmacist prescribing a drug over the weekend and ringing it through to the doctor on the Monday or something like that? Is that something that could happen?

Dr Dhupelia: Those collaborative agreements are still there in emergency situations in rural and remote towns. The other alternative is that, in most of the small rural and remote hospitals, there are impress systems put in place by pharmacists or the pharmacies of the rural and remote facilities to keep limited emergency stocks. Usually, what is stocked there is what they know the community is using, rather than some high-powered anticancer drug that has never been prescribed in that particular community. There are some safeguards and some measures already existing and there is collaboration. That does not mean that the scope of practice has been extended.

CHAIR: Dr Dhupelia, you talked about GPs and the 19-year-old lady with a melanoma that was picked up. We have had a couple of hundred submissions to the inquiry where pharmacists will say the same thing: they will have a conversation with a consumer who comes into their local pharmacy and they will unpack a few other issues that are there. They work in collaboration with the local GP to get that patient treated. It is a complex area. I say respectfully to the many thousands of medical practitioners out there: thank you for the work that you do. We understand that the patient care continuum starts at the medical end with the GP. We also understand that the pharmacist makes up an important part of the overall health care of every Queenslander. We have to find a happy medium in this inquiry. Dr Dhupelia, thank you very much for your time today and for the AMA's contribution.

Dr Dhupelia: I do not envy your position, but thank you very much.

SISKIND, Associate Professor Dan, Royal Australian and New Zealand College of Psychiatrists

Prof. Siskind: The Royal Australian and New Zealand College of Psychiatrists is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry; supports and enhances clinical practice; advocates for people who are affected by mental illness; and advises government on mental health care. The RANZCP is a peak body representing psychiatrists in Australia and New Zealand and is a binational college with strong ties in the Asia-Pacific region. We have over 6,000 members, including more than 4,000 qualified psychiatrists—fellows—and over 1,500 members who are in training to qualify as psychiatrists—trainees. In our Queensland branch we have 780 fellows and 280 trainees. Our members hold positions in public and private psychiatry or both. Many specialise in a range of areas including perinatal psychiatry, child and adolescent psychiatry and rural and remote psychiatry. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence based treatments to support a person on their journey of recovery.

I am a proud Queensland government employee. I work mostly with people with schizophrenia, so do not talk to me about your mother; talk to me more about the aliens. My area of research interest is around comorbid physical health. The medications that I prescribe are fairly lethal and cause serious issues like diabetes and metabolic disorders. My interest is how to improve the quality of life for the length of life of consumers, because our consumers die around 16 to 18 years younger in Australia than the general population.

CHAIR: Thank you, Dan, for the positive energy in your contribution today. In answer to question 18—'Should the scope of practice of pharmacists and pharmacy assistants in Queensland be extended? If so, in what areas of practice?'—you have replied—

> Community pharmacists have a strong primary health-care role, and are more accessible than other medical practitioners, particularly in rural and remote areas. Expanded scopes of practice for pharmacists may provide benefits to the community, primarily in the form of timely access to medication.

You have some concerns that it may come at the cost of the provision of specialised care. Can you unpack that statement a bit further for us?

Prof. Siskind: We are limiting this to psychiatry and the prescribing of psychotropic medications because that is our college's area of speciality. When I think about consumers in nursing homes I think about people in Parklands Residential at Kirwan, Opal Aged Care in the Nicklin electorate, Benevolent Aged Care in Bethesda and Rockhampton, Regis Wynnum and Edwin Marsden Tooth. One of the things we see is that psychotropics are often used off-label for the behavioural management of people with dementia. These are people who are dementing, who become agitated and might require the brief, short-term use of an antipsychotic to help manage aggressive behaviour. The problem is that we know these medications kill older people. Adjusting for all the other factors, they are 1½ times more likely to die than someone who is not prescribed an antipsychotic medication for behavioural disturbances.

The concern that I have is that these medications will be started by an inappropriately trained primary care provider or specialist older person's physician or older person's psychiatrist for the short term. When the nursing home sees that the prescription has run out they call the pharmacy and say, 'We need this to be continued.' That is where oversight is really required by a specialist medical professional, because sometimes older people are on a slew of medications, and when they remain on these antipsychotics inappropriately we kill them. It is not the role of Queensland to be killing people who live in our older persons aged-care homes. I have concerns around this particular scope of practice for pharmacists to continue prescribing medications, particularly psychotropics, when they really should be reviewed by a specialist in elder care and stopped if appropriate. That is my core concern.

CHAIR: Are you prescribing?

Prof. Siskind: Yes.

CHAIR: Can you talk to me a little bit about that in terms of electronic prescribing?

Prof. Siskind: This is more about convenience and efficiency and reducing medical errors. I talk to the pharmacists who look after my consumers a couple of times a week. I am someone who is in regular communication with pharmacists. I really value their input in letting me know what medication someone is on. Often our consumers will be seeing a psychiatrist, a GP and medical specialists, and each of us is writing a script because we all think we are awfully clever and we know the right thing to do, and we will not know what each other is doing. A good community pharmacist

can tell me, 'Actually, Ms X is on these medications.' I have to make a phone call to do that. If I want to write a script, I have to physically write the script out and I have to photocopy it—because there is a fairly good chance that my consumer is going to lose it on the journey to the pharmacy—or I have to post it, so e-prescribing might make some efficiencies around communication and thereby reduce medical errors.

CHAIR: With My Health Record, do you think that required shared access will find a space between pharmacists and GPs in prescribing?

Prof. Siskind: I am an optimist, but I do not think it is quite there yet.

CHAIR: No, it is going to take a little while.

Mr HUNT: You spoke a little bit about polypharmacy. I am interested in how that is currently monitored. If people in distress are seeing GPs, psychiatrists and pharmacists and they have bits of paper with them, how is this meticulously monitored? What is the current practice?

Prof. Siskind: I am speaking more from my own professional experience rather than my position with the college, so I apologise if I am going off script. It is ad hoc at the moment. Often the nursing home will carry a list of all the medications people are on, and hopefully a visiting GP, geriatrician or visiting psychiatrist will review that, but at the moment it is not well reviewed. I think there is a role for good-quality community pharmacy to collate those listed medications and provide information to the appropriate medical professional to make decisions around de-prescribing and drug interactions.

Mr HUNT: Currently there is no real monitoring of what drugs people are on? Nobody is really responsible for—

Prof. Siskind: Good physicians will take responsibility for it, but we know that in the medical model often people are busy. They do not have a lot of time to review medications, and I think there could be a role for quality community pharmacy to do reviews of medications and combine that information to make timely decisions. I cannot speak to exactly what the policies are in the nursing homes in your district, but at the moment I do not think there is a statewide policy of how that would be managed.

Mr HUNT: By way of a hypothetical, if I was seeing a psychiatrist and a GP and I got a prescription from the psychiatrist and I got a prescription from the GP and I got those two from two different pharmacies, would there be any current monitoring of that?

Prof. Siskind: It would be challenging. I think the fantasy is that My Health Record will combine all of that information together, but I think that, as the AMAQ president said, it is going to take a little bit of time before that is ready. I think your question is very wise. It is an issue. There is not often a way for us to know what medications people are on. That is an issue for me, because I often have to call two or three pharmacies to find out what medication my consumer is on to make sure they are not getting inappropriate medications from more than one person.

Mr HUNT: That is concerning, especially when you talk about death rates.

Prof. Siskind: Yes, and that is one of the drivers. Sometimes we do not know what people are on and we are adding medications without having good-quality information—not through lack of our best efforts to find out. I think the fantasy of My Health Record is that it will provide all of that in one place, but it is still a work in progress. I think it is a step in the right direction.

Mr BERKMAN: You have spoken largely about very high risk prescriptions, antipsychotics and the like, and the off-label use of those. Do you have a broad position in terms of the broader suite of mental health medications? Are there particular risks around those that we should be aware of?

Prof. Siskind: Most medications are risky; that is why they are on the PBS. I think if a stressed-out university student went to the pharmacist and said, 'Exams are coming up. I'm feeling really low in my mood. I just failed,' you would not want the pharmacist to hand out an antidepressant because they probably do not have real depression; they have life stressors which probably could be better dealt with by talking to a mental health professional. You would not want a pharmacist to be handing out antidepressant medication to someone who did not see someone and was screened appropriately. I do have some concerns about pharmacists being allowed to dispense medications for which a prescription has not been provided and an appropriate medical assessment has not occurred.

Mr BERKMAN: It is often very important that the use of these medications is not discontinued abruptly.

Prof. Siskind: Yes.

Mr BERKMAN: Is the scope different there in relation to the continuation of scripts?

Prof. Siskind: This is a fuzzy area. Often when one of my consumers has run out of medications because I maybe have not remembered to fill the scripts or they have not come back in to see me, I will get a call from a pharmacist saying, 'We need to ring up for some scripts.' Right now the position is pretty ad hoc: they will give me a call or they will send me a fax. If we had an e-prescribing system it might be very easy for me to review that, look back at the electronic medical records that I keep and that Queensland Health mandates that all psychiatrists use in public practice, and find out whether or not it was appropriate to continue that medication or ask the consumer to come in for a review, but I do think there needs to be some medical oversight. There might be some places where there is a bit of wiggle room, but one of the challenges of making a blanket statement is that maybe it is convenient that someone's blood pressure medication is continued for want of a script while they wait to get an appointment with the GP, but that might mean that you are also letting psychotropics be continued inappropriately as well, so you have this grey area. It might be convenient in one area but risky in another. It would require some complex, detailed legislation on your part to cover all of those options.

Mr O'ROURKE: I take you back to a comment you made earlier about aged-care facilities, residents with dementia and medication that is more about behaviour management. Would there be five scripts for that? When you are dealing with drugs like that, are they reviewed every month or two as it goes along? I just do not know.

Prof. Siskind: No. The model of good, safe prescribing would be that it would be reviewed once a month when someone comes in and it would not be continued. I think what does happen is that we have a system where errors occur. I guess your task is to help create a system where medical errors are reduced as much as possible. My concern is that, if there is an allowance for people to be continued on their medications in the absence of a medical review, you increase the risk of medical errors. The hope would be that, if someone had a behavioural disturbance for a short-term period, they are given a medication which might briefly assist with that disturbance and then that is reviewed and stopped. That is the ideal model.

Ms PEASE: I have just been made aware of circumstances where patients are released from hospital and given packs of different levels of medication, for example of five milligrams or 10 milligrams. I know this is not in your area, but how do you feel about it when they are sent home from the hospital with a pack of tablets and they have all of these different options? When they or someone on their behalf quickly makes a phone call and is told, 'You should maybe bump up that medication,' what is your position on that?

Prof. Siskind: What I can talk about is people with mental illness who have had a psychiatric hospitalisation and who are released with scripts. I think that if you are leaving a psychiatric facility you have had an acute episode of being unwell and you need to be followed up appropriately by a psychiatrist or, for certain conditions, by a properly trained GP, to help make those decisions about the appropriateness of continuing medications.

Ms PEASE: It would be inappropriate to send you home with three different levels of doses and tell you, 'Today you might take this one, and if it is not working bump it up to the next one'?

Prof. Siskind: You are asking a broad question, and I can only speak about people with mental illness and the need for them to be appropriately reviewed. Often the medications that people are on when they are in hospital and in extreme situations may not be what is required when they are in the community, and that is going to need to be reviewed. There is a challenging transition period from departing the hospital to being stable in the community, where there will often be medication reviews required. I think that an appropriately trained psychiatrist or mental health trained GP would be the right person to help these people make decisions.

Ms PEASE: Would people with a mental health condition be sent home with three different types of medication?

Prof. Siskind: I cannot speak to that for mental health. I do not know—

Ms PEASE: In your profession?

Prof. Siskind: Not in my professional capacity. I will speak specifically about diazepam, for example, which is a medication that is used for agitation and anxiety. People might be given a bottle of that and told to take it if they need it, but they would not be given very many tablets and they would be required to be reviewed. In fact, you mandate that my team must see people who have left hospital within seven days. You have a rule about seven-day follow-ups, and I think you would stop paying my mental health service if I did not follow those rules, which I think is not inappropriate.

Ms PEASE: With regard to follow-ups, I was under the impression there are certain medications that are reportable, so if you want to get a new script you have to check up. You cannot get a script—

Prof. Siskind: There are certainly authority scripts. Most of the medications that I would prescribe, the antipsychotic medications, require me to put a code on the prescription so they can be coordinated by the government or I need to call up a phone number. That allows some oversight by the government in finding out whether or not scripts have been filled or whether or not they are doctor shopping for multiple scripts. My antipsychotic medications tend to make the fun go away, so there does not tend to be much of an issue of diversion in relation to the medications that I prescribe that are under authority.

Mr McARDLE: You spoke about nursing homes and dementia and the issuance of antipsychotic drugs. In that case a telephone call is made to a pharmacist who will give one without a script; is that correct?

Prof. Siskind: That is not the case now. When we talk about scope of practice, my concern is that a nursing home on a Friday afternoon might realise that Doreen's medication—

Mr McARDLE: It is not reality now?

Prof. Siskind: It is not reality now, no.

Mr McARDLE: Do you think that, knowing pharmacists as you know them and the types of drugs we are talking about, they would do that without coming back to you?

Prof. Siskind: We are talking about altering the scope of practice.

Mr McARDLE: That is right.

Prof. Siskind: Most of the pharmacists I work with are lovely people who are passionate about consumers and their needs and wanting to make sure that people do not miss out on their medications.

Mr McARDLE: They would then make relevant investigations, because you are talking here about very serious drugs.

Prof. Siskind: It is a tricky thing you are asking. Clozapine is an antipsychotic which is kind of reserved for people who are really treatment refractory; it is that kind of last line of medication and it kills you. It will cause obesity, diabetes, neutropenia—a loss of white blood cells—and heart issues. You guys—actually your predecessors in the last parliament—altered the way that Clozapine could be prescribed. It was allowed to be moved from previously only being dispensed in hospital associated pharmacies to now any pharmacy.

I have been involved in a lot of training of pharmacists around appropriate use of Clozapine. You are only allowed to give one script for 30 days and you are only allowed to give another script if you get a blood test and the blood test shows results within a range, a doctor has written a script and then another 30 days has been given. However, I have seen pharmacists give out five repeats of this medication without any monitoring.

Mr McARDLE: You would be concerned that drugs of that nature were being given out without a script on an ongoing basis?

Prof. Siskind: Despite our best attempts, medical errors occur. I think what you guys want to do is minimise the risk of errors. That is my concern: we need to have a system of oversight.

Mr McARDLE: On almost the last page you refer to the PCF—and I will not go into the full terminology—whereby training could be undertaken by pharmacists and assistants and that would upskill them to a certain level. I am not aware of what that document states. I am aware of the dot points you have down here from one to seven. Would that be something that you would say is a prerequisite for enlarging the scope of practice, and that may be a course conducted at an institute or college, as the case may be?

Prof. Siskind: I think that all training to improve the skilling of practitioners can only be a good thing. The National Prescribing Service is a fantastic service that is run by the federal government that does great work around training, and I have been actively involved in the training of pharmacists through that.

Mr McARDLE: Would this put your mind at rest in regard to not all issues but many issues? This is your paper. You make the comment here that if it is going to happen this should occur.

Prof. Siskind: I am hesitant to say that it should happen. I do not want to be caught in a double bind here. It sounds like what you are asking me—and I want to clarify because you are the asker—is that you would have tiers of pharmacists much like you have tiers of psychiatrists. We have fantastic

general practitioners who can make decisions about medications that I do not know about, much like I have expertise in antipsychotic medications. Are you suggesting that you would have tiered pharmacists who have had particular levels of training?

Mr McARDLE: You have raised concerns about drugs of a very, very serious nature being given by pharmacists. At the same time you say, 'If this is to happen then this should occur.' I am asking you: do you believe that is the way it should happen? It is your paper, not mine.

Prof. Siskind: Your questions are very targeted and I appreciate it. As a psychiatrist I make a lot of forensic reports.

Mr McARDLE: Do not assess me, Doctor!

Prof. Siskind: I did that before, mate, yet you are still here!

Mr McARDLE: Can I ask for a second opinion?

Prof. Siskind: What I am suggesting is that often for reports we have to say, 'This is my recommendation, but if you do not listen to my recommendation these are the sorts of things that should go in there.' I have concerns about expanding scope of practice. However, if you as a panel chose to ignore my recommendations—and you have the right to do that—I think this sort of training is going to be an essential part of that.

CHAIR: Thank you very much.

FOX, Ms Melissa, Chief Executive Officer, Health Consumers Queensland

CHAIR: Welcome back.

Ms Fox: Thank you. It is always a delight to be here.

CHAIR: It is an interesting space, the pharmacy inquiry. Thank you for your submission. You have made some recommendations in there. I will get you to unpack your submission with an opening statement and then we can ask questions.

Ms Fox: As always, it is a delight to be here. Thank you for having me. Thank you for the opportunity to speak on behalf of consumers. I understand that there has been a large number of submissions, many from different groups of health professionals—some of them speaking for the community and consumers. I am delighted to be here to do that ourselves.

Health Consumers Queensland is the peak organisation representing Queensland consumers and carers across the state. We are a registered health promotion charity and we believe in improving the health outcomes for all Queenslanders. We believe in fair, just and affordable access to health care, so this is a topic of great interest to us. We are also concerned where quality and safety or consumer experience are issues of concern.

I would like to keep as much time as possible for questions from the panel, but I would like to share, if possible, some results of a survey that we circulated to members of our statewide consumer and carer network after submitting our submission—

CHAIR: We will have to seek leave to get that tabled. Leave is granted, so we will accept them afterwards. Thank you very much. You have some unresolved questions with regard to formation of a pharmacy council of Queensland. What are those? You say that you could not form a concrete view. Can you tell us a little bit more about that?

Ms Fox: We are grateful that something has answered those questions. We are grateful for the cost-benefit analysis of a pharmacy council. Our questions relied on the economic benefit of the quite substantial investment required in a new pharmacy council versus the existing situation of Queensland Health covering most of these functions. Having just read this recently released report, we have seen that, based on the data, the commission found no evidence that a council would result in better outcomes for producers and consumers and, in fact, said the cost of options was between $7.7 million and $11.1 million. As Queenslanders, we know that there are many, many areas of health which need investment. We know that the health system is under tight fiscal constraints. In terms of any recommendation of an investment of this size we would require great evidence that it would bring about greater health outcomes for Queenslanders. We believe that this shows that it would not.

CHAIR: In your conclusion you talked about increasing transparency to the public about measurable health outcomes. How could you do that if you did not have a council or an authority to report, probably annually, as other councils do?

Ms Fox: Public reporting of safety and quality in health care is one of our key issues. We are really delighted that Queensland's health minister is leading a national push around increased transparency. There is some consultation about to occur that we are going to support with the department around what the community would like to know about and what will help us make the right decisions for ourselves and the care that we need. We see pharmacy sitting squarely within that information that the community needs.

CHAIR: Talk to me about expanded scope of practice. I think most members would agree that affordable health care is something that we would like to see for all Queenslanders. In terms of getting a vaccination at a pharmacy, currently it is restricted to people 18 years of age or over. Do you see some benefits in expanding that to 16 or younger in terms of getting a vaccination without having to go to a GP?

Ms Fox: For the last 10 years we have been involved in efforts by the department to increase the scope of allied health professionals with the view and with the evidence that shows that consumers are very happy to receive health care from a health professional who has appropriate training and skill in that particular area. That also requires some concerted effort to put those policies and procedures and safety and quality mechanisms in place. In relation to the question you are asking, that would require some work behind it to ensure that if it was a decision moving forward it would be safe for Queenslanders.

CHAIR: That goes to the mandatory minimum vocational training and competencies for pharmacy assistants that you speak to, which is something we will talk to other submitters about. Thank you very much. I will pause there and we will move on to other members before I come back for another question. I do want to talk about that survey at some point and where it is at.

Mr BERKMAN: Taking into account what you have just told us about your position on the formation of a council, if we were to put aside the questions of cost, from a consumer perspective what are the main things that a council or some kind of other analogous body might bring to this space? Transparency and accountability obviously strike me as an area that is right for further involvement. What is your take on that?

Ms Fox: Transparency and accountability are absolutely No. 1. Depending on the make-up of the members of a council, whether it would provide that independence would be concerning to us. Currently, as it stands with the information being collected by Queensland Health, regulations and legislation would allow that information to be shared with the public; that would provide the information that we need now.

CHAIR: I am pausing for a moment because I am after the survey results. Can you talk to me a little bit about your survey?

Ms Fox: Absolutely. Eighty-six per cent of respondents were consumers and 14 per cent were health professionals. We are not sure of their background.

CHAIR: How big was the survey? How many people?

Ms Fox: We had 59 respondents. On reflection of those numbers, it was quite a long survey. I think you could say that these were people who were particularly passionate about this area and were knowledgeable in this space. For 70 per cent of those who responded, a community pharmacist was their most accessible health professional. That was for reasons of close distance but also that they provided free health care, consultation and advice. That was information regarding scripts, naturopath advice or advice around alternative medications and side effects. They were often more available because there was a long wait to get a GP appointment in their community and no appointment was necessary for those health professionals.

People accessed many, many services through the pharmacies including, of course, prescription medications, over-the-counter medications, healthcare advice and medication reviews and also less common services such as blood pressure checks, home delivery of medications, opioid replacement therapies, weight loss advice and smoking cessation advice.

When we asked the question whether they believed a community pharmacy must be owned by a pharmacist, 44 per cent said that deregulating pharmacy ownership and location rules can still ensure the professional, safe and competent provision of pharmacy services; 16 per cent said that it must be owned by a pharmacist; and, interestingly, 39 per cent skipped that question. There were the same statistics when they were asked whether deregulation would allow for innovative service delivery models. Those who said that it would said that in rural and regional communities the pharmacist may be the only person in the community helping with an overview of their health medications and that it would make access to medicine easier.

In terms of the suggestions that we put forward—some of those innovative solutions so that people might be able to have increased access to pharmacists through a relaxation in rules—89 per cent agreed that these were good outcomes—so depot pharmacies in small convenience stores in rural and remote towns, or telepharmacy where people in very remote locations can pick up securely stored medications and receive personalised instructions from a pharmacist. Increasing embedding of non-dispensing pharmacists in primary healthcare teams was very popular, as was allowing dispensing from a pharmacy co-located in a multidisciplinary primary health hub. Less clear was how people felt about supermarkets. There were some comments around the lack of competition within pharmacies and possibly driving out access to other medications.

Eighty per cent of respondents answered that there should be increasing transparency to the public about measurable outcomes for consumers by all community pharmacies. They talked about some things that could be measured including medication side effects; follow-ups, particularly within rural towns; the type and number of individual services used and complaints; the service quality, quality of advice, safe storage and security of items; and many more. That was a very popular question. That is a brief summary.

CHAIR: Thank you very much. You are going to table the results of that survey?

Ms Fox: Yes.

Mr McARDLE: Ms Fox, it is good to see you again. I did not catch how many surveys were put out to the public or those who completed them or did not complete them.

Ms Fox: It was one survey that we publicised through our e-alerts and on Facebook.

Mr McARDLE: That would be how many people, roughly speaking? Can you give a ballpark figure as to how many would have got notification of this?

Ms Fox: I did ask for that statistic this morning.

Mr McARDLE: You can take it on notice.

Ms Fox: Can I table it out of session?

Mr McARDLE: You can take it on notice.

Ms Fox: It was close to 1,900 but I can table the exact figure.

Mr McARDLE: If we accept that, a cohort return of 59 is not what you would call a good statistical number, is it?

Ms Fox: No. I recently did a survey for a health organisation and was delighted that it contained only two questions. I promised myself in future that I would try to have fewer questions. We had 12 questions in our survey.

Mr McARDLE: I want to delve into it further because surveys, depending upon how they are framed, who frames them and sometimes who wants the answers, can direct the style of questioning. Was information given out with the questions to explain why they were being asked, one, to answer the survey and, two, some details in relation to what the questions dealt with?

Ms Fox: Absolutely. We provided background information on the work of the committee, and we directed them to the committee's website and to our submissions so that if they wanted to—

Mr McARDLE: Can you table what documentation they had access to with the survey form or what was on the website for them to go to? I am trying to get an understanding of what was in the person's mind when they completed the survey. That is very important as well. Is that possible?

Ms Fox: Absolutely.

Mr McARDLE: I want to make a point in relation to the council. I know that you have now read the commission's report and the costs involved in that. That is over a 10-year period, not per annum, as you would appreciate. Taking into account that the commission says there is no role for a council in relation to regulation, advice and monitoring, is there a regulation for a council in any format, from your point of view? For example, could a council be there to advise the government on what is required for ownership or what standards are required for ownership or education of members? Is that something you would consider might be a role for a council going forward? It would not be an independent body necessarily.

Ms Fox: I guess on reflection there are several professional groups within the pharmacy space that I imagine are providing that professional advice now. Whether it needs an additional council on top to provide further advice I would question.

Mr McARDLE: So you would eliminate a council in almost all circumstances as being a relevant body to put in place?

Ms Fox: We would require a very clear line of sight between the creation of a council and better health outcomes for Queensland.

Mr McARDLE: Why do you say that? What is the basis on which you make that claim?

Ms Fox: It is because of our understanding of the tight fiscal environment within health and the many, many needs of Queenslanders—increasing rates of chronic disease and, in particular, the challenges around accessing primary health care in our local communities and overuse of our emergency departments. We would caution prudence in terms of future financial investments.

Mr McARDLE: Could you point to a body of work or a report that we could look at, because I am keen to understand the basis of your statement? I am not for one second denying your belief in that statement, but is there a body of work that substantiates your claim or is it a sense that from consumers' perspective that is where you stand?

Ms Fox: It is a sense from the various priorities that have been identified by consumers to us in our annual survey and in terms of the current work priorities of the government which are informed by policy and planning. We would urge caution around this issue.

Mr McARDLE: Does the survey encompass other questions outside of this inquiry?

Ms Fox: No, not that survey.

Mr McARDLE: Could you table all that data in relation to what they got by way of the survey information plus what was on the website?

Ms Fox: Yes.

Mr McARDLE: Was there a direct link between the survey and the website or did they have to go through the process again to access it?

Ms Fox: I am not sure. I would have to take that on notice.

CHAIR: Can I get your opinion, Ms Fox, in taking on the last point of the member for Caloundra? Remove the council idea for a moment. What about where there is limited cost to the consumer in terms of an advisory committee established to take in academics and others? I do not know if you have been following it, but we had a professor from QUT who was well behind the establishment of vaccinations to pharmacists. The make-up of it would be independent but would include some members of academia and other people. Do you think that is something that Health Consumers Queensland would look at, as opposed to a large cost with a formative council as per the QPC report?

Ms Fox: Absolutely. I think anything that brings together various stakeholders, particularly with consumers at the centre, with a shared vision for reform in an economically viable way is always really useful.

CHAIR: For Queensland specifically; I just wanted to get your views on that.

Mr O'ROURKE: Thank you for your report. To expand on that survey—which I am very much looking forward to reading—do we know how many people from rural and remote locations responded to that survey?

Ms Fox: I do have that response. Fifty per cent were urban; about 34 per cent identified as regional; about 12 to 13 rural; and then a small number remote.

Mr O'ROURKE: Does anything stand out from the rural areas that we need to be conscious of in our future considerations about pharmaceutical ownership?

Ms Fox: I think the biggest issue more broadly than just this issue is access to primary health care. We are contacted by members of our network who experience up to two to three weeks wait to get in to see their GP. Access to GP services is vital ideally where you have a relationship with someone who knows you and whom you trust, but in lieu of that people do report their pharmacist as being another trusted source of that information. I was listening to previous speakers and I think the term 'no wrong door' is the important one. No matter which health professional we go to, they recognise their own scope and if it is outside of their scope and there is an issue of concern they refer on to someone appropriate.

Mr McARDLE: Who prepared the survey questions?

Ms Fox: I believe that was me.

Mr McARDLE: Thank you very much.

Ms PEASE: What is your membership base? Do you have members or do people just contact you generally?

Ms Fox: People join our network in many ways. Sometimes they will have attended some training that we have delivered at a hospital or a health service. At other times they will be referred by their state member and they will join our network online. Other times they might have been involved in their own local hospital's community advisory group and they find out about us in that way. We have many people who have known about us ever since our inception 10 years ago.

Ms PEASE: Is it generally people in the health industry who are members of your organisation?

Ms Fox: Consumers and carers form the majority of the members of our network and some are staff, particularly those who engage with consumers in the planning, design and delivery of health services. They are members of our network who receive information on how to do that as well as possible.

Ms PEASE: What sort of training do you provide?

Ms Fox: We deliver general training—the fundamentals of consumer engagement—which we then tailor depending on the health services needs and the consumer's needs. We provide monthly training for Department of Health staff. We also have a graduate certificate in consumer engagement accredited by our sister organisation in Victoria, and we have a range of other courses that we are about to roll out and provide.

Ms PEASE: Who are they delivered to?

Ms Fox: They are delivered to consumers and carers who either are or are interested in sitting in representative roles within the health department or with health services. Those roles would entail being involved in the development of a new model of care or a policy or looking at some safety and quality data—a whole range of activities that are aimed at improving the health system.

Mr HUNT: In your introduction you mentioned advocacy of around 10 years for increased scope of practice for pharmacists. What are the key activities that you think could be added? Could you comment on the GPs' concerns earlier in relation to frequency of visits to GPs et cetera? What are the key activities that you think could be undertaken?

Ms Fox: To clarify my comment around 10 years of advocacy, that was 10 years of Queensland Health having come to us for participation in their activities around expanded scope of practice for all allied health professionals. In particular, in terms of the scope of practice of pharmacists, that includes a whole range of services, some of which are delivered in some areas and some of which are not. Again, greater transparency and accessibility of those services would be fantastic, but they are things from wound management through to a whole range of services—as I listed earlier, weight management, smoking cessation and vaccinations—working to their full scope, really.

Mr HUNT: Do you have any comments to make about GPs' concerns that they have brought forward?

Ms Fox: I spoke to the ideal model of having a known GP, someone who knows you and whom you trust. It is our sense, from members within our network, that a lot of people do not have that kind of access. They might visit a large GP practice where they do not always see the same person and they are reliant on good record keeping to provide that continuity for their care. As I said before, I think it comes back to, at the time, whoever can provide timely advice and appropriate treatment and then referral on if necessary. That is the key thing.

CHAIR: There being no other questions, Ms Fox, thank you very much.

Proceedings suspended from 10.41 am to 11.00 am.

CHAIR: We will resume the public hearing. Before we call up representatives from the Royal Australian College of General Practitioners, I will inform people in the gallery that the committee had a meeting to amend the program for today. We are out of time, but we have representatives here from the Pharmacy Guild of Australia so we have approved an amended timetable. It is unusual, but since we have those people in the room we think it would be beneficial to hear from them. From 12.30 to 1.15 we will invite representatives of the guild to present to the committee and answer any questions that might be raised today.

FLYNN, Mr James, State Manager, Royal Australian College of General Practitioners Queensland

WILLETT, Dr Bruce, Chair, Royal Australian College of General Practitioners Queensland

Dr Willett: My name is Bruce Willett; I am from the Royal Australian College of General Practitioners. We represent GPs across the country. We are primarily an academic college. We are responsible for training GPs, setting standards and curriculums, and maintaining quality in general practice across the country. More latterly, the RACGP has decided to become interested in representing the interests of GPs and our patients more widely in the public arena. We represent some 38,000 GPs across the country and 8,000 GPs within Queensland.

In terms of our submission, mostly we have focused on the extended scope of practice and our concerns with regard to that, particularly in terms of—as was talked about earlier—the conflict of interest that is created in terms of a prescriber being also a dispenser and the lack of a second check function with the prescriber also being the dispenser. It really is not likely to provide a substantial benefit in terms of outcomes for patients.

I note that earlier there were some discussions about the UK and the fact there have been no thorough studies in terms of demonstrating a diminished outcome with pharmacy prescribers. I would point to the fact that the studies have also failed to show any benefit. If anything, they have raised some criticisms about increased cost. On the other hand, there are strong studies showing advantages by having your healthcare needs taken care of at a single location and that that strongly equates to the best outcome for patients. There is abundant evidence of that all around the world. I would turn the discussion around and say that it is really incumbent on those wishing to extend the scope of practice to pharmacy prescribing to demonstrate a clear benefit, and that has not been demonstrated.

The other issue is that there is a likelihood of increased errors with pharmacists prescribing. The record is currently with the general practitioner. My Health Record, as has been pointed out on a number of occasions, is not going to be a substitute for that. The quality of information there is not likely to be sufficient to allow for safe prescribing. I have seen studies which show that upwards of 60 per cent of general practitioners say they will not be using the My Health Record because of concerns with regard to privacy. I think that is a shame because I think it is a very useful tool.

Finally, as the AMA representative said, there is already a strong function within the Therapeutic Goods Administration to control prescriptions and medications, and that is the proper place for those controls to be held. In our opinion, undermining the position of the TGA would not be helpful and would cause confusion.

CHAIR: Do you have any views on the ownership side of things with regard to what the guild is looking at doing in terms of better control? Some people see it as deregulation; some people see it as stronger control of pharmacy ownership. What are your views on the issue of ownership?

Dr Willett: We support the restriction of pharmacy ownership to pharmacists. We believe that there is some reason to perhaps increase the availability of pharmacies in terms of geographic restrictions, although we understand that is a Commonwealth issue. In terms of the restriction of pharmacy ownership to pharmacists, we would support that. It is somewhat strange that you cannot own more than five pharmacies within a state but you can own 30 pharmacies around the country. That seems slightly iniquitous.

CHAIR: You raised the UK model. Whilst you say there are no significant studies to show a decline in health outcomes, there is nothing that says to the contrary either. It has been around for 25 years. It has worked in the UK. I get concerned when I pick up the paper and read that the AMA's position is that Queenslanders will be harmed because of this, yet it has been functioning in the UK for a long, long time. What are your views on that?

Dr Willett: As I said, it is likely to increase costs because of the likely increase in the number of prescriptions that are written. It does open up the possibility of prescribing errors and for patients to be prescribed the same medication twice. You are probably aware that that is an increasing problem as the rollout of generics has occurred. It is very common for me to find that, as pharmacists change the name of the medication they are dispensing, patients will often get confused and take the same medication twice because it has two different names. That sort of error is likely to increase if pharmacists prescribe medications as well and patients are not going back to the doctor to have their medications checked.

I would say that there are a number of theoretical problems with this model in that it fragments care, and we know that that worsens outcomes. There is a likelihood of increased errors because the pharmacist does not know what else has been prescribed elsewhere in hospitals or by other practitioners. The onus of proof should be that there would be an improved outcome, and that is just not available. Quite frankly, the studies have not been conducted well enough to demonstrate one way or the other. When there is a theoretical and real risk of harm that cannot be disproved, there really needs to be a demonstrable benefit.

CHAIR: I am going to put to you the same questions I put to the doctor this morning. On page 1 of your submission you talk about medication misadventure and fragmentation of care. You say—

Between 2-3% of all hospital admissions are estimated to be related to medication misadventure.

You say these are largely preventable and that there is a cost to the health system of $500 million. I agree there is an on-cost. Do you have a breakdown of the figure of two to three per cent for medication misadventure? How did you come up with that number? Are you using data that looks at deliberate misadventure?

Dr Willett: No, that comes from Australian Institute of Health and Welfare studies. No, it does not break those figures down. A lot of it is accidental; some of it will be deliberate. Some of it will be a combination of factors. The point is that I think anything that is likely to increase an already significant problem is not going to be helpful.

CHAIR: Under 'Poor patient health outcomes' on page 2 you state—

There can also be unintended outcomes when a medication for the management of a chronic condition is available over-the counter.

I probably should have put this question to you and not the doctor, because I have mixed both of them up this morning. You were here this morning when I used the example of reliever medications for asthma. Do you think it is a step too far to allow pharmacists to—

Dr Willett: Not at all. I think the question is about urgency. If there is urgency then it is quite reasonable to provide that, and pharmacists already do. They provide nitrolingual sprays for people with angina without prescription in an emergency, but obviously in both cases if you are doing that the patient needs to be referred back to the GP to see why you need that emergency treatment. Something needs to be done to more adequately treat the root cause of both the angina and the asthma, and that patient needs to be reviewed for preventers. The problem is that with the existing arrangement with Ventolin that has not happened. We have seen a deterioration in the control of some of our chronic asthmatic patients because they are simply going to the chemist—

CHAIR: To get reliever medication when they should be on a preventer?

Dr Willett: Exactly.

CHAIR: That is about asthma education and control.

Dr Willett: Exactly. They are telling us that the chemists are not referring them back to us to get their asthma properly treated. That is what the patients say to us. I am sure they are probably saying something different to the pharmacists. The reality is that we have a significant number of asthmatic patients who are not being properly treated because they are able to go to the pharmacist and buy their reliever medications without having a proper asthma plan.

CHAIR: What are your views on vaccination? Should the age be lowered to 16?

Dr Willett: I think it is reasonable for uncomplicated adult patients to be vaccinated in pharmacies. As was said earlier this morning, with younger patients they are often live vaccines so there are a lot more contraindications. There is an increased risk of adverse reaction. It is similarly the case for elderly patients with more complex conditions. I think it is definitely more appropriate if they are vaccinated in a more supportive environment. Also there is the ability to track vaccines. It is very common, particularly for my elderly patients, to get confused about where they are up to in their

vaccination regime. They tell me they have already had their vaccination this year when it was last year or vice versa—not remember and seek a second vaccination when they have already been vaccinated. Again, it is the fragmentation of care that reduces outcomes.

CHAIR: I am not sure how long the vaccination program has been established in Queensland or the number of pharmacies. Those questions can be put to other people. Are you aware of any data that suggests that there has been significant increase in adverse reactions such as allergic reactions or anaphylaxis?

Dr Willett: No, I am not but I do not think it supports the extension of that to more vulnerable patients. It still does not allow for the confusion the patients have about where they are up to with their vaccinations.

Mr HUNT: You mention that you support the laws relating to pharmacy ownership by pharmacists and then outline that you could own multiple pharmacies. Is there any reason you support a pharmacist being the owner of five or six pharmacies?

Dr Willett: Quite frankly, in general practice we have seen corporate models roll out and a more profit driven ethos that tends to go with that. I think clinicians being directly responsible for the way the business is conducted does lead to better outcomes and fewer conflicts of interests. Again, it is consistent with the view that pharmacists should not be prescribing. There should not be a conflict of interest in terms of those pecuniary arrangements. This probably will lead to better outcomes if pharmacists continue to control their pharmacies.

Mr HUNT: An entrepreneurial pharmacist could own—I think we mentioned 30—pharmacies in multiple states. Under the current laws, I cannot glean why that particular entrepreneur needs to be a qualified pharmacist and how that translates to better care and outcomes for patients.

Dr Willett: I agree. I think that is a reasonable concern.

Mr HUNT: You also spoke about the scope of practice causing fragmented care. Some of my questions to the psychiatrists association this morning were around that—a prescription from a psychiatrist, a prescription from a GP and two separate pharmacies. There seems to already be an issue in that area of fragmented care. Would that be a fair statement?

Dr Willett: Absolutely, and it is a problem. I think that is why we do not want to make it worse, and this could substantially make it worse. It is the medical maxim of 'first do no harm'. The fantasy of the My Health Record, as we stated earlier, is that it is going to solve this problem. I do not agree with all of the previous speakers. The reality is that it will not, for the foreseeable future, solve the problem. The hope is that it will solve this problem. The RACGP does support the roll-out of the My Health Record.

CHAIR: Dr Willett, do you support the establishment of a council not just to take some control of ownership but also to have some input in regard to scope of practice? What position do you have on establishing a council in Queensland?

Dr Willett: We support the restrictions of ownership to pharmacists. We do not support the increased scope of practice. The third issue is in terms of accreditation of pharmacists. The RACGP has long instituted a program of accreditation of general practices and we have fairly strict accreditation criteria. It would seem reasonable that pharmacists have those. Whether or not a pharmacy board is necessary to do that, we are unconvinced of the evidence of that.

CHAIR: Other states and territories and jurisdictions have them. I put to you that it seems to work in other areas.

Dr Willett: Just because other states and territories have them does not necessarily mean that it is the right solution. I did note the Queensland Productivity Commission's report, and we take on board that they did not feel that it was necessary. We are unconvinced of that. If we put this in the context of your discussion about the UK experience of pharmacists and that one of the reasons for doing this is that lots of other countries have them, I note that most of the countries that roll this out have separated prescribing pharmacists from dispensing pharmacists which I think is an essential thing to do. It is unconscionable the idea that you should be prescribing and dispensing at the same time. I really think that needs to be off the table. I think there is a limited role for prescribing pharmacists in terms of prescribing within either Queensland Health or other institutions, but they should not be a dispensing pharmacist.

In terms of the global picture, I think one of the things that often gets lost is that the Australian healthcare system is one of the highest performing in the world. We consistently on all parameters perform in the top two or three. One of the things I personally find a little bit difficult is that we look to

things that have not worked or have not been proven to work overseas, and often have been shown to not work overseas, and look to institute them here just because they have been done overseas. Rather than having the experts from America come over and tell us how to do medicine, we probably should be going over there and telling them how to conduct a healthcare system. The same is true of Britain. We outperform Britain in most indices, except cost-effectiveness. That is the one they beat us on, but on most other indices we outperform the British health system.

CHAIR: If you do not support a council in Queensland then, hypothetically, what about an advisory committee where they can, together with members of—God forbid, that everyone would agree, but I think collaboration is key in health care. That is my view: everyone should be working in the best interests of the patient, from the GP to the pharmacist. Do you see an avenue for some kind of advisory council that takes in academia, the medical profession and the Pharmacy Guild to advise and, for better clinical governance, to have oversight of pharmacists in Queensland? You have just said that you think there could be a role for prescribing pharmacists—that there could be some room to expand the scope. We would need some kind of clinical governance or some kind of oversight of that. The department currently only looks at ownership.

Dr Willett: You are asking me to speak off the top of my head rather than to speak on behalf of my organisation. That is not something that we would rule out. It would depend on the details of how that was formed.

Mr BERKMAN: You have been very clear in the discussion so far that you support the ongoing restriction of ownership to pharmacists. I note in your submission that you have outlined that the RACGP's position is that the current rules restrict patient choice, inflate costs, stifle competition and limit potential improvements. It is not necessarily a disconnect, but can you explain the ways in which you think the current rules are outdated?

Dr Willett: Mostly I think it is in terms of the geographical rules—which are not in the remit of this organisation; it is a federal thing. I think there is some room for some relaxation of those geographical rules. There are a lot of young pharmacists who would like to own pharmacies who are struggling to do so. That is the sort of feedback I often hear from pharmacists who are frustrated about that.

Mr BERKMAN: Are there any issues within the state jurisdiction that you think contribute to those sorts of problems?

Dr Willett: I think it can be a problem in areas of really high growth that there is sometimes difficulty to get pharmacies where they need to be.

CHAIR: Deputy Chair, do you have any questions?

Mr McARDLE: No. I am fine.

CHAIR: I think we have unpacked your submission. You have certainly put your position forward. We thank you very much for your contribution and your submission.

GIANNOPOULOS, Mr Peter, Chief Executive Officer, Ramsay Pharmacy

CHAIR: Thank you for being here today and for your submission. Would you like to make an opening statement before questions are asked?

Mr Giannopoulos: I will. Thank you for the opportunity to provide a submission. I am a registered pharmacist. I am also the CEO of Ramsay Pharmacy Group within Ramsay Health Care, as well as being a Ramsay Pharmacy franchisee within an emerging franchise network across the eastern seaboard at the moment.

As a registered pharmacist, I have always felt privileged to service patients and communities who have relied on very valuable services such as community pharmacy. My early career saw me working in Melbourne, working for a proud Queenslander—Rhonda White—within the Terry White group, in a pharmacy that she owned within one of the Melbourne suburbs. My aspirations to own my own business saw me enter into small partnership within a group of four pharmacies within Melbourne. That saw me, within that role as a practising pharmacist, at the coalface of community pharmacy for nearly a decade. For the last 11 years I have been given very diverse opportunities within Ramsay Health Care—a very proud Australian organisation.

The common theme across my personal experiences regardless of my employment status, as an employer or an employee within a small to medium enterprise, is a consistent desire to provide quality services within a primary healthcare setting such as pharmacy. Underpinning the role as a pharmacist, irrespective of that employment, as I say, is trying to build meaningful relationships, trying to provide meaningful services to patients and communities and also making a difference as a contribution.

Ramsay Pharmacy is a wholly owned internal business unit of Ramsay Health Care. Ramsay Health Care was established by the late Paul Ramsay in 1964 and has a proud heritage in the provision of quality healthcare services across Australia. In Queensland, Ramsay Health Care operates 18 hospitals. We have in excess of 2,500 beds and we employ in excess of 10,000 Queenslanders.

In Queensland, we also operate community pharmacies through a franchise network. Since 2007, Ramsay Pharmacy has operated pharmacy services within the private hospitals that it operates. Currently, we operate 36 of those across our diverse network of hospitals. We provide the full suite of continuous pharmacy services and a full suite of professional services across our hospital network. That involves the provision of services to a number of patients.

We employ 350 pharmacists and 307 pharmacy support staff within a network of dispensaries and pharmacy departments within Queensland. In 2017 that saw us coordinate the provision of 40,000 complex chemotherapy doses to patients in need in acute hospital environments. It saw us dispensing in excess of 900,000 prescription medicines within that environment as well. As a group, inclusive of our hospital dispensaries and our community pharmacy network within a franchise structure, 2017 saw us dispensing in excess of three million prescriptions—so a significant contribution to the needs of communities within Queensland.

In 2013, Ramsay Pharmacy or Ramsay Health Care established the franchise network of community pharmacies. As at 30 June 2018, Ramsay Pharmacy has within its franchise network 54 pharmacies across Australia—27 of those are within Queensland trading under Ramsay Pharmacy or Malouf Pharmacies, which was a group acquired by franchisees, independent pharmacists, in December 2017. Ramsay Pharmacy also operates many regional and rural pharmacies in Queensland with geographical footprints that span from Cairns all the way to the Gold Coast, including two 24/7 pharmacies that provide invaluable access to services that are needed by communities.

Each franchise Ramsay community pharmacy is an independently owned pharmacy. It is owned by registered pharmacists in their own right, independently. The Ramsay Pharmacy Group provides, not dissimilar to many established franchises within Australia, a suite of services that are on an opt-in basis by franchisees. The franchisees choose to procure these services on the basis of services that they require to operate those businesses.

Our submission focuses on three key areas. The first is the ownership restrictions. Our view on the ownership restrictions is such that we do not view that they are a necessary requirement to protect consumers and to protect the object of the act. Equally, they are not required to promote affordable medicines and access to affordable medicines within Queensland in particular.

The structure of hospital pharmacies—for example, Ramsay Health Care has operated hospital based pharmacies and dispensaries for 11 years—does not lend itself to one that is known by pharmacists. That structure is such that the pharmacies and dispensaries are operated by Ramsay

Health Care, being the corporate entity. They are operated by those individual hospitals as corporate structures. In the last 11 years there has been no issue in terms of being in a position where the corporate structure, or one which is not owned by pharmacists individually, has undermined the provision of quality services to any of the patients who receive service within those operating environments.

Indeed, there is no basis to which we differentiate pharmacy from other healthcare professionals or healthcare services. For example, pharmacists can own medical practices. The limitations around ownership do not apply when it comes to pathology and radiology, so a pharmacist can own those practices. Hospitals can provide many valuable services that are not necessarily owned by doctors. It is important to note that the ownership structure is not mutually exclusive to the provision of quality services.

At Ramsay Pharmacy we do support a model of partial deregulation—not one where it is open to everyone; one where the model of ownership is limited to those who are fit and proper individuals but those who do not necessarily effectively pose a conflict of interest. We view retailers or operators who sell products that are in contrast to the provision of quality services or health outcomes such as tobacco and alcohol as not necessarily aligned with those parties that we see as fit and proper to be operating pharmacies.

Any removal of ownership restriction should always be subject to overarching principles that the dispensing of medications is undertaken and supervised, as is the case, by registered pharmacists. Underpinning the provision of all those services is the ability of pharmacists—and it is independent or agnostic to them being the owner of the pharmacy but registered pharmacists who are appointed as pharmacists in charge or pharmacists in charge at the time—to provide those services. I think that is what underpins the provision of quality services within a pharmacy environment, independent of being a community pharmacy or one that is operated within a hospital environment.

In terms of the establishment of community pharmacy, our view is that we do not believe it is a necessary requirement to establish a pharmacy council, nor would a pharmacy council improve community outcomes. Queensland Health has shown that it has been able to apply in an impartial way and competently and comprehensively administer the intent of the current regulatory regime. However, should a pharmacy council be established it should have representatives from a broad stakeholder group, not necessarily those who might be perceived to have a conflict of interest.

On the matter of pharmacy transfers—the third point of our submission—transfers of pharmacy ownership within Queensland over the last couple of years have included pharmacies that have been acquired by Ramsay franchisees. All these transfers were in strict accordance with the requirements of the Pharmacy Business Ownership Act 2001, and due diligence and review is undertaken by the department in strict accordance with the requirements of the act. The same process of approvals has also been undertaken in a collaborative way within New South Wales and Victoria over the last few years as our franchise network has expanded as well.

In closing, I would like to say that Ramsay Pharmacy is committed to providing exceptional care and expert advice within our hospital environment but, more importantly, through an expanded primary healthcare network and community pharmacy whilst giving its customers and communities its service and trusted destination for healthcare solutions. Pharmacies are a lot more than just the provision of dispensed medicines; they are healthcare hubs. I think in many ways they are under-utilised as those healthcare hubs.

At the heart of all that Ramsay Pharmacy undertakes is our strong desire to be trusted and reliable pharmacy service providers and to provide services to patients for whom we care, to the medical professions that we support as part of that multidisciplinary team and, more importantly, to the communities that we serve. We look forward to the outcome of the inquiry and I am very open to taking questions.

CHAIR: You are well versed in this particular space and the issues that are before the committee. We thank you for extensively unpacking that submission. You are well qualified. You have been around for a long time and help serve the needs of health care in Queensland. I was not aware of the thousands of beds that Ramsay had.

I will move to the key issues that are before us. You have talked about the make-up of a pharmacy council, if there were a need for one, having different people on that council and having some clinical governance and oversight of expanded scope of practice. On the expanded scope of practice and being a fellow pharmacist, I have two questions. Do you think we should extend that? Did you say you are a practising pharmacist?

Mr Giannopoulos: Yes, I am a registered practising pharmacist.

CHAIR: That might fly in the face of some other submitters such as AMA and others. Can I have your views on that? I think I wrote down that you employ 300 pharmacists.

Mr Giannopoulos: Yes.

CHAIR: Are any of those members of the guild?

Mr Giannopoulos: No, none of them are members of the guild.

CHAIR: I wanted to make sure there was no conflict of interest.

Mr Giannopoulos: No, there isn't. I think there are some who would be willing to be members of the guild but the invitation has not been extended to date.

CHAIR: Where do you see the pharmacist scope of practice going to?

Mr Giannopoulos: What is very clear—and I think pharmacists will endorse this—is that pharmacists are the medication specialists. They are the custodians of medicines. They are very well trained in all matters pertaining to medication. From my perspective, the scope of practice, or any extension to the scope of practice, would need to include aspects that pertain to medication management and optimisation of medication management or outcomes as they relate to patients either in a hospital environment or in a community setting. For example, vaccination programs are one area that pharmacists have actively been involved in. Vaccination programs are great. I think they increase access for patients and communities. From my perspective, I would like to see pharmacists in particular focus on improving their clinical interventions in a way that they clinically provide input as part of that multidisciplinary team.

I think some of the participants in the inquiry have noted that there are some meaningful contributions to be made by pharmacists within a primary healthcare network. GP pharmacists, for example, can make meaningful contributions as part of that. It is important to try to capture some of the prescribing inconsistencies before they occur rather than happening within a community pharmacy setting after the fact. To that end, I think it is very important for pharmacists to be more acutely involved as part of that team. Historically it has been a bit of a turf war between pharmacists and doctors, and we saw some of that come to life earlier today. From my perspective, to optimise patient outcomes and to improve the health and wellbeing of Queenslanders and, more broadly, Australians it is important that both disciplines work closely together. It is not about undermining or trying to push the boundaries around what the areas of scope of practice are. I think it is important we retain what is in the area of competency or what is within a scope of practice for pharmacists and optimise that. I think there are a lot of missed opportunities at the moment.

CHAIR: I agree. Patient care comes to the fore, and I think you have articulated that point very well. Do your pharmacists participate in the vaccination programs?

Mr Giannopoulos: We have a number that do within Queensland, yes.

CHAIR: I turn to minimum qualifications of pharmacists and expanding the role of pharmacy assistants. Does your group do any clinical governance outside of the Pharmacy Board of Australia? How do you do your checks and balances in terms of annual competency and credentialing?

Mr Giannopoulos: One of the benefits that come from an expanded group such as Ramsay Health Care, and one of the services that are offered to not only our franchisees but also our hospital pharmacy business, is being able to leverage off the audits and the governance frameworks that exist within a large organisation such as Ramsay.

We have quite a robust process in place where annual reviews of all our pharmacy staff are undertaken by our human resources team or our people team. They ensure that our pharmacists are within their scope so they do not have any limitations to their registrations, which sometimes can occur. There is a routine audit that occurs, at a minimum annually, to ensure that our pharmacists are registered and that they do not have any practice limitations—for example, they are not limited in their ability to dispense or provide certain medicines on their own due to restrictions on their registration.

Ramsay Health Care also has the Ramsay Training Institute, which is a registered training organisation. Through that we are able to customise the delivery of programs to support not only our pharmacists as part of on-boarding further development programs but also our assistants and retail technicians.

Mr HUNT: I have some questions around the ownership laws and your support for relaxing or removing the current laws. Can you comment on how the current laws are restricting your company and if they were relaxed or removed what your company would look like in the future? How would it move on from that? What would those restrictions look like?

Mr Giannopoulos: The prime example that we refer to is the way we conduct ourselves within our hospital pharmacy environment. We operate 36 hospital based dispensaries and pharmacy departments. They are operated within some of our larger hospital campuses. They provide a wide range of services, save for being able to provide services to patients walking in off the street. They are approved under what is referred to as a section 94 approval under the National Health Act. That allows us to dispense medicines under the PBS to patients who are treated in or at the facility, not walk-ins. The differentiator is the ability to service those patients who walk in off the street. We do everything else beyond that. We consume the PBS in a responsible way. We provide clinical services in a comprehensive manner as part of a diverse, evolved, multidisciplinary healthcare team. We overlay governance frameworks and we overlay auditing requirements that ensure we practise in accordance with the highest possible clinical standards. We support our staff with upskilling and development programs. We provide the opportunity to move people within our hospital network as part of development opportunities, and we are also in a position whereby we can invest infrastructure and technology to support those patient journeys.

What we have found within our environment—one of the catalysts for developing our franchise business—is that there is a distinct disconnect in the transition of care from hospital care, for example within an acute setting of the hospital. There is a gap that occurs when patients are transferred during a hospital admission into the community. Part of that is a result of technology, and I know we have a number of strategies that are trying to address that, but part of that is a collaborative approach across those patient continuums.

That was primarily one of the reasons we looked at franchise development as part of an area of opportunity to support our patients. Where we see the opportunity if the ownership rules were lifted or restrictions were minimised, for example, that allowed some entities that were considered fit to own pharmacies is such that we would be able to provide these services in areas that would otherwise be prohibitive. The economies of scale as a corporate are such that we view a business as an aggregated business so we are able to support what would otherwise be marginal businesses. I think we are flawed in assuming that pharmacies that are owned by pharmacists or corporates, if that was permitted, are not for profit. A pharmacist who owns their pharmacy wants it for profit. It needs to be a viable business for them to be sustainable.

What the relation of these laws would allow is for us to view this business as an aggregated consolidated business, which means that we would be able to have what would be marginal operations in regional areas funded by other more robust businesses in metro areas. We would be able to provide services across our wider network. We operate 70 hospitals across Australia. Many of those are within regional towns and regional locations. If ownership rules were lifted, we would be able to provide services in needed locations within rural and regional towns, so I foresee that.

I would also see an investment in infrastructure and technology that would support those patient journeys. I would also see the overlay—I guess the more considered overlay and probably the more diverse overlay—of processes that support clinical improvement in clinical outcomes.

CHAIR: A couple of hundred submitters have provided detailed submissions. What we found—and I seek your opinion on this—is that most traditional pharmacists and pharmacist organisations want to retain the status quo. Some traditional pharmacists want to tighten the regulation of ownership. It would appear that there are only a couple of independent submitters and discount pharmacies who want a relaxation of it. Where do we find the pendulum swinging? We have to consider this. The bulk of the submissions are pointing towards keeping tighter control and ownership and stopping monopolisation. What do you say to those submitters and those pharmacists?

Mr Giannopoulos: I say that there are very good lobby groups out there that are rallying the submissions and a number of submissions to the inquiry. To that end, I think the reality is there is really no risk of a monopoly. If anything, there are probably monopolies that occur at the moment through aggregation of ownership in many towns where pharmacists group together and they may have structures that effectively keep competitors out of the market.

We are seeing that there is a push to a more structured provision of services. Independent pharmacists do not have the capacity at the moment, given the erosion of margins and remuneration through strategies that are designed to create sustainability that has inadvertently impacted on pharmacists' capacity—when we are looking at pharmacists as individual business owners, not necessarily part of groups, it hampers their ability to reinvest in those businesses. We are finding that there are independent pharmacists out there who have not made any active contributions or investments in their business for many, many years. That does not lend itself to optimising improved community needs and meeting needs and, equally, it does not lend itself to optimising patient outcomes as it relates to medications. Medications are becoming increasingly more complex.

Medication regimes are becoming increasingly more diverse. We have chronic diseases that are being managed by what they call targeted therapies that require a greater level of clinical knowledge. These pharmacists operate as silos; they do not necessarily have the resources to tap into optimising or improving their clinical knowledge.

CHAIR: Respectfully, pharmacists in Townsville have said to me that traditional pharmacy ownership allows them to better interact with their local community. They do not want to necessarily expand to a bigger group; they like to be part of a small community. I am sharing with you the one-on-one—

Mr Giannopoulos: I agree.

CHAIR: They talk about packing Mrs Jones' Webster pack and delivering it to Garbutt—to a local area. I have to take that on board. These are people who have formed part of the healthcare continuum in my city. You did say that maybe they should expand, but I want to put the other side out there.

Mr Giannopoulos: Respectfully, I do acknowledge and appreciate that. We have 5,700 pharmacies in Australia. An aggregated or a consolidated model will not meet all those needs. I think there will always be a need for a niche offering within certain communities that require a certain level of service. Notwithstanding that, I own a pharmacy in Cairns where my staff will deliver medications 25 kilometres away. I have a pharmacy in Cairns where my staff will visit a patient after they have been discharged from the Cairns Private Hospital, which is not too far from that pharmacy that I own. They will travel 25 kilometres to provide services within the home to ensure that Mrs Jones is transitioned during her medication journey. They are not funded. That is not funded by the Commonwealth; that is a cost to the business. I think the ownership structure—or necessarily a pharmacist owning the business—does not necessarily preclude any other ownership structure from being able to provide those services.

CHAIR: A fair comment, thank you very much.

Mr O'ROURKE: I refer to your response to No. 12 about the functions that might be performed by the pharmaceutical council. Through your experience in working across jurisdictions across Australia, if you were to pick the eyes out of what works and what does not work on the ground, what would be the key things you think we should consider into the future, whether it is a pharmaceutical council, within Queensland Health or an expanded role is also required?

Mr Giannopoulos: The most important thing at the moment is that what is required to administer the intent or the object of the act is being delivered in a very considered way by the department. I think if there was a model that you were looking to potentially emulate or look at enhancing particular areas in terms of what is being provided, to that end there is only one, which is the premises registration and some oversight in terms of the provision of services. Everything else is being contemplated as we speak by the department as such in terms of the ownership aspects.

I think it is important to note that the Victorian Pharmacy Authority undertakes its role in a very considered way, as does the Pharmacy Council of New South Wales. They both serve the needs of the industry in those relevant jurisdictions in a very considered, evenly balanced and unbiased manner. If I was to look at potentially modelling on one or two variants—if the council was a preferred option as part of an outcome of the inquiry, I think I would be looking at those jurisdictions. We have had very collaborative engagements with both of them.

Ms PEASE: I am not sure if you were here when we heard from the Royal Australian College of General Practitioners. Dr Willett was commenting on why he believes we need to keep pharmacy ownership in pharmacists' hands. His response to that was because of the change of medical practice ownership going into a corporate structure and the impact that has had on the delivery. Would you like to provide a response to that?

Mr Giannopoulos: Of course. Again, we do not need to look too far in terms of our experience within Ramsay Health Care. The last 11 years have seen Ramsay operate its own pharmacy service within its hospitals under a corporate structure. Our 36 hospital departments and dispensaries operate under a corporate model—not owned by an independent pharmacist; they are owned by the individual hospitals themselves, effectively. They apply for the licence that effectively provides the access to the PBS approvals.

Throughout the 11 years there has been no incident or instance—and I have been employed for that entire time in this business—where there has been any undue influence applied to pharmacists for them to behave in an unethical manner. There has been no undue influence where there has been profit put ahead of patient outcome. On the contrary, actually: we find that we have quite a high demand for compassionate supply. We will often have our hospital CEOs notify our

pharmacies or pharmacists within one of our departments saying that they might have a patient being treated for a cancer, for example. There will be a submission made to pharmacy to effectively fund at no cost a compassionate initiation supply for a very high cost medication that ultimately may end up saving these patients. The structure that we have in particular within our dispensary environment within our hospital network is such that it is viewed as that patient continuum. There are no conflicting priorities around trying to profit from pharmacies as opposed to trying to undermine another part of the business. It is that continuum of care that we refer to constantly in our business that ensures that patients are put at the forefront. The beauty is that we have 11 years of evidence to demonstrate that within our environment.

Ms PEASE: Do you own private medical practices as well?

Mr Giannopoulos: No.

Ms PEASE: With regard to intervening with the provision of medication if needed, how does that work with the scope of practice of pharmacists? Does a doctor get involved in making that decision?

Mr Giannopoulos: Correct. A pharmacy effectively becomes the funder of the medications. The way it usually operates within a hospital environment is with visiting medical officers; they are usually specialists in their fields—not necessarily GPs. GPs will refer to them within the hospital space. It would be the visiting medical officer who would effectively oversee the provision of care for patients in our hospitals.

Ms PEASE: When you say a visiting medical officer, do you mean—

Mr Giannopoulos: They are not an employee of the hospital.

Ms PEASE: They would be an attendant?

Mr Giannopoulos: Correct.

Ms PEASE: In relation to the pharmacists that are operating out of the hospital, are they pharmacists or are they pharmacy technicians?

Mr Giannopoulos: No, they are registered pharmacists. Registered pharmacists need to be involved in the provision of dispensed medicines. They take responsibility. Their name, their licence and their registration are effectively applied each and every time they put their initials to the supply of a particular schedule medicine.

Ms PEASE: You will have to excuse my ignorance here. Do pharmacies that are set up within a hospital have to be registered with Queensland Health as well?

Mr Giannopoulos: The requirements are not such that they require premises registration, no. Within Victoria they are. Within New South Wales they are, yes.

Ms PEASE: When the hospital first started, for example, you just—

Mr Giannopoulos: There was an application made and effectively an application granted for the hospital to operate pharmacy services out of the hospital.

Ms PEASE: It was a corporate structure that got that?

Mr Giannopoulos: Correct. It is usually the owner of the particular hospital. Our largest hospital, Greenslopes Private Hospital in Brisbane, has its own section 94 approved hospital dispensary, which is owned by the hospital.

Mr BERKMAN: I think it is fair to strip it right back and say that a lot of the concerns that have driven this inquiry relate to particular transactions, such as the acquisition of the Malouf Pharmacies by Ramsay group. I am interested in both your perspective and that of the Pharmacy Guild on this. Are there any aspects of that transaction, the franchise arrangements—the whole box and dice—that are unusual or novel, in your view, compared to other more common or more familiar franchising arrangements that exist in the pharmacy space? Do those arrangements in any way challenge the ownership act in ways that require a novel response from the committee?

Mr Giannopoulos: The first thing is probably to dispel what has been inaccurately communicated and has been communicated since nine of our franchisees acquired independently the Malouf group of pharmacies in Queensland. Ramsay has not bought the Malouf group. Ramsay Health Care owns Ramsay Pharmacy, which is a franchisor, and it provides services to nine pharmacists who own 18 pharmacies that were part of the Malouf group effectively. Probably the most important thing is that Ramsay as a corporate does not own, and cannot own under the current regime, pharmacies.

It is pertinent to note that we have not been backward in coming forward around our desire to alter the ownership rules. We think we can optimise and improve the provision of services, as I indicated earlier, around a more corporatised structure, and we have demonstrated that, as I say,

through our hospital network. More importantly, our structure is not dissimilar—if anything, our franchise documentation is very much aligned—to what has been in place for many, many years in Queensland. Terry White chemists, for example, were one of the early pioneers of the franchised pharmacy system—some nearly 30 years ago. Our structure is not dissimilar to that. We provide services to pharmacists on an opt-in basis. We are also the lender of funds. That is probably something that does not necessarily occur routinely within the pharmacy landscape anymore. It used to occur many years ago, but, given the leaner margins within pharmacies and the competitive landscape that it is, that does not as readily occur. Ramsay, being a new entrant into the market in terms of a franchise entrant, is very keen to gain some traction and be able to provide very meaningful services to our patients in our communities. As such, it loans funds to acquire businesses.

Mr BERKMAN: Thank you. That is a very helpful answer. From what you have said—and I do not mean to verbal you here—it sounds like that role of Ramsay as a lender is somewhat unusual in the pharmacy landscape. Does that create any issues around pecuniary control over pharmacies and the ownership regime that is in place at the moment?

Mr Giannopoulos: Absolutely not, it does not. We have every comfort that our structure is compliant with all the regulations and requirements around ownership in particular as they relate to proprietary or pecuniary interest in pharmacies. There is no contravening that in any way. It is an arm's-length funding arrangement. Our franchisees are free to go out and source their own funding if they so choose. Again, it is there as a service that is offered.

Mr McARDLE: My friend from Maiwar raised the issue of ownership, and that has been touched upon in a submission. I want to talk about ownership and control, because they are both equally important. You have spoken a lot about ownership. In relation to the loan that is provided by Ramsay to the relevant pharmacist, in this case Malouf, are you able to table a copy of documentation that details the terms and conditions of such a loan—a blank one—

Mr Giannopoulos: Yes, I can.

Mr McARDLE:—to give us a full indication of exactly what is undertaken by both sides with regard to the funds being provided? In addition, is it a requirement that the pharmacists are obligated to only obtain goods and services from Ramsay?

Mr Giannopoulos: The short answer to that is no. Ramsay Pharmacy, like a lot of franchise systems, makes available, through its ability to leverage off economies of scale, pricing and access to pricing for its franchisee members that give it a more advantageous commercial benefit. There is a greater opportunity to buy a greater volume which in turn means greater buying power for the franchise members. Again, it is not dissimilar to what occurs across many other groups. Ramsay Pharmacy makes those products available to pharmacists. They can opt in to procure them. If they feel they can procure them at a more competitive price, they can do that.

Mr McARDLE: In terms of the hiring and firing of staff, who does that rest with? Is a contract of employment that Ramsay puts together on behalf of the pharmacist or is that independent to the pharmacist? I am trying to gauge the strength of the relationship—that is, in whose favour is it weighted, if I can put it that way.

Mr Giannopoulos: One of the opt-in services that pharmacists can procure is the provision of labour hire services. One of the services that a pharmacist such as myself can procure through Ramsay Pharmacy is the ability to leverage off, again, the network and leverage off the ability to hire employees or staff that support the provision of services across my pharmacies. I as the owner can opt to do that independently or I can opt to leverage off, again, a pool of pharmacists or a pool of support staff across the network to provide those services.

Mr McARDLE: We can go back and forth regarding headings. It might be easier if you can provide the committee—and undertake to do so within a certain set period of time—documentation that you provide to a pharmacist around the loan, around services and around goods and services. Can that be undertaken?

Mr Giannopoulos: Sure.

CHAIR: If you could take that on notice and we will let you know the date when you have to report back.

Mr Giannopoulos: Sure.

Mr McARDLE: I am taking from what I read in the submission that there has been some issue in relation to Queensland Health and Ramsay in relation to a transfer of some sort. Has Ramsay been subject to an inquiry by Queensland Health in relation to a transfer?

Mr Giannopoulos: Not as far as I am aware. The department took some time to approve the Malouf transaction, and that was on fair reason. They took external counsel around all of the documentation and the fact that it does comply with the requirements of the act, it does comply with the current ownership rules and it does comply with all the frameworks that oversee the provision of pharmacy within Queensland. That took some time. It took three months, which is a lot longer than it takes typically, but I think it went through the rigorous process to ensure it met the requirements.

Mr McARDLE: You would say to me that Queensland Health performed their function to a level that they were satisfied that the transfer was in accordance with the terms of the act?

Mr Giannopoulos: I would strongly say that Queensland Health performed the duties that are required to deliver the object of the act and to ensure that the provision of transfer of ownership was undertaken in a manner that met the requirements of the ownership rules.

Mr McARDLE: Whatever you supplied to them with regard to their questions satisfied their curiosity or requirements to say you were complying with the act?

Mr Giannopoulos: Correct. To expand on that, the documents and the advice were given to their external counsel. It was not only administered by members of the department; there was external counsel sought to ensure that the appropriate level of comfort was given to the department around the transaction.

Mr McARDLE: Are you able to indicate what the questions were about that Queensland Health forwarded to you in relation to their queries?

Mr Giannopoulos: I was not directly involved with that particular process in terms of the exchange, but I might be able to take that on notice and see what there was. Notwithstanding that, as I say, it went through a very rigorous process over a three-month period that met the requirements of the department and equally of those independent external counsel that were advising the department.

Mr McARDLE: That would be good if you could take that on notice. That would be excellent.

Mr Giannopoulos: Sure.

CHAIR: Just following on from the deputy chair with that approval process and transaction, what types of documents? What is the process when you approach Queensland Health to say, 'We want to acquire a pharmacy'? What level of documentation do you typically give? Can you speak to that?

Mr Giannopoulos: Sure. There is a suite of franchise documents that support the provision of opt-in services that pharmacists can choose to procure, effectively. There is an application documentation that goes to elaborate on the ownership transaction and then there is supporting documentation that pertains to the franchise itself if there is a requirement to submit any additional information.

Mr McARDLE: So you would propose partial deregulation using the fit and proper person test, if I recall? That would eliminate Coles or Woolworths, I suspect, because they sell alcohol and/or tobacco either on their premises or somewhere else.

Mr Giannopoulos: Correct.

Mr McARDLE: Do you have a concept of what that person would look like? I know it is very difficult. I may not qualify.

Mr Giannopoulos: There is a small subset of what we would consider individuals or entities that probably would not qualify or satisfy the requirements of a fit and proper person. That would essentially be pharmaceutical manufacturers, because they would be conflicted in that they would be incentivised by the provision of product and their profits would be directly proportional to the sale of those products, so they would be exempt from our cohort of who we would consider fit and proper persons; supermarkets, because tobacco and alcohol are at direct odds to optimising health outcomes of not only Queenslanders but nationally in terms of the objectives around improved health outcomes in general; and GPs or doctors who are able to prescribe are those that we would also preclude, for the same reason that the AMA earlier indicated that they felt pharmacists should not be able to prescribe themselves.

Mr McARDLE: Thank you very much.

CHAIR: As there are no further questions, Mr Giannopoulos, thank you very much for your contribution today.

Mr Giannopoulos: Thank you. I appreciate the opportunity.

SCLAVOS, Dr Kos, Vice-President, Queensland Branch, Pharmacy Guild of Australia

TWOMEY, Adjunct Associate Professor Trent, President, Queensland Branch, Pharmacy Guild of Australia

WATSON, Ms Fiona, Committee Member, Queensland Branch, Pharmacy Guild of Australia

CHAIR: We welcome your contribution here this morning. As we indicated earlier, we met to talk about a procedural issue of allowing a balance to respond to issues raised in today's hearing and, given the fact that you are here and have travelled, we have allowed that as a committee procedure. Would you like to start with an opening statement perhaps to take on some of the issues raised by previous submitters before we go to questions?

Prof. Twomey: Sure. Thank you for that, Chair. I would like to start by acknowledging the traditional owners of the land on which we meet, and the guild and I would like to personally pay our respects to their elders past, present and emerging and acknowledge that Queensland is the only state blessed to have our two traditional owners.

I have sat in both of these sessions as an observer and I have to say that I genuinely feel that the committee members know their local community pharmacist and support their local community pharmacist. I would like to thank you for taking on the role of reviewing these two different aspects, and I will talk to the two different aspects. I will keep my opening remarks brief because this ability for us to give evidence was on short notice and I would like to defer our official submission to the one that I will be giving in Cairns.

CHAIR: Just to clarify, we are not talking to your submission, per se. We will allow that for Cairns. This is to respond to any questions.

Prof. Twomey: That is fine. There is the Pharmacy Business Ownership Act and then there is scope of practice, and I will talk to the Pharmacy Business Ownership Act in the first instance. The concept of pharmacist owned pharmacies is not something that was in the terms of reference as originally introduced into the Queensland parliament on the advice of the minister. We would like to say that the concept of pharmacist owned pharmacies is something that enjoys bipartisan support not just in the state of Queensland but in every state and territory in fact and at the Commonwealth level. We enjoy the support of this by the Australian Labor Party in Queensland, by the Liberal National Party in Queensland but also by minor parties such as the Australian Greens at the national and Queensland level and also with Pauline Hanson's One Nation and Katter's Australian Party. We do that from a privileged position as an approved pharmacist under Medicare Australia, and in fact my two colleagues here are that as well. I am an approved pharmacist to dispense subsidised medicines on behalf of the Commonwealth of Australia, but I am also registered under the Australian health practitioners regulation framework to provide pharmaceutical services, and I do that for the benefit of the public.

The Pharmacy Business Ownership Act, which restricts pharmacist owned pharmacies or pharmacies being owned by pharmacists, does so in the public benefit—not to benefit me, not to benefit the guild, not to benefit my colleagues but to ensure the high level of quality service not just to all of Australia through the 5,700 pharmacies in Australia but to all Queenslanders through the 1,140 pharmacies in the state of Queensland.

Page 32 of the guild's submission refers to why there is a need for the establishment of a pharmacy council in Queensland and it goes to two important elements. The first element is the fact that the Pharmacy Business Ownership Act in Queensland restricts only pharmacists from having a proprietary interest in a community pharmacy—that is, who owns it, which I suppose goes to some of the questioning that I have been hearing over the past two days. The other, though, is on pecuniary interest, and some interstate legislations specifically outline both of those, so a pecuniary interest and a proprietary interest.

I am not a lawyer and I would like to say that the guild has put a request in for our specific legal counsel and our specific accounting counsel to be provided with the opportunity to give evidence to the committee. We would hope that that invitation is extended to those two particular subject matter experts, because it is best that you hear directly from a lawyer who specialises in this aspect and an accountant who specialises in this aspect who can talk with greater authority than I about where both pecuniary and proprietary interests lie in particular franchise models but also how both pharmacists

and non-pharmacists—whether they be incorporated entities or other natural persons—can gain either a proprietary or a pecuniary interest in a pharmacy by using clever accounting principles to get around those.

The second aspect of the Pharmacy Business Ownership Act and why we believe that there should be the establishment of a pharmacy council in Queensland, or by whatever name that you choose, rather than this being administered by Queensland Health, is the public interest policy map. I am not going to go into details on that, but it is outlined on page 32 of our submission, which says that it is at odds that Queensland Health can be both the regulator or the judge and the jury in this and there needs to be some form of separation. In fact, it goes into some detail of saying how two of the four key threshold issues which are required to be passed in order for a decision to be made on whether or not there is an independent entity of some particular nature have in fact been addressed.

On scope, I think I should just say that I get along really well with my local GP and I really hope that she gets along really well with me. I am sure my two colleagues here can give you a list of examples, as Karen from TerryWhite Chemmart on the first day also gave. When it comes to scope—and I am talking now specifically to pharmacists as opposed to pharmacy assistants—I think we need to differentiate—and no speaker to date has been able to do so—between what is currently within our scope but is forbidden because of some form of anomaly in state government acts or state government regulations and what is not within our scope that may be both of interest to consumers in Queensland to access from a community pharmacy and of interest to community pharmacists being able to provide, and those two things are very different.

There are things that are already within my scope. I already have the skills and knowledge to be able to perform very specific tasks, and those tasks can be put together to help me achieve the role that it is to be a community pharmacist. Unfortunately, I cannot practise to the full scope of my current practice, even though I have the skills and the knowledge to perform those tasks, because there is a degree of anomaly that currently exists in Queensland government regulation that prevents me from doing that. I think the best example is medication continuance. This is not me prescribing. This is not me as a community pharmacist diagnosing and initiating treatment. This is me simply saying, 'The GP says you should be on this and you've run out of the bit of paper that says that I can give it to you.' That is called medication continuance. We heard one of my colleagues from one of the medical groups say that the first rule is to do no harm, and we agree with that, but sometimes 'do no harm' is making sure the person stays on their medication rather than making sure that that person goes without. They are two very different things: what is currently within the scope of practice and what are those new things that we can do?

CHAIR: Trent, thank you very much for that. Sorry to interrupt you, but how long for that continuation of medication? Do you think there should be a restriction of, say, Mrs Jones running out of a certain medication? Should there be a time limit and some kind of collaboration back to the GP or some form of communication to say, 'She's run out. We've extended her script for a month,' or whatever it is? Do you think there should be something else that binds that transaction?

Prof. Twomey: Absolutely. My very enthusiastic deputy president said that, with your indulgence, he would love to be able to answer that question.

Dr Sclavos: I think the main thing is to make sure that there is an audit trail. First of all, we have a quality assurance system in pharmacy and we have pharmacy software. An audit trail is critical. If somebody comes into a myPharmacy on a Sunday—it is open on a Sunday—and they need another month of therapy because they have run out, at the moment our concern is that there is an emergency provision, which is three days supply, but almost every medicine now has security seals on it. No consumer wants to have the subsequent supply when the seal has been broken. Currently, many pharmacists do not provide emergency supply provision of three days. They may be sent for. For example, from my CBD pharmacy I have a Mater emergency priority. I am hundreds of dollars out of pocket. There is no bulk-billing doctor in the CBD of Brisbane on a Sunday. There are audit trails and there is pharmacy software. This is not something that we have to invent. These are existing protocols in place. There is training. For example, at the university level you would start by training the pharmacist on whatever the scope of practice is.

I will give you a personal example. I am on the board of Epilepsy Queensland. We have heard people even today say that they represent consumers. There is no more serious medication than epilepsy medication. For someone to come into my pharmacy and not have continuous supply, that can directly lead to a seizure.

CHAIR: This is medication such as Epilim?

Dr Sclavos: Absolutely. A pharmacist can continue a one-month full pack, so the pharmacist is not compromising that supply and the person continues their therapy. The pharmacist notates a record of that. If the best-practice protocol was to send an automatic report back to the doctor or the electronic health record, those are logical steps.

CHAIR: I think that is a very good example, the epileptic patient.

Dr Sclavos: People would say that was a serious medication. We are not proposing anything where it puts the pharmacist in a position of moral hazard.

CHAIR: What other medications do you consider should be on that list for continuation of medication?

Dr Sclavos: A lot of chronic therapy medication should be on it, apart from those medications where there are questions of misuse.

CHAIR: Such as?

Dr Sclavos: Pain therapy. We would not put any form of pain therapy or even antibiotics now, given Australia's significant moves for antibiotic resistance, even if somebody ran out of antibiotics. It is just like vaccinations. We first established vaccinations in Queensland. We were the first state. We showed there were no concerns. Every doctor group was jumping up and down as if Queenslanders would be falling over. No concerns were raised. There have been no adverse events, as in the question earlier today, from that program. It has been expanded.

The same thing could happen with an incremental step whereby pharmacists continue therapy with many chronic therapy conditions, whether it is cardiovascular disease, cholesterol medications, diabetes—serious medications that in the wrong hands could do a lot of damage. However, for patients who understand these medications and because their conditions are long, it is critical that a pharmacist is able to continue the therapy. At the moment, if we are talking about access and out-of-pockets, those patients cannot get to a doctor quick enough and those patients do not have the funds to pay what we call an ad hoc visit to comply with some administrative error.

CHAIR: I want to clarify the list of medications. Could you take it on notice to provide the committee with what you think should and should not be on that list? To go further, you may have been in the room today when I spoke of the asthmatic or the patient who presents with chest pain. Do the emergency provisions for three days relate to the reliever medication I was talking about, be it Ventolin or GTN nitrate spray? I want to break it down. People should be able to access affordable health care on a Sunday afternoon. You give a good example of someone walking through the mall and having a sudden onset, because of pollen or whatever, who just needs a reliever.

Dr Sclavos: I think it is important, because this is about moving with where the health system is going. There are some asthma therapies that are combination. The same unit, the same device, is both the reliever and the ongoing therapy. That is a great example of how things have got out of hand. The legislation has not caught up with the reality of asthma therapy. Sure, I heard earlier about the examples of Ventolin and the other. There are medications now that do both. In fact, without mentioning proprietary names, that is the No. 1 asthma drug in terms of PBS. At the moment, we would not be allowed to give that therapy because that is a prescription-only medicine. If it has already been initiated by a doctor—so it is not a pharmacist initiating that therapy—and somebody says, 'I am out of my medication. Can I have another one?,' I do not understand the risk. There is no moral hazard and the pharmacist is not being opportunistic in terms of giving that therapy. However, with devices there is no such thing as a three-day supply; it is either the full pack or no pack. Does that make sense?

CHAIR: I understand you. As I indicated earlier publicly, in my previous role in the Ambulance Service I attended people because they had run out of medication. There is an on-cost to Queensland Health. The Queensland ambulance had some one million interactions with Queenslanders last year. We can speak about ambulance officers having to attend patients because they have run out of medication and the on-cost of transporting them to the emergency department. We need to consider that going forward. There are some simple relieving medications where you would not put an impost on the health service in Queensland. At the same time, when a pharmacist sees those people, if there are existing corridors of information and information sharing with regard to emergency provisions or the continuation of medication, I think that is a step in the right direction. That is just my opinion. I would welcome the list of medications.

Prof. Twomey: Can I talk to that, Chair? I refer to the Alberta Pharmacists' Association submission. I am sorry I do not have it immediately in front of me. It specifically outlines the exemptions. I should say here that the guild would caution saying that pharmacists can ensure medication continuance for these particular subsets. It should be the opposite: pharmacists can

ensure medication continuance except for these subsets. I do apologise that I do not have the submission in front of me and the scheduling system is different in Canada, New Zealand and United Kingdom to Australia and, indeed, Queensland. From memory, the exemptions are narcotics, sedatives and psychotropics. Other than those, with everything else a pharmacist can ensure that there is medication continuance, as per the original prescriber's intent.

CHAIR: The AMA might contest differently when it comes to cardiovascular, warfarin levels—

Prof. Twomey: I have no doubt.

CHAIR:—where people need blood tests. What are your thoughts on that?

Prof. Twomey: This is where it comes down to the systems and processes through which this happens. Clinical guidelines are set by clinicians in multidisciplinary teams and are endorsed by the relevant authorities. There are clinical guidelines. The Australian Therapeutic Guidelines, not to put too fine a point on it, have input from all of the different carers and they are signed off by all of those peak bodies. Regardless of who provides that care, it is the same clinical guidelines that are followed: if this happens, you do this; after that, you do this; here is first line, here is second line, here is third line. Adjusting warfarin dosing, as per someone's INR, is an exact science based off a one-page matrix. I do this every week in my pharmacies. I have patients that have packed dose administration aids or Webster-paks, as I think someone referred to it today. They have to get weekly blood tests.

More often than not in practice, I have to tell you, the pathology results go to the pharmacy and the GP at the same time. It can take several hours for the general practitioner to have a look at that. In the meantime, we have already packed it as per the INR results, because it is a simple matrix. We just have to wait until the general practitioner sees it to hand it out. Either way, it is consistent with the Australian Therapeutic Guidelines.

Dr Sclavos: The warfarin is a good example. There is no other drug that has saved more lives, but also there is no other drug that has put more lives at risk. Traditionally in a pharmacy a person may have a one-milligram supply, a two-milligram supply or a five-milligram supply. What we are proposing, even on warfarin, is that continuation of therapy. For example, say somebody runs out of their one-milligram supply. They usually keep one- and five-milligram supplies, but the blood test says they need to go to four milligrams. We then have a bizarre situation where people are trying to cut four-fifths of a tablet. That is a real-life example I can quote you. The pharmacist is not able to give whatever strength makes up the prescribed amount, which varies on a drug like warfarin. Warfarin is a very good example, because on warfarin there definitely should be medication continuance. Generally, the person will have all three strengths of the warfarin therapy, so they can work out it is seven milligrams this week, two milligrams this week—whatever the milligram is.

CHAIR: For the benefit of people watching, can you explain about warfarin? My memory is that INR stands for international normalised ratio.

Prof. Twomey: Warfarin is a blood thinner.

CHAIR: Thank you very much. I will open up for other questions.

Mr BERKMAN: Thank you for being here, especially to give such impromptu evidence. You would have heard my question to Mr Giannopoulos about the particular transactions that are at the core of this. What is the guild's position? You have mentioned Ramsay Health specifically in the submission, although we are not going to that today. Why does that pose particular concerns in the guild's mind?

Prof. Twomey: I will answer that question by addressing the systems and processes through which the Pharmacy Business Ownership Act is currently being administered and why the guild is of the firm belief that the systems and processes are deficient. I should say at the outset that we do not believe—and we are walking a fine line here—that our friends in the department have intentionally maladministered an act. That is not what we are saying. We are saying that the resources that have been allocated to the implementation and oversight of the Pharmacy Business Ownership Act—resources being not just finance but also people, systems and processes to ensure that there is enough drilling down of the evidence that is being provided and enough questions being asked about whether or not, at face value, these transactions, whilst they may appear to be consistent with the act, in fact, if we peeled back the various layers, are not.

It goes to the heart of what I said in my opening statement: where does pecuniary and proprietary interest lie? Though it might have my name on the door, where do the funds go? If the pharmacy made a loss in the month of July, do I have to cover that loss if I am part of this particular franchise or do I just receive my annual salary and my monthly stipend and someone else covers the loss? Conversely, the opposite may be true: if the pharmacy makes a profit in that particular month, do I continue to receive my regular salary or do I get a percentage of the profits?

As I said in my introductory comments as well, the guild holds concerns that in the state of Queensland creative accounting mechanisms are being used by a variety of—and I use the term loosely—franchisees that are shielding from the authority, from Queensland Health, where the true pecuniary and/or proprietary interest lies. As I addressed before, because of the public interest policy map test, we need an independent body to say, 'Hang on. Something does not quite smell right here. I want more information,' and continually probe until they are satisfied that all aspects of the act, at a pecuniary and a proprietary level, have been satisfied. We simply do not believe that that is the case with the current structure.

Ms Watson: Can I add to that, please. My role on the guild is a very new role for me. I have been a community pharmacist for more than 15 years. If I am a member of a franchise group and I get cranky with something that is going on, I can go to them and say, 'I am not happy about this,' and if we cannot come to an agreement then I can leave. If I have borrowed money from them, I do not see how that independence still exists.

We have talked before about franchisees and the difference between the different franchisee groups in Queensland. I think it is really important that you understand or see from a franchise's perspective why so many independent pharmacists in Australia are upset about what is happening, and it is that autonomy. As an independent pharmacy owner, I have the autonomy to say to my franchisor, 'I am sorry, but I disagree with what you are asking me to do,' and I have the choice to leave and go to another franchisor who is offering me something different or I can choose to be independent.

Dr Sclavos: I saw the questions and the offer of Ramsay to get back to you. The key question should have been: can you submit all documents that franchisees sign as part of your franchise agreement? To be honest, as a past national president I get a lot of people approaching me making a lot of accusations and complaints. I thought, 'There is a lot of speculation and talk about Ramsay buying Malouf. I will go and visit those pharmacies.' As Kos Sclavos citizen, I walk into one of those pharmacies and I ask, 'Who is the owner here?' They name the owner. I say, 'Have you ever met the owner?' The staff at a Ramsay Malouf pharmacy say, 'I have never met the owner.' I am thinking to myself, 'Something does not smell right here, if they have never met the owner. How is this person really exuding control?' As a pharmacist, our priority is whether the professional conduct of the pharmacy is occurring.

From a market perspective, normally if there are businesses selling—there are lots of pharmacy brokers; there are pharmacies-listed-for-sale sites. There has never been a Ramsay franchise for a franchisee to buy a business. I am not a legal expert, but in other states there is a merit based board—and we should stress that this is not colleagues judging—where there is legal expertise, there is consumer expertise for consumer interests and there are pharmacists ascertaining the structure, ascertaining the issues of control and ascertaining whether this is just decoration to get around the act.

I think you asked the key question. You asked what novel instruments there are. There was one offered on loan, but five minutes later we found out about the labour hire services. That is critical. Am I employing the pharmacist or is somebody else employing the pharmacist? As an owner, if I want to discipline my staff for doing something unprofessionally, can I do that if I do not employ them? These are important questions. With the greatest respect, there is just no chance that a Queensland Health employee understands the full infrastructure of community pharmacies. That is why in other states where they have applied, for example Western Australia, they have not been approved. While Mr Giannopoulos offered the New South Wales and Victoria example, one has to ask why they have not opened up in Western Australia. They are the facts that go fundamentally to why we are saying we need this.

In relation to the cost to Queenslanders from the Consumers Health Forum, we are happy. The pharmacists pay fees in those states. We would expect the pharmacists to pay fees here for these services. We are not being a burden on Queenslanders for the establishment of this authority. Good health practice now in 2018 is that that authority could make public information on which pharmacies vaccinate and which pharmacies have specialised services.

One of my areas of expertise at the moment is medicinal cannabis. Because of the expense and cost, there is just no way any consumer knows which pharmacy is happy to facilitate supply of medicinal cannabis and which one is not. I can tell you I am embarrassed by that, because in epilepsy—I am on the board of Epilepsy Queensland—it is a significant issue. Many consumers want to know who can help them access medicinal cannabis. There are lots of benefits with an authority.

There is a lot of public interest in the role that authority could play. Especially on the issue of control and making sure that a pharmacy is operating according to the act, we think that authority is necessary.

Prof. Twomey: I should just add that it is the nuance. I think this goes to the questions the deputy chair asked of Consumers Health—that is, the response you get depends on how you ask the question. 'What documents are you requiring your franchisees to sign?' 'They are not required to sign any of them.' 'Well, what ones are they able to sign?' 'You do not have to get finance from me, but also you do not have to give me power of attorney to have control over your business.' 'You do not have to use my services at all, but I will not give you finance if you do not use my services.' 'What range of services do you offer? What range of services is a potential franchisee able to take benefit from?' When you read all of these together, each one of them individually may seem like they are an opt-in service but, in fact, unless you take all of them you are not allowed to participate.

Mr BERKMAN: Thank you very much for your comprehensive answers. I do not mean to chew up too much time here, but a lot of the response has been about compliance with the act specifically. I am interested to try to get you to step beyond that. Can you help the committee with what evidence there is, if any, of a detrimental community outcome as a consequence of any alleged breach or potential noncompliance with the act?

Prof. Twomey: There are two particular points there. The subject matter experts who are best placed to address that are the legal counsel and the accounting counsel who we are hoping that you accept the invitation to hear from. They are the subject matter experts. I just cannot see how somebody who, with the greatest respect, is looking from outside our profession in can make an informed decision without hearing from those two people because we are talking about finance, we are talking about legal and we are talking about accounting so you would want to hear from someone who specialises in those areas.

In terms of front-line detrimental impacts to the consumer, I have to say that the best answer that I have heard so far in sitting in on these two days is the one that you heard from Fiona. It is that control. She is an independent community pharmacy owner. If she cannot practise independently, how can the consumers who walk into her pharmacy have confidence that she can deliver the quality use of medicines that is required? A medicine, a drug by another name, is not a normal item of commerce. A fit and proper person test is fine if you are BHP Billiton and drilling oil or bauxite out of the ground, but a drug is not a normal item of commerce.

Ms Watson: I think it is also important to understand the consequences to me of misadventure. If I do something inappropriate, I lose my registration as a pharmacist and I have to sell my business. I have worked in the UK, and the corporate structure over there is phenomenal—as are the consequences to the pharmacists. The pharmacy board have literally said, 'I am disbarring you as a pharmacist. I know that the only reason you did that action was to get your corporate employer off your back, but, I am sorry, you did the wrong thing. You have got to go.' There is no consequence to the corporate employer. The corporate employer continues to say, 'You have a target to meet and you need to meet it regardless, because I would really like those NHS funds in my bank, thanks very much.' The cost to the consumer as a taxpayer is phenomenal because you oversupply. You literally have photos of the managers writing on the board, 'Dear locums, three MURs a day or no shifts.'

CHAIR: What is an MUR?

Ms Watson: It is a medication review. You get paid by the government, the same as you do here, to review someone's medicine. I am an independent pharmacist and I want to do the best by my consumer so I pick somebody who needs that service. They are time consuming. They are complicated. They are on complex medications. They have lots of issues. They have side effects. They are on this medication because of the side effect from another one. I am going to spend time to do it right. I am going to send the doctor a letter and I am going to get my reimbursement from the government. If I am required by my employer to meet three a day, I do not have that time. You have come in: 'You are on a painkiller. Let us just do a quick MUR. Are you getting constipation? Excellent! Done! Thanks very much.' But that is not a valuable way of spending that taxpayer dollar.

Prof. Twomey: I can give you a specific example as well, Chair. I have the distinct privilege of serving on the World Pharmacy Council, which is the guilds of all of those other developed countries. I was hearing from the CEO from the National Community Pharmacists Association in America in Canada four days ago and he was talking about the quality assurance measures that are being imposed on his independent members. This is medication compliance: 'Is my patient taking the medication when they need to take it?' That sounds like a good thing, doesn't it? 'What other outcomes can I measure?'

The result of these corporates pushing down these quality assurance mechanisms to the front-line health practitioner is that it simply forces out those people who are going to drag down their ratio. If I am provided with that in my pharmacies in Far North Queensland and I have to meet the key performance indicators that are given to me by that corporate hanging over me, the patients who are going to be pushed out are those who are most needy, those who are really struggling because of low socio-economic status, those of Indigenous or Torres Strait Islander descent, those who are below the bell curve. If the only way I can meet that overarching and higher bar is to squeeze out those people who are dragging my averages down—well, I have to say that is not a system that I think Queenslanders would want.

Dr Sclavos: I do not want to get too emotional, but I have lived in the US for a while. I lost a child who was 11 years old to leukaemia. We went to New York to try to save his life. I found it abhorrent—that is why I am so passionate about this topic—that there were many pharmacies there but, because some medicines needed a high level of care, a pharmacy did not want to dispense and nor was there any obligation on them to. This is the corporate model in the US. I was living in Manhattan, the most densely populated part of the planet, and yet I had to go to four different pharmacies to access a sick child's medications. In Australia, where the onus is on the ownership of the pharmacy by a pharmacist, if I do not do something that is in the best professional interests of the patient then it is on me and I am in trouble, whereas in the US and other markets they can pick and choose. Dealing with needle and syringe, dealing with methadone: 'That is a bit difficult. I don't like those customers. We will not deal with them here. Let them go to another independent pharmacy who has survived. Let's not worry about that corporate.'

What we are talking about here in Queensland, the most decentralised state, is that you do not want to create an instrument or a model, because once the damage is done you cannot undo it. At the moment across Queensland, pharmacists have obligations to do methadone, to do needle and syringe, to do a whole bunch of other services where, because it is the owner who is in charge of the pharmacist, no-one can tell me at corporate office, 'We don't want those people on methadone in this pharmacy.' There are a lot of structures that we have seen firsthand—and I have lived it in the US—where the ownership and control of a pharmacy directly relates to the care of the patient.

To answer the earlier question, unfortunately you people are just too nice. There are a lot of nasty people out there. All I have to do is employ my cousin and then I will have a structure where I have control. If it is a doctor and they are not allowed to own a pharmacy, they can put their wife in to own the pharmacy if you want to deregulate the model. Unfortunately, there are a lot of people out there who employ very smart lawyers and accountants. That is why we want them to appear before this committee. You set the rules and they will come up with a way to get around the rules. Unfortunately in Queensland, people are getting around the rules.

CHAIR: Kos, we will move on. The matter of listening to lawyers at your request will be for the committee to deliberate upon. There has been some correspondence in your submission. We will get back to you on that. Have you read the Queensland Productivity Commission report? There are some conclusions in there about the costs of establishing a council: $7.7 million over 10 years—or 11, depending on the model. What are your thoughts on that?

Prof. Twomey: We met—I am sure it was declared in the report, but I am sorry I do not have it in front of me—with the Queensland Productivity Commission to give our views on the cost-benefit. It is the second part of it; it is not the cost that we want to focus on. We are not asking Queenslanders to bear one dollar of the cost of this. Our members want to bear the cost of this because it is the benefit of it which is not something that we believe the Queensland Productivity Commission's report went into detail on. They focused on the cost. It is not the cost that is an issue. We are taking that off the table because we believe a pharmacy council in Queensland by whatever name should be by cost recovery from the 1,140 pharmacies in Queensland.

The benefit of it, we have no doubt, stands on its own two feet. Kos has gone through a variety of those. It is not only to make sure that pharmacies in the state of Queensland comply with the Pharmacy Business Ownership Act; it is also to provide a register of products and services, whether it be opioid replacement, whether it be medicinal cannabis, whether it be pharmacist vaccinations, which currently does not exist. A consumer in Queensland cannot google 'where is the closest pharmacy that provides this particular service?'—just like they cannot with general practices, because not all general practices are the same.

You might ask, 'Well, can this be done by Queensland Health in its own right or can this be done by some form of advisory committee or an independent body?' Well, no, it cannot. Chair, you are a healthcare professional. The very definition of a professional is that we are self-regulated and self-governed, albeit under a national framework. We self-regulate. Just because I can do something

does not mean I do. If you are asking Queensland pharmacies to pay a fee, then we want it to be to an independent statutory body. If you are asking Queensland pharmacies to practise to the full extent of their scope to be able to meet the health needs of Queenslanders in an ever-tightening fiscal environment and an ever-increasing environment of consumer expectations, then we stand here before you wanting to help and, in fact, are willing to help. We just want to make sure that as a healthcare profession, like the paramedic profession, there is a degree of self-regulation and self-autonomy, albeit with an independent chair, consumer representatives and other healthcare representatives on that board.

Dr Sclavos: Importantly, we cannot be the health minister for a day. When we look at legislation, I actually do pretend and I put on the health minister's hat and look at the issues.

Prof. Twomey: We would love to.

Dr Sclavos: I would love to, yes. One of the issues is: if it is an independent body that is making that decision, it protects political games and it protects the minister, saying, 'Is this an important issue for the people of Queensland to have access to?' At the end of the day, whether it is a pharmacist's scope of practice, I do not think it is fair on the minister of the day getting advice from the department on what that should be. It should be an independent committee, with doctors and others saying, 'Yes, this is a scope of practice that a pharmacist should undertake'—and we have not spoken at all so far about pharmacy assistants—and saying, 'Yes, it is okay for a pharmacy assistant to record information that adds to the electronic health record,' or supports NDIS applications or other issues such as that. At the moment I think we should be removing the political pressure from the health minister of the day being able to be lobbied by groups like us and anyone else. By taking it to this independent authority, there are multiple tasks where we depoliticise the process and ensure that Queenslanders are getting the best outcome because that is the best outcome for the patient, not because someone is able to exert more political pressure.

Prof. Twomey: We fully support the national registration of health practitioners for all of the reasons the previous Rudd government did that. It ensured mobility of a workforce around the Commonwealth. I remember I was transferring from Queensland to New South Wales, specifically Newcastle, at the time and it was before that and it was an absolute nightmare to get registered. The guild does not believe there is an overlap between a proposed pharmacy council in Queensland and the authority, roles and responsibilities of the Pharmacy Board of Australia under an AHPRA process. They are complementary. The purpose of it is to remove from within the department those functions it currently has into an independent statutory body.

CHAIR: Just to clarify, I hung up the stethoscope some months ago. After 28 years I think I have done my bit.

Prof. Twomey: Congratulations.

Ms PEASE: You might have been in the room earlier when the AMA president talked about non-prescribing pharmacists operating out of medical practices. They also talked about the 20 home checks. Could you elaborate on that to give some clarity for me, please?

Prof. Twomey: I might make an opening remark and then hand to my committee member to answer that question. I should correct something: the Home Medicines Review cap is 20 per practitioner per month, not 20 per year. I think the previous medical professional got a bit tongue tied in that. I would love it to be higher. Who wouldn't? There needs to be more money and there simply is not. We should just say that from the outset.

A well-renowned Queensland pharmacist whose name escapes me—I am happy to give it to you offline—said, 'You can't have the quality use of medicines without medicines.' I am a dispensing pharmacist. I dispense a medicine to a consumer. Dispensing is more than just supply. The supply is if I went and bought something from Coles, Woolworths or a supermarket and I just got that particular product. Dispensing is the clinical function of making sure they provide that in a safe and efficacious way to achieve the outcomes originally intended by the prescriber. That is dispensing.

I cannot outsource or abdicate my responsibility as a dispensing pharmacist to another pharmacist that happens to be in another building doing the review and just say, 'That person did the review so all I need to do now is hand it out.' It is my responsibility. I cannot abdicate it. If I hand out that drug to that consumer, I cannot divorce my medicolegal responsibility for that. To answer your question more specifically, if it is okay with you, Mr Chair, I would ask Fiona.

Ms Watson: What he was talking about is the HMR, which is where the pharmacist goes out to the consumer at home, gets all their medication out of the box, takes away all the out-of-date product, has a good review, writes a letter to the doctor and involves the community pharmacy in that

communication. If the pharmacist has said to the doctor, 'I don't believe we need medication X because the patient hasn't had reflux for the past 10 years but they're still on a really high dose,' the community pharmacist knows that that is what the recommendation is. If potentially it has not happened in a month or so they can say to the doctor, 'Did you get that letter? Have you seen that we have done the review?' The community pharmacist is a really important part of that transaction because they are the second check.

Dr Sclavos: And the doctor gets remunerated to respond. People say, 'Doctors are busy.' They get remunerated under that program to also review the pharmacist report.

Ms Watson: The doctors are not capped, are they?

Dr Sclavos: No.

Ms Watson: The cap is on the pharmacist provider. It is not even on the pharmacy. As a pharmacy I can say to the doctor, 'My person A has hit their 20 cap but my person B who is also an accredited pharmacist and who is very good has not hit their cap, so if you want to do 30 that month that is no drama.' My GPs unfortunately do not quite hit that 30 a month, but I would really love to be able to do that because then I know that (a) I have got rid of a whole lot of medication that that person does not need at home and (b) it has improved their communication about what is happening with their medicine.

Part of what we do is watch them use inhalers, watch them use the spray and ask them where they keep their insulin. On the bench is not okay if it was given to them three months ago and we are going to have to take it away. It is a very relevant service but to suggest, as the AMA did, that it is not being done properly at the moment because we are not capable I found a bit—

Dr Sclavos: It was offensive.

Prof. Twomey: Well it is. What does success look like, Chair? Success for our members would look like a recommendation from the committee which said, 'The committee wishes that all barriers that prevent pharmacists in the state of Queensland from practising to their current scope of practice be removed'—not an increased scope of practice but that which is currently defined by the Pharmacy Board of Australia under the Australian Health Practitioner Regulation Authority, the COAG agreement that the fine doctors who came up and gave evidence before us have said they fully support. Any barriers which prevent pharmacists from acting to their full scope of practice in the state of Queensland should immediately be removed.

In terms of extending scope, that is something, I have to say, about which we are in fierce agreement with the medical professionals who gave evidence before, because there is a structured process under which we are currently participating. Let us say that pharmacists should be able to prescribe in the state of Queensland. I can draw your attention to what is happening in the United Kingdom, New Zealand and Canada, where there is something extra that you have to do to be able to independently and autonomously prescribe—so to diagnose someone with a condition and write a prescription.

Dr Sclavos: Let us give a different example, because everyone seems to be going over the same ground. Our best example for an extended scope is travel vaccines. In many countries' jurisdictions and provinces, pharmacists can give travel vaccines. There is no moral hazard because if you are going to Peru or some country in South America that is on a register, then you either need that medication or you do not. Generally the rules are: if it is not putting the pharmacist in a position of moral hazard, what is the training that is required? In this case here, generally it is injection technique training, it is the suite of vaccines, how they are sourced, how they are stored and who administers. In a state like Queensland where we are decentralised and access to services is an issue, a very expensive service is travel doctors. Because they are doctors and because it is immediate use, the doctors can dispense those, so they both prescribe and dispense.

Prof. Twomey: No conflict there.

Dr Sclavos: There is no conflict there, but what we are saying is that at some stage an expert committee like a council should look at that and say, 'Yes, we think this is an expanded scope and these are the measures we will put in place for a pharmacist to do that.' Will it be all pharmacists? No. Will they have to jump through credentialing or accreditation? Yes. That is a good example to bring up something new that we have not discussed on the differences between current scope versus expanded scope.

CHAIR: That is where an advisory committee or council—whatever you want to call it—has some kind of oversight of clinical governance and can work independently. Who do you consider would be independent to make up the board?

Prof. Twomey: That is covered in our submission, but to briefly highlight it we believe there should be practising pharmacy owners on that board. Should they make up the majority? No. Should they be the chair? No. Should there be a consumer rep or a medical rep? Yes. Should there be legal and accounting representatives? Absolutely. An ideal person to form an independent chair, to be honest, because it is a unique skill set, is probably a former pharmacist owner who understands the nuances of the sector. That is my own personal opinion.

Dr Sclavos: Best practice is to add someone from Queensland Health, because you need to have some input on what is feasible, what are the regulatory barriers and so forth. There are other members of the committee that we should be looking at.

CHAIR: Of the 1,140 pharmacists in Queensland, how many are members of the guild?

Prof. Twomey: What is our membership percentage?

Dr Sclavos: It is 940 or 950, something like that.

Prof. Twomey: It is one of the highest in the country.

Mr HUNT: There are two issues around ownership. The first one is whether or not the act is being complied with and whether current oversight of that is sufficient. If we leave that aside, the second one I am trying to get my head around is the act itself and the ownership laws. You gave good reasons why a pharmacy should be owned by a pharmacist in terms of patient care and you have commented that it is necessary to protect consumers. What I cannot get my head around is that a pharmacist can own 30 pharmacies across Australia and how that differs from a corporate ownership. The question is: are the current laws sufficient in your eyes or would you like to see them tightened?

Prof. Twomey: I can give you my personal opinion on that. I do not believe a pharmacist should own 30 pharmacies. I believe that if you took 30 times the average turnover of a community pharmacy it would, by its very definition, satisfy the large proprietary company definition under the Australian Securities and Investments Commission. They are no longer small business men and women then. Unfortunately, we exist in a Federation so the Pharmacy Business Ownership Act in Queensland is a result of the evolution of our Federation. If you go back over 100 years, there is no way someone from Cairns like myself would own a pharmacy in Sydney because it would be logistically impossible, but in today's day and age that is happening.

My personal opinion is that the ownership restrictions—and in Queensland it is five—should be national. There used to be residency provisions in Western Australia, where only a pharmacist who lives and practises in Western Australia can have a pecuniary and/or proprietary interest in a pharmacist in Western Australia. Due to lobby groups—and I think the previous speaker may have referred to those—those residency provisions were removed. That then saw these large corporates—these monopolies—enter the state of Western Australia. Western Australia was one of the last bastions where these conglomerates did not exist because of those residency provisions.

I support pharmacists and pharmacies because I support the just shy of 900 small business men and women in the state of Queensland who have put their homes on the line, like I have. If I do something ethically wrong and I am deregistered, I do not just lose my business; I lose my home. I support small business men and women owning pharmacies. I agree with you that that is an anomaly and if there was a way to fix that I would be extremely personally very supportive.

Mr HUNT: Given the current laws and given that is the case, is it worth having oversight of them when those laws are deficient?

Prof. Twomey: Yes, there is. I think we are missing a key point here. There are people who have interests—I am led to believe, without prejudice—in far more than 30. We are talking 400. There is a clear difference between a small business person owning one pharmacy and owning 30. There is an even bigger difference between someone owning 30 and owning 400 or having a pecuniary or proprietary interest in 400. Just because it is imperfect does not mean it is not worth protecting. I agree with you because of that anomaly, and if I could iron that anomaly out that would be ideal, but it does not mean that we use that anomaly to justify that we do not need a pharmacy council in the state of Queensland.

Dr Sclavos: The PBS is such a large part of infrastructure in Australia. It is probably blasphemous for me as a past national guild president to say this, but generally for PBS medicines pensioners pay the same price whether it is my pharmacy or any one of the other 5,000 but the majority of the cost is not the $6-odd. The cost of the medication is funded by the Australian taxpayer. There are very good reasons why we do not want to deregulate that market and allow it. If there was no PBS, it would probably be a case that we would have a difficulty to stand on because to get full market forces on subsidised government funded medicines it would be in the hands of the market.

While we have such an important piece of public infrastructure as the Pharmaceutical Benefits Scheme and we have pharmacists funding state government services—you provide us with methadone and other services that we get at no cost from Queensland Health, for example, with needle and syringe support services—while that taxpayer funded support goes to the infrastructure of a pharmacy, it should be in our interests as to who owns and controls these businesses and how they are set up. That is our view at the guild.

Mr McARDLE: There was some toing and froing about taking a question on notice. I think that became a bit lost in translation. You made the comment that there are drugs you can dispense at the moment and there are drugs that are in scope that you cannot dispense; is that correct?

Prof. Twomey: Yes.

Mr McARDLE: Can you provide the committee with a list of the drugs that you say are in scope that you can dispense, the drugs that are in scope that you cannot dispense, but, more importantly, the drugs that are outside your scope that you should be able to dispense and the reasons why and the qualifications of people who should be allowed to dispense those drugs over and above your normal pharmacy degree?

Prof. Twomey: I will make a clarifying comment, so please challenge me if I have said this wrong so that I am providing you and the committee with accurate information. Pharmacists can dispense all medicines. It is just under what circumstances.

Mr McARDLE: That is what I am trying to get at. That is what I am trying to understand. What are the three categories we are talking about here?

Prof. Twomey: There is continued dispensing—

Mr McARDLE: Sorry, what we want you to do is provide a list to the committee.

CHAIR: I think I asked that earlier.

Prof. Twomey: We will provide you with a list, but it will be by exception. Will that satisfy you?

Mr McARDLE: That is fine. You also made the comment that you should have the right to dispense extended scope as well. Then you used the word 'who' and the qualifications required to do that. What are the qualifications that should be imposed to dispense certain types of drugs? I will leave that with you. It will help me because I am a little bit confused about exactly what you are saying in regard to the types of drugs.

CHAIR: For clarification, could we have those back by 12 September, because I believe we are speaking to you in Cairns on the 13th?

Prof. Twomey: We will provide it to you in ample time for you to digest it and ask further questions, yes.

Mr McARDLE: Can we make it non-Latin as well?

Dr Sclavos: We will even have a graphic. There is a graphic we can use.

Prof. Twomey: We have pictures, Deputy Chair.

Mr McARDLE: Excellent.

CHAIR: We are in Cairns on the 12th.

Prof. Twomey: When would you like it?

CHAIR: I would like it before, if possible.

Prof. Twomey: You will definitely have it before. Give me a date.

Mr McARDLE: How about the 10th—two days beforehand?

CHAIR: To satisfy the deputy chair, because he is opening a pharmacy—no.

Prof. Twomey: Under the current laws you probably could. This Friday—done.

Mr McARDLE: I will go on to the issue of the question asked by the member for Maiwar. He asked: is there anything by way of evidence that substantiates that, even though the rules of the act have not been complied with, there have been adverse outcomes for Queenslanders? You made the comment that we need to look at the legal advice. That was a phrase you used, or words to that effect. Would that be right?

Prof. Twomey: Correct.

Mr McARDLE: It strikes me as a little bit odd. You provide the instructions to your legal adviser. Why wouldn't you know that already? Why wouldn't your feedback—

Dr Sclavos: Otherwise we would be quoting specific pharmacists or circumstances that we know. I should state that the guild is an insurer. The majority of pharmacists in Australia are insured by the Pharmacy Guild, as we are the leading insurer for many other professions. We are in a privileged position where we know some examples of practice and so forth. We would rather speak in general terms or have someone who presents who does not put us in a position of moral hazard.

Mr McARDLE: Let us try to drill down a little bit on that. You are an insurer. Therefore, a complaint goes to the guild. It is investigated by your investigatory team. Then a payment is made or a legal action commences, roughly speaking. Those claims would be across all pharmacies. Are you saying you can drill down to those pharmacies where ownership does not comply with an act? I would have thought they would have been generic. How does that help us in relation to the compromise of Queenslanders' health if you are not targeting the question of ownership being the reason for the negative outcome?

Dr Sclavos: I will give you one example from my time as president, so that is a while back. There was concern that a pharmacy that was a member of the guild was not structured correctly or legally correct. There was an action against that pharmacy relating to a hazardous issue that that pharmacist had attained through a third party who had, we believe, an interest in that pharmacy or the pharmacist felt pressured due to some other commercial arrangement on the practice of that pharmacy—similar to what we heard today, that people have agreements and other things where on paper they may not have ownership or control but by any other means you dress it up it was ownership or control. That is what I am saying. In terms of those documents, we can speak in general terms. We have been advised that it should be by a lawyer. If we are talking about specific documents that put the health of Queenslanders at risk, those documents are not something that we would be willing or able to discuss.

Mr McARDLE: If you are going to put up a legal opinion that tries to link ownership to outcomes, you need to be very clear in that.

Prof. Twomey: That is not what we put up. They were two separate questions about front-line outcomes and about compliance with the PBO. Our legal advice is about compliance with the PBO. Measuring outcomes is something that I can tell you, not just as a health practitioner but also as a leader of the profession, all of the professions are striving to achieve. Queensland Health itself, I would put to you, have not cracked how they are going to measure outcomes, other than occasion of services moving through their departments. If the burden of proof for the pharmacist profession in Queensland is that we must prove measurement of outcomes, we would be the first profession in the Commonwealth to be able to do that.

Mr McARDLE: Good on you too. I want to look quickly at pages 30 and 31 of your submission.

Prof. Twomey: Which I have to say I do not have in front of me, sorry.

Mr McARDLE: My apologies. You refer to Victoria and Tasmania rules and regulations in relation to an authority in Victoria and an authority in Tasmania. There are some fairly extensive powers that are provided to both of those authorities, including licensing of a person to carry on registration of a premises and the like. Would you be looking at a similar authority if a council were put in place in Queensland—that is, the right to register or refuse registration of pharmacy ownership and the right to refuse registration of premises as well? I am just looking at the scope of what you are looking to achieve.

Prof. Twomey: The answer to that simply is both. It is an annual licensing provision. We are not asking the committee—and this is clear, I believe, in our submission—other than to do an audit retrospectively of those transactions for the past 24 months, retrospectively to do an audit of all transactions approved by Queensland Health since the implementation of the PBO. If the committee was of a mind, and the parliament thereafter, to implement a pharmacy council in the state of Queensland, the annual licensing provisions would provide an annual checkpoint for a pharmacy council in Queensland to do two things. One is to ensure compliance with not only the Pharmacy Business Ownership Act but also all Queensland rules and regulations as they become available, not just at a fixed point in time retrospectively 20 years ago when that entity bought the pharmacy.

We want to ensure that not only are the practitioners—and the three of us here before you are health practitioners—governed by the professional practice standards that you saw the Pharmaceutical Society of Australia give evidence to and the health practitioner board but, most importantly, the premises are governed. It is through these two things that good quality use of medicines is delivered through high-quality practitioners governed under the federal Pharmacy Board and high-quality premises governed by a pharmacy council of Queensland. As standards remain contemporary and as the bar of quality is continually raised, as we hope it is—and as the guild has

form over our 90-year history ensuring that the bar is raised—the 1,140 pharmacies in Queensland annually have a checkpoint of ensuring that the infrastructure and facilities, together with the individual practitioners, deliver good quality health outcomes.

Mr McARDLE: I get the retrospective nature. I accept that that is an arduous and time-consuming exercise. Come 1 July 2019 and we have the new body, with all the bells and whistles—and you have power of registration et cetera—if pharmacy X came to you, would you accept that registration under the old regime meant that they complied with the terms of ownership as at 1 July 2019 or would you want to revisit that based upon a fresh application filed with the new body?

Prof. Twomey: It is the latter, simply because the council would be responsible for ensuring, as I said before, that the infrastructure complies with all Queensland Health rules and regulations, not just the Pharmacy Business Ownership Act. As rules and regulations in the great state of Queensland evolve, so too should the practices and they should be subject to assessment at the point of renewal, not at the point of settlement, which may have been two decades previous.

Mr McARDLE: What you are then saying is that Queensland Health have got it wrong. If you do not accept prior acknowledgement of ownership and you then say, no, you have to start the process again as to me buying a pharmacy six months post 1 July 2019, Queensland Health have got it wrong.

Prof. Twomey: We are saying that the systems and processes currently being used by Queensland Health are insufficient. They are insufficiently resourced and they have an insufficient skill set to be able to provide informed and accurate advice to the delegate under the act for him or her to be able to make an informed decision.

Mr McARDLE: I am going to leave my questions for Cairns. Thank you very kindly on such short notice.

Ms Watson: Can I just give an example in relation to your question. We are talking about premises. When we started doing vaccinations, the boards and councils in other states said to the pharmacies, 'If you want to do vaccination in your premises, your premises needs to comply with X, Y and Z.' As a Queensland pharmacist, I could not find that information. That information did not exist. Because I wanted to get a room in and I wanted to vaccinate, I just whacked one up using one of my lovely local builders. Now it quite possibly will not comply with what is expected. I need to be told by Queensland Health, 'This is the expectation for your premises to comply with,' and I would expect that if it did not match it I would fix it in order to be able to provide that service.

Mr McARDLE: Thank you very much indeed. I do accept that.

CHAIR: If there are no other questions from members, I thank the Pharmacy Guild for your time today. I thank all submitters on what is a challenging inquiry in front of us. We are better informed by everybody's contribution today. We look forward to progressing this inquiry through the committee process.

The committee adjourned at 1.11 pm.