STATE DEVELOPMENT, NATURAL RESOURCES AND AGRICULTURAL INDUSTRY DEVELOPMENT COMMITTEE

Members present:

Mr CG Whiting MP (Chair)
Mr DJ Batt MP
Ms CP McMillan MP
Mr JE Madden MP
Mr BA Mickelberg MP
Ms JC Pugh MP
Mr PT Weir MP

Staff present:

Dr J Dewar (Committee Secretary)
Ms C Furlong (Assistant Committee Secretary)

PUBLIC HEARING—INQUIRY INTO THE MEDICINES AND POISONS BILL 2019

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 20 JUNE 2019

Brisbane

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The committee met at 9.46 am.

CHAIR: Good morning. I declare open this public hearing for the committee's inquiry into the Medicines and Poisons Bill 2019. I acknowledge the traditional owners of the land on which we meet today. Thank you for your interest and your attendance here. My name is Chris Whiting. I am the member for Bancroft and the chair of the committee. The other committee members with us today are Mr Pat Weir, the deputy chair and member for Condamine; Mr David Batt, the member for Bundaberg, who is currently on a plane and has been delayed; Mr Jim Madden, the member for Ipswich West; Mr Brent Mickelberg, the member for Buderim; and we also welcome Ms Corrine McMillan, the member for Mansfield, who is substituting today for Ms Jess Pugh, the member for Mount Ommaney, who will be with us later on.

The committee's proceedings are proceedings of the Queensland parliament and are subject to the standing rules and orders of the parliament. They are being recorded by Hansard and broadcast live on the parliament's website. Media may be present and will be subject to the chair's direction at all times. The media rules endorsed by the committee are available from committee staff if required. All those present today should note that it is possible you might be filmed or photographed during the proceedings. I ask everyone to turn their mobile phones off or to silent mode.

On 14 May 2019 the Hon. Dr Steven Miles MP, Minister for Health and Minister for Ambulance Services, introduced the Medicines and Poisons Bill 2019 into the parliament. The bill was referred to this committee for consideration.

KIDD, Dr Richard, Chair, AMA Queensland Council of General Practice

CHAIR: I now welcome Dr Richard Kidd from the Australian Medical Association. For the record, could you please state your full name and the capacity in which you appear today?

Dr Kidd: My name is Richard Anthony Kidd. I am the chair of the AMA Queensland Council of General Practice. I should mention a couple of other things that may be seen as conflicts or relevant interests. I am also on the Queensland statewide monitored substances steering committee, the Queensland care at the end of life steering committee, the Queensland Persistent Pain Statewide Steering Committee and Minister Wyatt's clinical advisory group for aged care. All of those have relevance to this issue.

CHAIR: Thank you very much. Would you like to make an opening statement, after which we will probably have some questions for you?

Dr Kidd: The AMA Queensland and the AMA federally is very strongly supportive of the movements that have been made in Queensland parliament, with the Medicines and Poisons Bill opening the way to be able to get real-time prescription monitoring in place and to be able to properly monitor substances that are dangerous. I forgot to mention that I am also the past chair of ScriptWise, an organisation that is dedicated to trying to minimise the harm of prescription medicines, particularly opioids and benzodiazepines. I would just make the note that every day four Australians die from overdose and the majority of those are from prescription medicines, particularly opioids and benzodiazepines.

AMA Queensland is strongly supportive of this bill. The only thing that I guess I would really want to highlight here is that in the implementation of the bill we do everything we can to prevent deaths from prescription medicines, particularly doctor-shopping activities, which is what the real-time prescription monitoring will go to, but we do it in a common-sense way, acknowledging that doctors and pharmacists in particular are very busy professionals and we need to have a balance where we have a system in place that will encourage us, and maybe even mandate us, to check those at risk but not have to do that every single time we prescribe these sorts of medications.

There are many situations in which it would not really be appropriate to expect a prescriber or a dispenser to have to do this exercise, such as residents of aged-care facilities who often have chronic pain and severe anxiety and depression and may be on a number of the medications that are of interest in this bill. Obviously in end-of-life situations where people are in palliative care, again you cannot imagine that there would be doctor shopping happening in those sorts of situations. So long

as we have some common sense about who it is that we are expected to check and if we have technological systems that seamlessly integrate with the software of the doctors and the pharmacists then this will become a workable system. If it is a system that involves doctors and pharmacists having to go out of their own software and do some sort of double log-in process at some other website every single time they need to check a new patient, it is going to add significantly to the workload and expense and is going to greatly reduce the efficiency of primary care and delivering the excellent services that we provide to date.

CHAIR: In your submission you quite strongly make the point about the double log-in requirements. For the benefit of the committee and those listening and reading the report, could you describe the system you have now?

Dr Kidd: I would be very happy to.

CHAIR: If I am seeing this for the first time, a description would be helpful.

Dr Kidd: I will give you a very nice recent example. A lady presented fairly late on a Friday afternoon, which is kind of a red-flag time, with a letter that looked to me to be a forgery from Victoria. She was seeking some opioids and benzodiazepines. She had conditions that were on the letter that would be appropriate for that sort of medication but the letter itself looked a bit dodgy. We are used to seeing referrals and letters from our colleagues, and this had a number of things that were inconsistent.

I checked with Queensland's medicines regulatory unit, or DDU as it used to be known. They had no record of her as she had just recently arrived in the state. She had very cleverly changed her date of birth, which made her invisible to the system. I had such a strong suspicion that I called the Victorian equivalent organisation, and because of the change of the date of birth initially they did not have a record either. I was still very suspicious so I tried to call the doctor and the doctor was not available. Then I got onto someone else in Victoria and started to put together that, in fact, she was a doctor shopper. By the time I had done all of this and informed the medicines regulatory unit in Queensland, I had lost an hour and a half. If I had real-time prescription monitoring it would have taken 30 seconds. Of course, the lady did a runner. I did not get paid for my time and no-one will pay my time for that. That was just a good citizen act that I did.

At the moment, at the other extreme, sadly we see still in the coroners court examples of doctors who do not spend an hour and a half doing that kind of due diligence and who will give prescriptions to people who are doctor shopping and, sadly, there are tragic outcomes. Those doctors find themselves in the coroners court trying to explain why they had not been more careful and spent more time. We are very keen to get a system that will enable us to much more safely look after these people who are putting themselves at risk.

Mr WEIR: Will the system you are talking about operate between states and will it pick up instances such as you are talking about?

Dr Kidd: No. That is why I stressed that I had to phone the Queensland medicines regulatory unit and then I had to phone the Victorian equivalent. At the moment the borders are hard borders in terms of the sort of checking that we do. Thankfully, I am not further down towards the border. I know that on the Gold Coast it is a real problem with people who jump back and forth across the border. At the moment the systems do not speak to each other. A doctor who is concerned would have to phone New South Wales as well as Queensland and try to put a picture together. The other thing that the AMA federally is really wanting is a nationally integrated system so that we can see what this person is doing across different states.

Mr WEIR: This proposed system at the moment does not do that?

Dr Kidd: As I understand it, the system that this bill supports will still be one in which each state has its own database. Having said that, because of the work I am doing on the monitored substances steering committee, I do know that Sue Ballantyne and her group are looking at trying to develop a way where different states will have in the future some kind of arrangement—and there are privacy laws and all sorts of things that have to be looked at with their variations from state to state—whereby there is better cooperation and integration across borders—New South Wales and Queensland or New South Wales and Victoria, for example—but we are not there yet. This is a body of work that we know we have to do.

Mr MADDEN: Thank you very much for coming in today. I very much thank any other witnesses who are coming in today for taking the time and making the effort to be here today. My question relates to the prescription of medicinal cannabis. Just as the chair asked you to compare how things are now to how things will be with this bill, could you explain how things are now with medicinal cannabis and how they will change as a result of the provisions in this bill?

Dr Kidd: I have not got myself up to speed completely on this but, as I understand it, medicinal cannabis at the moment in Queensland is subject to clinical trials. Different products have been developed that have different things removed from the original herbal product. There are studies being done around Australia looking at use for very difficult to control epilepsy in children as well as palliative care in older Australians, and I think there are a couple of other applications.

This bill will enable general practitioners to prescribe one of these medicinal products that have specific uses for specific conditions much more easily, although, of course, the whole system will be still looking at it carefully. At the moment I think the reality is that there are very, very few people prescribing it in any kind of direct exposure to consumers. It is nothing like California, for example, where my feeling is that they are prescribing the herbal product to virtually anyone who wants it. We do not want that happening here.

Mr MADDEN: So this will become just like antibiotics, where you will go to your GP and the only restriction is that you will be able to get only what is currently being trialled?

Dr Kidd: I expect that there would be some intermediary steps whereby, for example, if a new cancer drug comes in, when it gets to a point where GPs might be allowed to prescribe it there will be very clear indications and some, for want of a better word, regulations around it to try to restrict the prescribing so that it is done safely and appropriately for certain conditions.

Mr MADDEN: Thank you very much for clarifying that, Dr Kidd.

Mr MICKELBERG: My question goes to the issue of logging in twice. In instances where somebody might be on an S8 medication for chronic pain, for example, would it be feasible that that individual needs to go through the double log-in process and a bit more of a rigorous checking process for interactions and medical history in the first instance, to establish that there is not a case or an issue—as opposed to the process for repeats, where they might come in to get a prescription to be subsequently filled and they have already had that medication?

Dr Kidd: I think that is an area that needs to be thought through carefully. A few years ago there was a coroners case of a nurse from Toowoomba who ended up seeing, I think, about 50 different prescribers. Most of those were in emergency departments. We have to remember that we are not just talking about GPs; we are also talking especially about emergency departments. She was getting a lot of controlled substances. In her case, the interesting thing was that I gather the thing that killed her was fentanyl, for which she had never had a prescription. She had somehow got the fentanyl, possibly stolen from hospitals. It is not at all clear where she got it from.

The point I want to make with that coroners case is that at the time the GP had always prescribed appropriately but had no idea that she was seeing lots of other prescribers. As much as GPs cherish the relationship with their patients, which is built up over time and has a core of trust in it, if we are looking particularly at younger people, I would think, who have chronic pain issues and maybe anxiety, it may be appropriate that at least three or four times a year, or something like that, a check is still done, just because at some point they might start seeing other prescribers as well as their usual prescriber. If you assume that you are always the only one prescribing, that could be a trap.

Mr MICKELBERG: Having not seen the proposed system, is it your understanding that the system might, for example, have flags?

Dr Kidd: Yes.

Mr MICKELBERG: I do not know enough about medicines to understand how this might work, but, for example, if it is reasonable that one would take four doses of a prescription medicine each day on an ongoing basis over six months, and if the usage or the amount of prescription exceeded that by X percentage, could that flag within the system, as opposed to going through checking that you have a prescription from Dr Smith and Dr Jones? Is that how you would envisage this system working?

Dr Kidd: Yes. I hope I am not speaking out of turn, because I am not sure how much of what I am doing with the monitored substances steering committee is confidential at this stage. I know that one of the things Sue Ballantyne is looking at is a system that would integrate with general practice software and pharmacy software, where when you open up that patient file there would be a traffic light that would have, for example, a green button or orange button or red button, which goes to what you are asking. The algorithms behind that would be fairly complex, because it would be if the system is showing that this person is seeing multiple prescribers, or if this person is accessing or being prescribed what might be thought unsafe levels of medications or medications that could interact in a bad way.

The list of medicines that we want to monitor in the real-time prescription monitoring is more extensive than any other state at this stage for those reasons. We are hoping that the other states will follow suit and we will have consistency across Australia. All of that will go into algorithms that will be behind whether it is a green, amber or red light. That will trigger different behaviours. Obviously, a green light would suggest that, as far as the system can tell, the person is not behaving in a way that is putting themselves at risk or having medications at such a dose that they are a risk or having medications that could interact in a dangerous way for them.

Ms McMILLAN: Obviously there are many benefits associated with this bill. I read here that some of your concerns are around the possible increase in assaults against GPs. I think it is important for our committee to understand that. It is important for you as a profession and us as a government to ensure that doctors have some processes in place. Can you talk us through what happens there? Is it the delay in finding out whether you can prescribe the medication? How do we manage that risk?

Dr Kidd: I guess I have had a fair bit of experience over the years now. We are talking about different communities of patients and people. A significant number of people who start becoming doctor shoppers are never going to be a threat to health professionals but there are others who will. There are people who are quite violent and who are drug dependent. I suppose I have been lucky in that, over the years, where I have confronted those situations I have been able to find a way through it, but I am well aware that some of my colleagues have been severely treated.

There was one doctor who was an authorised prescriber by the state for MATOD, the Medication Assisted Treatment for Opioid Dependence. He had self-selected, to a certain extent, a large group of those dangerous patients. He was trying to de-escalate the amount of medication this person was having. This person snapped. He was probably already going through a bit of withdrawal. He broke the doctor's ribs, threw the doctor down the stairs and broke his neck. The doctor survived, but it was a terribly traumatic episode. That is an example of what can happen.

People who are perhaps already withdrawing from these powerful drugs of dependency can behave very desperately and be very dangerous. We need some protections for that sort of situation. There needs to be some leniency in the system where a doctor might identify that the person in front of them is a drug addict and is picking up signs that that person may well be a threat to their own safety or even their life. In that situation, they may choose to simply give the prescription and let the person go and then contact the authorities. I think we have to make sure that for health professionals—and the same goes for pharmacists—there are some protections for them when they might do the wrong thing in order to save their own lives.

Ms McMILLAN: Absolutely. Dr Kidd, the situation now requires that sort of management and the situation into the future would require both education and foreseeable management?

Dr Kidd: Yes.

CHAIR: Dr Kidd, you have stressed how training in prescribing medicinal cannabis would be very necessary. How do you envisage that being done by the state?

Dr Kidd: We have had some precedents with other things, like when hepatitis C medications became available for general practitioners to prescribe directly. Educational programs were developed to help enable GPs to prescribe those antiviral medications safely, effectively and appropriately. We have groups such as NPS MedicineWise and ScriptWise that in situations like this will work collaboratively with state health departments to develop an educational program and campaigns to raise awareness amongst prescribers and make educational modules available that could have continuing professional development points attached to them, so that those prescribers would be incentivised to do those modules.

CHAIR: Are there examples where those modules have been delivered in a collaborative way between, for example, the AMA and the health department?

Dr Kidd: Yes.

CHAIR: And that would be for a number of stakeholders?

Dr Kidd: Yes.

Mr WEIR: Dr Kidd, I want a bit of clarity on a comment that you made in your introduction. You talked about the number of deaths from prescribed medicines. We have talked about those who are doctor shopping and are trying to seek more than they should. You were also including those medicines that are not compatible with one another, which can cause deaths.

Dr Kidd: Yes.

Mr WEIR: Will this system pick that up as well?

Dr Kidd: Not completely. Some of those deaths are not necessarily interactions between the list of medicines that will be on the monitored substances database and programs. I have forgotten the exact number, but basically it is all the opioids, the benzodiazepines, the Z-drugs and I think Seroquel might be on there as well, and there are a couple of other ones. There is a very long list of ones that could potentially be on there. To begin with, we need to start with something we can manage.

The prescribing software that doctors have does pick up a lot of interactions between different medications. For example, say I was going to prescribe Digoxin for someone with a heart condition who had already been prescribed something else. If I had that in my database, my software would warn me about possible interactions. There is also product information that I could click on and go through and double-check, if I had the time. The software is pretty good at giving warnings, as long as the prescriber has the full list of medications that that person is taking.

This system will pick up things like someone taking a benzodiazepine as well as an opioid, and maybe Zolpidem and some Seroquel. That person should be flagged as very, very high risk. A very small number of deaths may be from drug interactions that are not on that list, so it will not pick up all of them.

Mr MICKELBERG: Is the issue purely related to interactions between drugs or does the individual's condition and symptoms also play a part with respect to an adverse outcome?

Dr Kidd: The drugs on this list are, by and large, drugs of dependency. The danger with them, by and large, is that people develop some tolerance. People are not taking these necessarily just to control pain. A situation develops where they are taking the medication because it does something else that feels nice or it gets them into a different space. When they are seeking that other kind of buzz or hit or whatever you want to call it, often they have to escalate the doses. When you have a couple of different drugs that are doing similar but different things, you can get to a situation where the side effects become very dangerous. For example with the benzodiazepines, if you take enough you will forget to breathe. If you take that in combination with narcotics or opioids, that can happen at much lower doses.

One of the other big dangers for people is that their supply might be variable depending on who they are getting it from and how often they can access prescribers. They might have built up a certain level of taking an opioid and a benzodiazepine but then gone through withdrawal and not had that sort of dose for a while. When they get it again, they will immediately take the dose that they used to take, but that is now an overdose for them because they have lost the tolerance. There are a couple of different ways that it can kill them.

Mr MICKELBERG: You spoke about the software that doctors use to fill prescriptions. Are there a number of different providers? If so, are there a couple of dominant providers? Is there a preponderance of usage across the industry of one software provider? If so, that is probably something we need to talk to.

Dr Kidd: In terms of the general practice software there are two major vendors, another couple of significant vendors and then a couple of other less significant vendors. By and large, they have collaborated when they have been incentivised—maybe not appropriately but incentivised—to work with other agencies or other software developers.

A recent example of that is My Health Record. That is an Australian government development and now all of the software providers, including a lot of the hospital software computer providers—and, for that matter, the software that goes into pharmacies, which is a different group again—talk with My Health Record in a fairly seamless way. It would be the same kind of process as the one we used to get My Health Record working seamlessly. We should be able to get this system working seamlessly, but it would probably take some incentivising.

CHAIR: Thank you very much. The time allocated for this session has now expired. Dr Kidd, thank you very much for appearing before the committee today. We have no questions on notice.

PRENTICE, Mr Daniel, Professional Research Officer, Queensland Nurses and Midwives' Union

SHEPHERD, Mr Jamie, Professional Officer and Team Leader, Queensland Nurses and Midwives' Union

TODHUNTER, Dr Elizabeth, Research and Policy Officer, Queensland Nurses and Midwives' Union

TWIGG, Ms Deborah, Research and Policy Officer, Queensland Nurses and Midwives' Union

CHAIR: I now welcome representatives from the Queensland Nurses and Midwives' Union. Who would like to start off by the making an opening statement?

Mr Prentice: I drew the short straw on that. Good morning, my name is Dan Prentice. I am here today with my colleagues Mr Jamie Shepherd, professional officer, Dr Liz Todhunter and Ms Deb Twigg, both research and policy officers, appearing on behalf the Queensland Nurses and Midwives' Union. We thank the committee for the opportunity to speak with you regarding the Medicines and Poisons Bill 2019.

The QNMU has over 60,000 members across the public, private and aged-care sectors. Virtually all of them will be affected in terms of their practice by this bill. While the QNMU has provided a comprehensive written submission to the committee regarding the legislation, today we would like to focus on three important areas relating to the medicines aspects of the bill. These areas are: the role of unregistered healthcare workers within the proposed regulatory framework; the approach of using substance management plans as a core aspect of the regulatory framework; and extended practice authorities and the potential impact on nurses and midwives.

Prior to addressing these areas of concern, I would also like to take the opportunity to thank Queensland Health and in particular the Office of the Chief Nursing and Midwifery Officer for their ongoing consultation and efforts to address the QNMU's concerns regarding this bill. We appreciate the opportunity to provide detailed feedback and look forward to ongoing collaboration to resolve these issues.

As a general introductory comment, the QMNU supports the overall process of updating the legislative and regulatory framework for medicines, poisons and therapeutic goods in Queensland. The current Health (Drugs and Poisons) Regulation is dated, and greater alignment with national regulatory processes is timely. The QNMU believes that, properly considered, this legislation represents the opportunity for Queensland to implement exemplar legislation that can serve as a model for other jurisdictions. That said, we urge the committee to consider our concerns regarding the three areas previously highlighted.

I would first like to speak to our concerns regarding unregistered healthcare workers and this legislation, which includes those working in aged care. A significant concern of the QNMU is administration of medicines by unregistered healthcare workers in settings such as aged care and disability services. This is a disturbing trend in residential aged care in particular where the QNMU believes providers are taking advantage of the current ambiguity of the Health (Drugs and Poisons) Regulation to move medication administration away from nurses to unregistered healthcare workers who lack any knowledge of pharmacology and safe medication practice.

To be clear, the QNMU believes that unregistered healthcare workers have an essential role in aged care—for example, working under the delegation and supervision of registered nurses. Nursing professional standards identify that unregistered healthcare workers do have a place in assisting cognitively competent people to self-administer their medications. However, the QNMU believes that only enrolled and registered nurses have the theoretical and practical knowledge, training and experience to undertake medication administration. Given that many older Australians receiving care also take a number of often high-risk drugs, this is very much a safety issue.

We would like to make the following points regarding the medication management using aged care as an example. Medication administration is more than just giving someone a dose of a drug; it involves assessment prior, during and after to ensure that the therapeutic effective is achieved and any unanticipated consequences are detected and resolved. Nurses receive hundreds of hours of theoretical and practice based training around medication management. To believe that the very limited training of unregistered healthcare workers can safely substitute for this role is clearly ill advised.

The consequences of unregistered healthcare workers administering medication can be fatal. In fact, very recently we were made aware of the unexpected death of a woman in a Queensland residential facility shortly after being administered medication by an unregistered healthcare worker. Older Australians deserve the same standard of care, irrespective of where they receive that care. In relation to medication management, we would find it unacceptable for unregistered healthcare workers to administer medications in a hospital setting, so why do we think this is acceptable in the residential setting? The drugs are the same; therefore the risks are the same.

The primary aim of medication management must be the safety of those receiving care and who is best to achieve this. Arguments about cost and workforce must not be allowed to compromise safety or standards of care. From a workforce perspective, most enrolled nurses are qualified to administer medications, and it is the view of the QMNU that poor wages and conditions are a major disincentive to employment in regional and rural areas rather than provider arguments around availability of registered nurses.

Medication related complaints remain one of the highest complaint areas in aged care. The declining number of registered nurses in aged care means they are already stretched from a supervisory standpoint. Expecting them to supervise administration by others only increases the risk of error. This and the vulnerable nature of those in residential aged-care facilities and their significant medication use highlights that medication management is a critical clinical process in aged care, just as it is in the acute sector.

If medication related errors and adverse events remain a high risk in the acute sector, despite the availability of highly trained staff, comprehensive standards and wideranging medication safety processes, it is hard to believe that transferring medication administration to unregistered healthcare workers will maintain safety in aged care. Legitimising the role of unregistered healthcare workers in relation to medication administration will only exacerbate this situation and put elderly Queenslanders at risk of preventable death.

The QNMU is concerned that section 51 of the bill legitimises the administering of medicines, even high-risk medicines, and injectables by unregistered healthcare workers. We urge that the appropriate and safe role of unregistered healthcare workers in any care services—that is, being the assistants of cognitively competent care recipients—be specifically clarified and dealt with in regulation. The committee has the opportunity here to ensure that appropriate healthcare standards are met in Queensland's aged and disability services. The QNMU is readily available to assist with drafting of regulations in this area.

We would also refer to section 53 of the bill that provides unregistered healthcare workers with a defence for making an error in medications administration. Workers have a common law and statutory duty of care and conduct regardless of their work environment. Those who have not been provided with suitable equipment, facilities training or other resources by the entity should certainly not be engaging in any activity regulated by this act. The QNMU believes that giving those workers a defence from prosecution or civil action for failing to comply with a law of the state or engaging in negligent conduct undermines the integrity of accountability for patient and resident safety, and section 53 should be removed entirely.

I would like move onto substance management plans, our second area of concern.

CHAIR: Mr Prentice, we were keen to get to questions. Could you briefly touch on those areas, because we are keen to talk about SMPs. Did you want to touch on SMPs before we ask you questions?

Mr Prentice: Yes, that is a little shorter. A central attribute of the legislation relating to people's health and the supporting regulatory frameworks that are created must be the safety of the public first and foremost. Modernising and simplifying regulatory frameworks must not be the end in itself.

The Medicines and Poisons Bill takes a coregulatory approach to medicines management. The QNMU is very concerned that this approach does not offer the robust regulatory environment needed to ensure the safety of the public. The legislation defines a substance management plan as a document setting out how known and foreseeable risks associated with any dealing with a regulated substance are to be managed at the regulated place. While advantages of coregulation claim to be flexibility, lower compliance costs and a reduced administration burden, the QNMU is concerned this approach will diminish rather than increase the safety of the public for the following reasons.

CHAIR: Mr Prentice, we can offer you the opportunity to table that document, if you would like, so we can go through it. That would be in addition to what you have already presented. I will start with some questions. You have made very good points about aged-care workers and what needs to

be done there. Are there any jurisdictions in Australia where aged-care workers who are not registered or qualified nurses are allowed to administer medicines? If so, what has been the experience in those jurisdictions?

Mr Shepherd: There are other jurisdictions that have legislation and regulations that give limited opportunity for unregistered healthcare workers to assist with medication. Victoria is one—it is probably a good example—where they have to ensure that they are doing that according to the instructions and delegation of the registered nurse and in accordance with professional standards. Indeed, the Aged Care Act and the quality of care principles require all aged-care workers, whether they are registered or unregistered, to comply with professional standards and guidelines. Those professional standards exist from a nursing perspective, but they are not well enforced. That would be the best way to put it.

CHAIR: Hence the delegation provisions that you have outlined in your submission you feel should be included or perhaps enhanced in this bill?

Mr Shepherd: They could certainly be enhanced either in the bill or through the regulation when it is finally determined. In their response to our submission the government quoted the federal Department of Health's *Guiding principles for medication management in residential aged care facilities* guiding principle 14, which talks about delegation and the Nursing and Midwifery Board of Australia's delegation framework and decision-making framework. Unfortunately, that response failed to identify that in chapter 14 there is also a nursing resource titled *Nursing guidelines for medication management in aged care*. It is those guidelines that are quoted by the federal department that say aged care or unregistered healthcare workers should only be involved in medication assistance if the resident or patient is competent to self-administer, knows what the drug is, knows when to take it, knows when not to take it and all those sorts of things, and still under the supervision of the registered nurse.

Mr Prentice: I would like to add that unregistered healthcare workers administering medications is not completely the norm in aged care. A number of providers—and one that I until recently worked for—had a nursing model of medication management and administration. They are planning to move to a carer based model of medication administration, and that was one of the reasons I left that job after about 11 years. It has been increasing over time, and we would attribute a lot of that to the ambiguity of the current carer provisions of the HDPR. We think that having clarity around that is essential from a safety perspective.

Mr Shepherd: There is certainly an opportunity here for Queensland to implement a best practice model and be an exemplar to the rest of the country.

Mr WEIR: My question is about substance management plans. You have listed a few of your concerns. I am very curious, because I thought some of these would have been automatic. In relation to the substance management plan, you say that the document is not required to be lodged with any authorised external body, there is no apparent oversight of quality control of the document, and you list a couple of other points. I would have thought they would be the prime reason for having such a management plan. I imagine you would have been consulted with regard to the formulation of this legislation and I am very surprised that that would not have been covered. What is the purpose of the document if there is no oversight of the document?

Mr Prentice: That would be our position. Certainly we were consulted. I think that consultation began late last year.

Mr Shepherd: In September or October.

Mr Prentice: In our consultations that was an issue that we raised. In my 40-odd years experience as a registered nurse, plans and documents are not particularly useful if they are only taken out after the fact when something happens. Our position is that we believe it is essential that, if we introduce a new mechanism within a regulatory framework, it has to be robust and of a reasonable standard. It does not really do very much good if it is only something that is consulted after, for example, some medication related incident. It does not seem to be a very proactive approach if it does not see the light of day. That is probably an oversimplification, because we would imagine that would be part of the documentation which, for example, federal aged care assessors may do as part of their aged care accreditation process, but I guess that is on my part.

We think that for this to be adopted a much more proactive approach to the development and oversight of those documents would be appropriate and some kind of auditing mechanism would be warranted, as we do with all other kinds of plans like that, and the regulator having sufficient capacity in terms of resources to undertake that oversight role. I guess a bit of a concern is that, in other areas

like financial services and, as you pointed out, aged care, what we have seen is oftentimes the regulators lack the capacity to regulate the patch over which their purview extends. We would hope that, from a regulatory point of view, in Queensland the regulator is given the capacity to make sure that the mechanisms in this bill such as substance management plans are oversighted to a degree to ensure they are doing what they are meant to do.

Mr Shepherd: We would expect that substance management plans would be made under close due diligence by health practitioners, but our concern would be that the bill and the regulation make that assumption. We would expect that certainly to happen in the hospital sector and the private health and primary healthcare sectors, but there may be considerable issues in making that assumption in aged care because there are quite a few aged-care facilities where their facility manager is not a health practitioner.

Mr WEIR: Which would be the relevant body that ideally should have oversight of that?

Mr Shepherd: I would suggest that the Medicines Regulation and Quality Unit should have oversight. That would be our expectation, but we were certainly appreciative of the fact that they probably do not have the resources to do that. The resources of MRQ certainly received some comment by the Health Ombudsman in his recent publication *Undoing the knots constraining medicine regulation in Queensland*.

Mr MADDEN: I would like some clarification with regard to your submission that suggests unregulated care workers should only be given legislative authority to administer medicines where the resident is assessed as competent to self-administer. I understand the purpose but it is just one word: 'unregulated'. In your submission, Mr Prentice, I think you used the word 'unregulated' interchangeably with 'unregistered'.

Mr Prentice: Yes.

Mr MADDEN: Are we talking about people who are not registered nurses or enrolled nurses, or are we talking about people who are just not covered by legislation?

Mr Prentice: I do apologise; we have changed that to align more with currently accepted terminology. Our focus would be on those workers in a caring role, as in disability, aged-care assistance in nursing, personal care workers or however named, who work in that capacity usually as part of a larger team headed up by a registered nurse or nurses. That is where our main concerns lie, and that would be the group that we would have as the focus of that, yes.

Mr MADDEN: Are we talking about people without professional qualifications?

Mr Shepherd: When we use the term 'unregistered healthcare worker' we are using the term that the Health Ombudsman uses under the national code of conduct for unregistered healthcare workers. An unregistered healthcare worker is any health person engaging in a health service who is not subject to the Health Practitioner Regulation National Law Act that applies across the country. We are talking about any person providing health care who is not captured by the registration process under AHPRA. That can include people who do have a qualification in health care or a qualification relevant to health care but not necessarily captured under AHPRA. A good example would be social workers.

Mr MADDEN: In your submission you refer to section 22 of the Civil Liability Act and you use the word 'unregulated', but perhaps the word 'unregistered' should have been used?

Mr Prentice: Yes.

Mr Shepherd: Yes. When we have spoken to aged-care providers and regulators about it we have traditionally used 'unregulated healthcare worker', but we made a bit of a change to be consistent with the Health Ombudsman's requirements.

Mr MICKELBERG: My question is about substance management plans as well. In your submission you talk about advocating for a statewide recognised template for SMPs, which I guess makes sense. This bill deals with medicines and poisons. Presumably, for medicines that template would be quite consistent, but it might deal with something like 1080 in a rural setting which would have completely different considerations with respect to how it is ingested et cetera and that template may look very different. My question is a clarification: do you think that template should apply to all medicines and potentially there is a different template for poisons? Was that your intent?

Dr Todhunter: Our focus has been on medicines.

Mr Shepherd: Yes. We come from the context of the regulation of medicines. None of us have any qualification or experience in regulating poisons such as those you are describing. I can certainly see where there would be a template for medicines. It would be fairly consistent, but there would be a different template for managing medicines.

Mr MICKELBERG: You mention clause 127 in relation to the minister or the CE of a health service making a public statement in relation to offences committed against law et cetera and concerns with respect to natural justice. I think you use the term 'blurring' of regulatory roles. You talked about the fact that the Health Ombudsman should be the best person to make those declarations. Understanding your concerns, do you think the public good of having that information more widely disseminated outweighs any of those concerns with respect to potential natural justice issues and/or the blurring of roles that you talk about?

Dr Todhunter: I think we were more concentrating on who had the delegated authority to make a comment on it. I do not think we even took into account the factors of natural justice. We were looking at the body that was going to be making that statement. I think it reflects the fact that we are very much concentrating on medicines rather than the poisons side of things. We felt that the OHO was best placed to make that sort of call.

Mr MICKELBERG: If I use the instance last year with respect to strawberry contamination where we had the Chief Health Officer, from memory, standing up and making a public statement, you have quite wide dissemination across all forms of media. To be honest, I had to look up where the Office of the Health Ombudsman is. My point is that potentially there is greater public awareness of other means by which to disseminate information. Presumably if that information is being disseminated, it is being disseminated for a public good reason; that is, to prevent further instances of an offence or to educate the public in some form. From my perspective, I would say the wider that information is disseminated the better. That is where I am coming from. Through that lens, do you think the minister, for example, making a public statement outweighs the potential negative connotations associated with just restricting it to the Office of the Health Ombudsman?

Mr Shepherd: In the context of the quality use of medicines, we would say that the Health Ombudsman and the Nursing and Midwifery Board of Australia and all of the health practitioner boards have the expertise to determine whether or not medicines have been used appropriately and in a quality way. We would certainly not oppose the minister speaking about something around public health. The example that you spoke about, the strawberry contamination, would be of great public interest and cautions being put appropriately. In the context of the quality use of medicines, I think the expertise on whether or not there has been a quality use lies with the qualified officers of the Health Ombudsman and AHPRA.

Mr MICKELBERG: Just for clarification and to see if you are thinking the same way as I am, the determination should be made by the appropriate people, the Health Ombudsman.

Mr Shepherd: Yes.

Mr MICKELBERG: But the dissemination of that determination could well be through other means as well.

Mr Shepherd: Yes.

CHAIR: Just briefly, should the template for SMPs also include the outlined training needed for people involved in that? You have talked about training. Would putting that in an SMP template be appropriate?

Dr Todhunter: That might depend on the staffing at the time.

Mr Shepherd: The scrutiny of what training would be required absolutely should be in the template, but it is always going to be varied depending on where that SMP is going to be applied to. If you are going to do it in a hospital or if you are going to do it in an aged-care facility there may be different training needs, but I think there should be something in the template that identifies the potential need for training.

Mr Prentice: Potentially also around the standard of that training. The downside is that you could potentially lower the bar in your SMP around the level of training required, which may be less rigorous, for example, than a formal program of training or used to substitute for something.

CHAIR: Thank you. The time allocated for this session has now expired. We do not have any questions on notice. Thank you very much for appearing before us today.

IFEDIORA, Dr Chris, Council Member, Royal Australian College of General Practitioners Queensland

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

CHAIR: Good morning. Would you like to make an opening statement and then we will ask some questions?

Dr Willett: Thank you, and thank you for the invitation. My plan is to restrict my comments to real-time prescription monitoring and the guidelines around the prescription of monitored substances. The RACGP strongly welcomes this initiative from the government and praises the department for the work they have done on this. It has been excellent. The RACGP represents approximately 8,000 general practitioners in Queensland and consequently, after the patients who will be involved in this measure, the largest group of people who will be affected by these changes in the legislation.

To be clear, it will impose an additional burden on GPs, and that is in the context of, as everyone is aware, eight years of Medicare freezes and a lack of indexation in Medicare rebates beyond that. GPs are constantly being asked to do more and more during their consultations in terms of legal requirements and explanations to patients and increasing red tape. Even just referring patients to tertiary hospitals has become a far more complicated procedure. However, despite the fact that we are being asked to do more for less, this is a measure that we would strongly support because we feel confident that it will save the lives of Queenslanders in the future. Thank you for the measure.

In terms of its implementation, we feel that it is really important that this measure is phased in over a period of time. We understand that eventually the use of a prescription monitoring service will become compulsory, and that is reasonable. However, there needs to be a sufficient period of time for that to become implemented into the system. We would suggest that that is probably a number of years. Over that time it is necessary that the real-time prescription monitoring system becomes implemented into the software prescribing systems. We would not like to see it become compulsory until at least 95 per cent of medical software is compliant with the system. That is purely from a usability point of view. Any other web based system will require such security that it would be unwieldy and too difficult to use during a consultation unless it is built into the software that we are using.

Additionally, we feel it is very important that the real-time prescription monitoring and the framework of prescribing monitored substances around that applies to all prescriptions that are going into the community. I think that is a really important principle for that. While many prescriptions are generated in primary care, I would suggest possibly a majority of monitored substances are initiated outside of primary care—either in an emergency department or as part of a discharge—so it is important that those prescriptions are monitored and subject to the framework as well. When those substances are initiated in an emergency department or in a hospital, sometimes there is an issue with clinical handover to the primary care practitioner but also to the patient—creating the idea in the patient's mind that these are temporary medications and not to be permanent. Often patients will present to their GP saying that these medications have been initiated in a hospital and put a lot of pressure on GPs to continue the prescription.

The third thing that we have outlined in our rather brief submission is that education is very important for GPs and for patients. That education should be built into the framework of the prescription monitoring system. We contend that there should be links to the requirements under the legislation about the new requirements under the legislation in terms of what is required for all prescribers to prescribe these medications. There should also be links to educational material. When this comes into force there will be a lot of patients who have been receiving these monitored substances for long periods of time who will then need to be stepped down or stepped off their medications. I can tell you from experience that that is an extremely difficult process and takes a lot of doing and it takes a whole new skill set. I do think there will be some prescribers who will be unprepared for that and they will need some help with that in terms of techniques and ways of helping those patients get on to a more helpful medication regime.

If that does not occur, there are a couple of risks. One is that public hospital services will be overwhelmed. Pain clinics and addiction services already cannot keep up nearly with demand and there will be an increased burden on those services as this system is rolled out. It is important that general practice is properly equipped to actually fulfil those roles because the services just are not there outside of general practice, quite frankly. The other risk is the so-called chilling effect that you

have probably heard about, where prescribers go, 'It's all too hard and in fact I'm not going to give you any of these medications.' Sometimes these patients actually do require these substances, so the important thing is getting the balance right between proper prescribing and perhaps less wise prescribing.

In short, again I would like to thank the Queensland parliament for this initiative. I again thank the department for the really hard work and good work they have done on it and we would like to support what they have done. That was brief.

CHAIR: That was good; we like brief. I will start off with questions. What advantage would the inclusion of all prescriptions in that real-time monitoring bring to GPs?

Dr Willett: The inclusion is not for all prescriptions. It is an expanded prescription set over what has happened in Victoria and Tasmania. I think the department wisely have looked at the experience in the other states and the evidence around those and have expanded the list to a wider range of substances, and I think they have come up with a good set of substances.

The advantage is, of course, that patients in this country are not restricted to seeing one GP and they will, as you know, do some doctor shopping, as the term is. They will go to a number of GPs. There are some patients who will do that accidentally, there are some patients who will do it deliberately and there are some patients who will do it with an element of subterfuge. The problem is that they then build up banks of multiple substances and that results in overdose deaths. There have been innumerable coroners reports about this.

CHAIR: Just to clarify, it is an expanded range of prescriptions monitored under this system, as occurs in jurisdictions such as Tasmania and Victoria, I think you said.

Dr Willett: Yes.

CHAIR: The experience with that has been that people can monitor the cumulative amount.

Dr Willett: That is exactly right. Some of the additional substances that have been recommended actually report little problems with toxic doses in overdose in themselves, but the issue around the world has been particularly with the combination of substances. The vast majority of people who die from overdoses—and that is mostly what we are concerned about with this—have taken a number of substances. That is largely responsible for the expanded medications on the Queensland set as opposed to the other states.

CHAIR: Thank you.

Mr WEIR: How long do you think you would need all of that information for? If we include extra prescriptions, you are going to have a large data bank of information that is going to accumulate. How long would you keep that? How long would that information be relevant for?

Dr Willett: The way the system is proposed to work is that the data is actually not stored in the general practice; it is stored centrally with Queensland Health. The important thing is that it needs to be when we open the patient's file in the medical record, rather than having to consult a web page and use two-factor authentication and have long and complicated passwords that change every eight days. That sort of thing is just a nightmare. It then goes out to the central database and it will flag on our software. We will not keep any data on that ourselves.

Once the patient is flagged, we are proposing that there is a link we can click on in the software and it will show the prescriptions that patient has received—only of these monitored substances—from other practitioners. If a patient comes in and tells me that they have come from another part of the state and they have run out of their opioid prescriptions and they need it and they are starting to withdraw and are feeling unpleasant, I can see that they have actually had five prescriptions from three other doctors in the last little while and avoid that situation.

Mr WEIR: Is that a whole-of-life record?

Dr Ifediora: If I can come in here just to bring in a bit of clarity, the medications involved are not all medications; these are medications that pose a high risk of addiction and injuries to the patient. Most patients would not have to be subjected to this, but if a patient came in to ask for that particular set of medications on the list the doctor would be compelled to look up that particular patient's history. Currently we have no means of checking on any patient we see. A patient could have just walked away from another practice and walked into yours. You have no way of checking. Even when you ring up the drug monitoring office, they only have records of those flagged, not all of them. What you find out is that you may end up giving the patient the same medication he might have had just the day before or the week before and they end up stacking all these things up.

What this system does is compel doctors to look. What we are asking for, in the list we have done, is to make it appear similar so that we do not have to be burdened with having to check this thing. It will come up automatically on the screen because it is built into the system. Like Bruce said, we are very confident that this is going to save lives. If these measures are put in place it is also going to be quite easy to ensure compliance from the doctors.

Dr Willett: To answer your question, I am unaware of the plans for how long Queensland Health will store the data. We will only be able to see the prescriptions from the last few months to be able to make a risk assessment. That is the data that we receive. If I write a prescription for a patient who is doctor shopping, I will receive a letter from Queensland Health outlining the prescriptions they have received elsewhere in the last three months—I am not sure. I imagine that system would be the same. How long that is stored on Queensland Health's database I cannot tell you.

CHAIR: That might be a question for the department when they appear.

Mr MADDEN: Good question. I was very interested that in your submission you dealt with the issue of education. You would have heard the questions I asked previously about unregistered caregivers. There is an incredible range of people and institutions that will have to be educated about a wide range of things with this bill when it hopefully becomes an act. I do not come from a medical background, but with regard to the education of general practitioners, can you give us a snapshot of what the educational program would entail with regard to this bill?

Dr Willett: In terms of the background of education for general practitioners, it is a four-year educational program to become a GP after completion of your medical degree and your hospital training. In that there is education about dealing with addiction and substance abuse. Over my period of being a general practitioner that has improved substantially from when I graduated. My younger colleagues entered general practice much better prepared than I did.

In terms of the education that I think would be necessary for this, there will be in terms of the framework in prescribing these substances a change in emphasis from the entity formerly known as the DDU—what are they called now? Currently if I am prescribing an addictive substance to a patient on an ongoing basis, I will apply to Queensland Health for permission to prescribe that substance and be that person's single prescriber. The proposed change will shift that emphasis from me getting an external permission endorsement to prescribe that to me self-complying with the regulations. It is a big shift in emphasis. It is not inappropriate, but it is really important that all prescribers—GPs and others—understand the increased responsibility that that will place on each and every one of them to be compliant with.

The requirements are over and above—significantly over and above—what prescribers would do now. Again, it is not inappropriate, but it will be necessary for prescribers to have a good understanding of what those are. The best way to do that would be, as part of this program, to actually have links to what the standards are for each of those substances. Last time I looked there were 30 or 40 pages of requirements that each GP is going to have to have in his or her head each time they write those prescriptions. It is quite involved, and it is quite a wide range of drugs. It is sleeping tablets, a lot of painkillers that you would have taken—things like codeine—that previously people were buying over the counter. It is quite an extensive list of medications. Again, it is appropriate but it is quite a bit.

Mr MADDEN: With regard to that educational program, are we talking about online modules, webinars, conferences, literature or all of those?

Dr Willett: All of those. The college is an educational body at its heart, so we would be keen to work with Queensland Health on this. At a minimum, as I said, having some links to what the minimum requirements are is essential. I would like to see links to online modules as well beyond that for practitioners who are struggling with this. As I said, it can be very difficult to deal with. It sounds easy to just say no to someone, but if someone is complaining of terrible withdrawals or terrible pain it can be quite difficult and there is a whole skill set that is necessary to develop around that. The college already conducts a lot of education around this area, but there will be a need for substantial stepping up with these changes.

Dr Ifediora: I will talk a bit more about the education part. There are two parts of the education here. One is for the doctors to get used to the new system. As we all know, change is difficult and it takes time to adjust to any change. Most GPs do not know yet that this is coming. Even when they do know, it will require them to readjust from what they are used to doing to a completely new system. Part of the education we are asking for is the phased-in procedures for them to get used to the new system.

The second part of the education is getting used to the guidelines. Most of these medications are restricted and they have guidelines guiding their prescriptions and dispensation now. There are quite a few of them and it is not something we prescribe every day. It helps to have an education link. It does not mean that you have to go to a place to be taught, but there could just be a link for the doctor to click on to acquaint himself with the current guidelines or changes. This is the type of education I am talking about. Then also the doctor can make a judgement on whether it is safe to go ahead with this and what are the alternatives to stopping that and re-educating the patient. We could have that education system built into the software so that a click of the button takes you to the link.

Mr MICKELBERG: If I have a My Health Record and you are my doctor, can you see the prescriptions that I have had historically?

Dr Willett: In theory.

Mr MICKELBERG: How does it work in practice?

Dr Willett: It depends on the software. With my current software, which is the leading one, I cannot generally see them. The My Health Record—and it is important in other contexts—is not complete. We know that there are over a million people opting out; we know that a lot of people do not have records. I use the leading software proprietor and that information is not currently visible to me. The other issue with that is there is a significant delay in that information going there. The real-time part of this is extremely important, because we know that people who intentionally or unintentionally take overdoses will often collect scripts in a reasonably short period of time.

Dr Ifediora: Something you might wish to know about My Health Record, because it is fairly new—and I have used it quite a lot. The key thing is that most patients that this may affect might have opted out of My Health Record. Even though you can see if you get prescriptions—I have in the last few weeks—you might not have it on the system. Most of them walk in and they are not under My Health Record.

Mr MICKELBERG: Understood. In terms of the software providers that you use—we asked this question earlier of the AMA and we are interested in your thoughts. You talk about the leading software providers. What are the names of those providers that provide the majority of services to GPs? You talk about 95 per cent of users in Queensland. Would 95 per cent be using two, three or four providers?

Dr Willett: Yes. That would be four at most, and I suspect three would get you to that level.

Mr MICKELBERG: Is that the same three or four that are used in Victoria that you said are currently—

Dr Willett: No. Most of them already have it, so that does not seem like a particularly difficult bar to me, but it is essential. The essential things are that it is built into the software and, because it is a substantial change in the way the onus of responsibility will work and the way this will be handled and the work flows and practice, there is a period of time for practitioners to adjust before this becomes a compulsory component.

Mr MADDEN: I have just one question, but I am giving you the option as to whether or not to answer this question. At the beginning, Dr Willett, you said that your submissions relate just to the prescription aspect. I am inviting both of you to make comment about the changes with regard to medicinal cannabis and if you personally or your college supports those changes. Again, I am giving you the opportunity to decline to make comment or to make comment.

Dr Willett: The college has supported the changes to medicinal cannabis, subject to—and the risk is, of course, that we do not want to create the same problem that we are trying to solve with the real-time prescription monitoring. They are actually tight areas of evidence about where medicinal cannabis is useful. Practitioners will come under intense pressure to prescribe outside of those areas. I think there needs to be a very tight framework around sticking to those areas where there is evidence that it is useful. I think it is really important that practitioners are supported in the legislation to do that.

Mr MADDEN: I am pleased to hear that the college supports the proposals with those restrictions as you have outlined.

CHAIR: I imagine there would be a great desire amongst GPs for greater training in dealing with those issues relating to medicinal cannabis, because it is a whole new tranche of procedures and a whole different world that they would need to deal with. Am I correct in that?

Dr Willett: Yes, it is. It is true. It is still quite difficult to prescribe. The vast majority of GPs do not prescribe it because of the administrative burden and difficulty.

CHAIR: That has certainly been my experience with people in my area.

Dr Ifediora: To give you an insight into how difficult it is, in my practice, which is a large practice—we have about 11 doctors—no-one prescribes. If patients walk in asking for it then we have to make arrangements with another practice where there is one doctor who does that. That gives you an idea of how difficult it is.

CHAIR: That has certainly been my experience from talking to local doctors in my electorate as well. There being no further questions, we will bring this session to a close. Thank you very much for appearing before us today. We have no questions on notice.

Dr Willett: Thank you for the opportunity and for the initiative.

Proceedings suspended from 11.12 am to 11.29 am.

CAMPBELL, Mr Chris, Queensland President, Pharmaceutical Society of Australia

LOCK, Mr Mark, State Manager—Queensland, Pharmaceutical Society of Australia

CHAIR: I now welcome representatives from the Pharmaceutical Society of Australia. Would you like to start with an opening statement, and we will have some questions afterwards.

Mr Lock: I thank the committee for inviting and allowing the Pharmaceutical Society of Australia, the peak professional body for pharmacists in Australia, to appear at the public hearing today. Among other roles, PSA is the recognised professional standards setting body for pharmacists and is the custodian of the code of ethics, the national competency standards, professional practice standards and other relevant practice standards and professional guidelines relevant to pharmacists' practice. These are the frameworks that guide the practice of pharmacy here in Australia and are referenced by the Pharmacy Board of Australia under the Australian Health Practitioners Regulation Agency. I would like to table these documents for the committee's reference: the code of ethics, the national competency standards and the professional practice standards.

CHAIR: Thank you. It is so tabled.

Mr Lock: Overall the society views the bill and the draft regulations as a step in the right direction to modernise the regulatory framework, but we believe that the Queensland government has the opportunity to do more to ensure the new framework reflects current and future opportunities within the contemporary practice of pharmacy. In January this year, PSA released *Medicine safety: take care,* which I would like to table for the committee as well.

CHAIR: Thank you. That is tabled.

Mr Lock: This report revealed that each year in Australia 250,000 patients are admitted to hospitals due to problems with medications, costing the system a total of $1.4 billion. Another 400,000 additional presentations to emergency departments are likely due to medication related problems, and these numbers are growing. The report also revealed alarming statistics associated with medication related problems in transitions of care, aged care and community settings. To help address these issues, this year PSA released *Pharmacists in 2023: for patients, for our profession, for Australia's health system*, which is an action plan that I table for the committee as well.

CHAIR: Thank you.

Mr Lock: This document contains 11 actions for change that are needed in order to better utilise pharmacists as medicines experts to address medication safety for all Australians. A key action item, No. 9, relates to addressing issues related to rural, regional and remote areas. We all know that Queensland is the most decentralised state in the country, and this presents challenges to the healthcare system. This was highlighted in last week's state budget. This is particularly relevant to medication access for consumers in these areas. In terms of emergency supply and continued dispensing of medicines, regulatory provisions are vital to ensure the ongoing medicine supply to consumers where access to doctors is not possible. Challenges to accessing medical care in regional, rural and remote areas of Queensland can be very difficult to address. More flexibility to provide greater quantities and a larger range of medicines under existing emergency supply and continued dispensing regulations is essential to allow ongoing supply of life-saving and illness-preventing medicines for all Queenslanders.

We also know that Queensland continually faces natural disasters and extreme weather events. Again, this was highlighted in the recent state budget. This is another example where the current regulations pertaining to a three-day emergency supply and continued dispensing of a very limited number of medications are inadequate to ensure the health of all Queenslanders. PSA encourages the Queensland government to change the current regulatory provisions to enable pharmacists to supply a standard manufacturer's pack for emergency supply provisions and allow continued dispensing of all schedule 4 medicines, particularly those needed to manage chronic illness. This will help ensure the health and wellbeing of Queenslanders.

Finally, PSA would also like to highlight the importance of the need for a regulatory framework that stays relevant with contemporary practice, which will continue to evolve in the future. This has been echoed in other submissions to the committee by representatives of other health practitioners as well. We need to ensure that the regulatory framework does not become a barrier to a health practitioner practising within their scope of practice but rather an enabler. The scope of practice of AHPRA registered health practitioners is determined by the relevant national boards. Public safeguards are in place under these boards through various codes and guidelines to which pharmacists and other health practitioners must adhere, including the documents that we have tabled today which are relevant to pharmacists.

Many health services, including the prescribing and administering of medicines, fall within the current skill set and competencies of a pharmacist, but state legislation and regulation is the limiting factor. The need to remove regulatory barriers to non-medical prescribing and medication administration has been echoed by other health practitioners in their submissions as well. One of the actions in the Pharmacists in 2023 action plan—No. 4—is to facilitate pharmacists prescribing. Queensland has the opportunity to be a leader in health care by utilising pharmacists and other health practitioners to their full scope and ensuring the legislation does not continue to be a barrier to this. PSA encourages the Queensland government to remove those barriers. Thank you for the opportunity to give a statement. I am happy to take some questions.

CHAIR: I will start with one issue that has occupied us a bit today—that is, the IT interface. Other stakeholders have spoken about the double log-in and the time taken to access the real-time monitoring, for example. Could you give us a picture of, say, one of your members logging on? How would their systems integrate with a real-time monitoring system? From what we understand, there are a number of commercial providers of software and they have to integrate with that government database?

Mr Lock: I will let Chris answer that question, but I declare that both of us are on the working group for the monitoring medicines unit, working with Sue Ballantyne.

Mr Campbell: In terms of the required work flow, a system like this would flag at the point of dispensing an item. You would be going through the same work flow and it would highlight, almost like a flag, that there may be a need for further investigation. Without having that implemented yet, we envision that would open onto another screen to look at what is included in the real-time prescription monitoring database in terms of what sort of alert flags there would be: 'has it been dispensed elsewhere in a previous three-month period?' It is a clinical decision support tool at point of dispense.

CHAIR: The GPs, for example, indicated that flags would come up on their system. Then flags would come up on the systems of pharmacists as well. Is that duplicating the system or is it a case of there being appropriate checks at different points in the process?

Mr Campbell: It is not necessarily duplicating a system; it is enhancing the system we have currently. If a patient was utilising only one pharmacy, within your own dispense offer you can see that. There is a level of rigor around 'I can see a dispense history', but that is just within one practice. Yes, we do have access to the My Health Record if the patient has not opted out. There is an ability to do that but it is not mandatory; there is a level of barrier to access it. It is not within work flow, whereas having that real-time check as part of that dispense process would be. I have seen the Victorian SafeScript and the way that is integrated. I do not see any different implementation or work flow for Queensland. That involves opening up to another screen to look at it further. The flag will identify that, as a pharmacist, I need to investigate further. Has it been prescribed by multiple prescribers or has it been dispensed by multiple dispensers in a short period of time? Do I need to act on that?

Mr WEIR: My question concerns substance management plans. What would that document look like and who has oversight of that document?

Mr Campbell: It is an excellent question. We as a society were quite interested to look at what template would be suggested by the state government. In community pharmacy we have accreditation standards that we need to adhere to around substance management, but without the details around what would be required it is a difficult question to answer. However, there are quality standards that pharmacies need to meet in order to be accredited—the majority are—through the nationwide Quality Care Pharmacy Program. There are requirements under the current legislation around how we deal with scheduled medications. If we are looking at schedule 8 medications—controlled drugs—there are processes that specifically point to the way a pharmacy deals with those. Our assumption is that there would be a level of crossover with what is in that regulation. I am not sure whether I have fully answered the question. We see reference to it, but we would hope to see an example template of what is required.

Mr WEIR: I note that you support it, so you must have some vision in your mind of what that document should look like. Who has oversight of this document?

Mr Lock: Within an individual pharmacy?

Mr WEIR: Yes.

Mr Lock: I believe that the draft regulation suggested that the owner of a pharmacy has the oversight, to ensure it is in place and complied with.

Mr WEIR: That is just for the pharmacy. What about on a larger scale?

Mr Lock: On a larger scale for the whole system?

Mr Campbell: It makes sense for MRQ to oversight that. Within that premise, it is the pharmacy owner, or in a hospital pharmacy the head of department, who would be the owner of that document within the pharmacy and responsible for its implementation. If the requirements of the substance management plan were specific enough, they would be under the same requirements that we currently have with MRQ to adhere to those standards. Again, in my mind, the devil is in the detail.

Mr MADDEN: I thank the Pharmaceutical Society of Australia for its great support of Skilling Queenslanders for Work. It makes a very innovative contribution to that program. How does your society intend to provide educational programs for your members and staff with regard to this, assuming that this bill is passed by parliament? Secondly, how will life change for individual pharmacies should this bill be passed by parliament?

Mr Lock: The society is the largest provider in the country of education for pharmacists and we do a lot of continuing professional development. This would then form part of ensuring that pharmacists have appropriate training to ensure they are upskilled for when this is implemented. There would be various different aspects to that, depending on what changes occur. That would definitely be a priority for us when this legislation comes into force.

Mr Campbell: There is a high level of requirement in dispensing process. There is the time and the impost of looking into the system. We support the system. It helps make a better clinical decision than guessing that someone looks like they may have seen another doctor or may have seen another pharmacist. It gives us a level of certainty around our clinical decision, but there will be a longer period of time or a higher wage impost to dispense a prescription safely. From an education perspective, yes, we have pharmacists' education. We also have the entire team, so our pharmacy assistants. PSA provides education to the support staff as well.

Mr MADDEN: Is that done by webinars or module training?

Mr Campbell: Multiple ways.

Mr Lock: We do everything from face-to-face, online, print—all forms of education, yes. We would be happy to work with the department to deliver that education for the pharmacists across the state.

Mr MADDEN: That is good news. Thanks, gentlemen.

Mr BATT: Thanks for your time, gentlemen. Earlier you mentioned the supply of S4 medicines in urgent circumstances and a possible modification of that from three days to a minimum standard pack. I just wondered if you could go through that a bit further as to why that is required from your perspective. Have you had any conversations, other than writing it into this submission, with the department about that and have they given you any response to that?

Mr Lock: The difficulty lies in being able to access a doctor in a short period of time in an emergency situation when someone has run out of their medication, in particular in rural and remote areas, and then beyond that when a natural disaster has happened. We have had discussions with the department on that before. We have not gone much further, but we have had those discussions. We also mentioned as part of the pharmacy inquiry last year, as did other stakeholders, the importance of being able to provide that continuation of medication beyond just three days, which is obviously a very short period of time, especially when you are talking about a Friday afternoon.

Mr Campbell: 'When Queensland happens'.

Mr Lock: Yes.

Mr BATT: That is a good line.

Ms PUGH: Is that slogan catching on, is it?

Mr Campbell: I think it is. Further, there is precedent that continued dispensing is a process that is appropriate for pharmacy. We have statins and the oral contraceptive as examples under current existing legislation that supports that. It is looking at that standard minimum pack to ensure the continuation of an already prescribed medication, so it is ensuring someone does not stop inappropriately.

Ms PUGH: I note that in your brief outline there is mention of the potential for substance management plans. How might you see those being implemented and why?

Mr Lock: In terms of an implementation process, we are going to see it probably in a staged process because obviously there would be a period of time to bring everyone along on that particular journey. Because pharmacies, under the current accreditation program, do reaccreditation every two years, we would want to see that fit in with that cycle just to ease the burden on the workforce in transitioning.

Ms PUGH: So training would be the key thing there in that you want to make sure your workforce is up to scratch?

Mr Lock: Yes.

Mr Campbell: Yes, and also the implementation time. Again, it depends on exactly what is required within that substance management plan and whether or not they will need structural changes. It is about exactly what is in that requirement. We currently have accreditation standards around how we deal with medications.

Ms PUGH: Excellent. After listening to your opening statement, I just want to be really clear: did you say 250,000 admissions a year on prescribed medication? Do you have any data or information of some of the medications that might be causing the highest volume of those admissions? That is a really staggering number.

Mr Lock: Yes. Some of that data is in that medicine safety report. If there are any particular ones that you want, we can take that question on notice and find some more for you if you would like.

Mr Campbell: It is a continuation. If we look at the monitored substances, there is a natural link there. It is why the expansion of a lot of the monitored substances will include not just schedule 8 controlled drugs, which we currently upload once a week, but also S4 medications like pregabalin. There are other high-risk medications that will be part of the real-time prescription monitoring as one example, but there are other high-risk medications, most definitely, that pharmacists flag to make sure we are doing our duty of care.

Ms PUGH: Awesome. You just mentioned real-time prescription monitoring. What is your view on how that might roll out for your members? Do you see any benefits or drawbacks for not only your members but also their clients?

Mr Lock: We are at the point where, once it is integrated, we believe that that would be the time for it then to be mandatory, but until it is fully integrated into dispensing software, or a certain percentage of the dispensing software, we would see that that would be part of the transition period where we would encourage people to use it but it would not be mandatory due to workforce implications.

Mr Campbell: From a clinical perspective, it is that communication with a prescriber in ensuring that free flow of communication occurs. There may be scenarios where that is highlighted and that communication needs to happen. It has been mentioned in previous sessions today around ensuring that we have easy access to alcohol and other drug services and to chronic pain management services. In our mind the education is not just around the real-time prescription monitoring—the technical side of things—but also the referral on. For example, let us say we have identified someone who may be in need of further care. Whether that is substance use disorder or there is chronic pain, there is extra care that is required and then there is the referral pathway either from the pharmacy or through a GP or even directly to those services. We would hate to see a scenario where a patient is denied supply of a medication and then will go on to illegal substances et cetera. It is about making sure that we close the loop.

Mr MICKELBERG: I want to expand on the question from the member for Bundaberg in relation to the supply of S4 medications in urgent circumstances. It just strikes me, particularly in rural areas like Cape York, where you have a wet season, that that is going to be a considerable issue for people in that part of the world. Can you give me some examples of drugs—it does not have to be a brand name but just generic examples—where conditions require a steady state to be established in the blood and if you stop taking medication for a period of time you basically have to start again to re-establish it? I understand with epilepsy medications, for example, you have to go through a process to get it to a steady state and keep it within that tolerance. Are there other examples?

Mr Campbell: There are plenty of examples. An easy way to group it would be anything for a chronic condition—anything. Imagine supplying three days of insulin for someone. Imagine someone who is stabilised on their heart medication and we go, 'Oh, sorry. You've only got three days. That's all the legislation provides,' and they do not have that stabilisation of their blood pressure or they throw a clot and have a heart attack or a stroke. Epilepsy was a great example but there are plenty. It would be anything that is a chronic condition.

Mr MICKELBERG: You said earlier that there is precedent, effectively, with respect to oral contraceptive pills. Without putting words in your mouth, I guess logically it extends that if they are life-sustaining type medications the principle should hold that an individual can maintain supply sufficient to not suffer from the acute condition?

Mr Campbell: Yes.

Mr MICKELBERG: If the principle holds, for example, for the oral contraceptive pill?

Mr Campbell: Yes.

Mr MICKELBERG: Thank you. You talk in your submission about the sale of pseudoephedrine as an S3 medication but say that not all supplies of pseudoephedrine are S3. Can you give us some examples of non-S3 supply of pseudoephedrine that would not be captured within the real-time reporting?

Mr Lock: That would be when a doctor is prescribing it in a quantity that is greater than an S3 quantity and therefore being provided on a script and that does not have to go through the real-time Project STOP at that point. Capturing all of the data on all supplies of pseudoephedrine is the intent of what we said.

Mr MICKELBERG: This may be a question for the department, but your understanding of the rationale for not capturing that non-S3 supply is—

Mr Campbell: It is an omission. I think it was clerical.

CHAIR: In your submission you talk about how under this bill an extended practice authority, an EPA, can be adopted and you support the placement of that by a drug therapy protocol but you feel that perhaps may put the ability of your association to provide vaccinations at risk. Have I got that right?

Mr Lock: No. It surrounds transferring those drug therapy protocols into the extended practice authority but then whether something is an extended practice that you are doing versus something that is within your scope but does not actually fit within the current legislation. That is what we are talking about there. Vaccinations are within scope and therefore not necessarily an extension and therefore should fit, either within the legislation or under terminology that reflects current scope.

Mr Campbell: It is looking at ensuring that there is ability for the regulations to allow for that fulfilment of scope, so administering a medication is a scope activity and it specifically says that vaccination is extended—removing the word 'vaccination' from there. Then further on from that it is not an extended practice; it is part of scope, so it is a structured practice authority. It is a nomenclature.

CHAIR: To paraphrase that, you are happy where that lies at the moment but you are making sure, because it is in scope, that it is not lost?

Mr Campbell: It is an extended practice authority to use for when there is an extension of practice, so you are requiring or credentialing to do a certain task, whereas the drug therapy protocol, for example, allows a pharmacist to administer adrenaline or administer an immunisation or multiple immunisations under a drug therapy protocol. As it is proposed to move into the new one, it is quite prescriptive that it is for a vaccination extended practice authority. Does that make sense?

CHAIR: Yes.

Mr Campbell: It is prohibitive if there is another medication to be administered by a pharmacist.

CHAIR: Has the department been responsive to your suggestions on this? How have you worked with the department when dealing with this particular issue?

Mr Lock: We deal with them on a regular basis as it pertains to the drug therapy protocol currently for vaccinations and around what sits under that. We have had discussions about expanding it to other things—other vaccinations and other medications that can be administered, which falls under the same training that pharmacists take to administer vaccinations. There are other medications that pharmacists are qualified to administer based on the training they do, but the DTP only allows you to administer vaccinations.

Mr Campbell: They have been quite supportive to make sure the legislation is enabling of the health professional, so making sure that it enables us to be able do it in a regulatory framework. Given the tight time frames they had to turn it around, perhaps that was something that was not considered. If we look at what our current scope of practice is, you would want to ensure that the legislation is future looking—that is, what is happening overseas? Are we two decades behind the UK, for example, or the United States? There is evidence of where the profession has moved elsewhere and it is ensuring that our state legislation allows that to occur.

CHAIR: Good. Thank you for that.

Mr WEIR: I note that you are also affected by the changes to the poisons act, so what aspects of that are you supportive of? How is it going to improve things for the pharmacy industry?

Mr Lock: We are supportive of streamlining anything to reduce any administrative burden that exists and anything that can lead to national consistency—so referring to the poisons standards nationally to get some consistency. Pharmacists are registered across the country and move between states. That consistency reduces the confusion that can occur.

Mr WEIR: Yes.

Mr Campbell: Yes, a national consistency.

CHAIR: There being no other questions, we will conclude this session. Do you have a question on notice?

Ms PUGH: Yes, if that is all right. I would really appreciate—

CHAIR: And that was about—

Ms PUGH: The high-risk medications that most patients were presenting to hospital within that 250,000 visitations to hospital cohort.

CHAIR: We would appreciate it if the answer to that question on notice could be provided by Tuesday, 25 June 2019.

Mr Lock: Yes.

BOWEN, Mr Tim, Senior Solicitor, Advocacy, Claims and Education, Medical Insurance Group Australia (via teleconference)

CHAIR: Welcome. We have your submission and we have questions. I ask you to make an opening statement and we will follow up with some questions.

Mr Bowen: Thank you for the opportunity to appear before the committee today. I apologise for not being able to be there in person. We are a medical defence organisation and professional indemnity insurer advising, educating and advocating for our members around prescription medication issues across the country. We support the clearer modernised model for prescription for doctors that the bill and the regulations are seeking to provide. In particular, we are very supportive of the move towards real-time prescribing.

Queensland Health has helpfully responded to a number of the issues that we raised in our submission through its response on the inquiry's website. We are encouraged by their commitment to a risk based, education-first approach to enforcement before quasi-criminal court processes and financial penalties are pursued and also to educate the professions around this new regime. We still have some concerns about the implications of prescribing errors, doctors who have their own health issues and digital health initiatives.

On prescribing errors, Queensland Health has acknowledged that more needs to be done to explain the authorised way—in other words, the appropriate way—to prescribe medication in order to avoid exposing one's self to a financial penalty. We think this underscores the complexity that doctors will be faced with around prescribing obligations and our concern that well-intentioned doctors trying to do the right thing may do it the wrong way, given that the obligations can be complex. We do not think well-meaning errors should be dealt with by financial penalty but, rather, by counselling and education. We encourage Queensland Health to consult with us and other professional stakeholders on what they have outlined as an intended internal policy around the reasonable excuse defence for prescription errors.

On the issue of self-prescribing and health issues, we agree that self-prescription by doctors of high-risk medications is problematic, potentially risky to them and the community, and may indicate an impairment issue. The Medical Board has well-developed paths for dealing with impairment and doctors' health issues, reinforcing in our mind the need for referral of these matters to the board rather than seeking a financial penalty through a court process.

Issues around treating practitioner mandatory reporting, which were recently considered by the parliament's health committee, illustrate the need to avoid placing barriers to doctors seeking help for impairment. We are concerned that the spectre of a court process and financial penalty, if self-prescription emerges, after seeking professional care could well be another barrier to doctors seeking that care and ensuring the public remain safe.

Finally, on digital health systems, we do not dispute at all that regulators should be able to access digital health databases, like the real-time prescribing system, as part of ensuring safe practice. We remain concerned about the apparent intention to proactively check if doctors are using the new system correctly. We are not encouraged by this approach as we sense, and we are concerned, that it may also be presumptive of doctors getting it wrong in a new regime and could leave doctors with an uneasy feeling as they engage with it. Thank you.

CHAIR: Thank you very much, Mr Bowen. Are there any other jurisdictions where self-prescription is criminalised? Is that common across Australia?

Mr Bowen: I understand there is a provision in Victoria around that.

CHAIR: How has that proceeded so far?

Mr Bowen: I am not aware of any experiences that we have had of that.

Mr WEIR: My question goes to your last point. You talked about the monitoring of the register. What did you mean by that?

Mr Bowen: There are principles or objectives of the bill that talk about the object of the real-time prescribing system. One of them is to ensure compliance and provide access to regulators to ensure that things are being complied with. We are concerned that that indicates a hint, or perhaps might be taken by others to be an encouragement, towards monitoring the database to try to pick up errors by doctors that would then potentially expose them to a penalty.

Mr WEIR: If there were not some form of oversight, how would you ensure that the system was working?

Mr Bowen: We acknowledge the need for oversight; we are just concerned about where the line is around how much proactive checking there is. The regulation of doctors and the broader health profession is not necessarily something where a regulator has bodies or groups sitting there proactively to check what doctors are doing as they do it. It might be where patterns of concern arise or where a complaint or another issue has arisen.

Mr MADDEN: Mr Bowen, my question relates to the issue that has already been raised, which is the issue of the potential criminalisation of self-prescription as provided by the bill. Could you outline what drugs we are talking about and also advise the committee as to how medical practitioners who are found to have self-prescribed are dealt with by Queensland Health and medical organisations?

Mr Bowen: We are dealing with schedule 8 prescriptions or other things that might have an addictive potential to them. They are medications that are concerning, both for the doctor and for the patients in the community, in terms of how they may affect that doctor's practice. If that occurs, it would normally be handled by the Medical Board through its health program, or health pathway as it is called.

Where it is an issue of being able to remediate and stop that occurring, they would involve other independent health professionals to work with that doctor—perhaps impose some conditions that they consult a GP or other specialist regularly—to avoid that issue arising again. We think that is a good path and a good approach. Our concern is that, if that is not the default path as such, we might be seeing doctors who think, 'If I see someone and disclose self-prescription, or they see it, I will suddenly be before a court process and facing a financial penalty.' The way to stop that, if these issues emerge during the review of what the doctors are doing as part of the department's obligations, is to refer these issues to the Medical Board in the first instance.

Mr MADDEN: Just to make it clear, when you say 'schedule 8' drugs, are you referring to drugs like morphine and other painkillers?

Mr Bowen: Yes, certain opioid based painkillers, although it would not be all painkillers caught by the regime, as I understand it.

Mr BATT: Mr Bowen, at the moment it is a criminal offence for any person to supply those types of drugs to anyone inappropriately, whether they are a doctor or someone else in the community; is that correct?

Mr Bowen: There is a range of criminal provisions around how things are prescribed and supplied but, as a broad proposition, yes, there is a significant amount of criminal penalties around how one prescribes and supplies at the moment for doctors.

Mr BATT: If a doctor inappropriately supplies one of those drugs now to somebody else they commit a criminal offence, but you are saying that if they supply it to themselves it should not be a criminal offence?

Mr Bowen: We have concerns about how it is dealt with. We acknowledge that there may be situations where a criminal penalty is appropriate. We might be talking about situations of wilful or ongoing conduct. Where we have a doctor with a health problem who does not have the insight initially but is able to recognise that problem with appropriate counselling, we would like to see them go to that Medical Board health program first, before any consideration is given to a penalty as such. We are concerned that having the spectre of that penalty is a problem in encouraging doctors to seek help.

Similarly for the prescription error, we acknowledge that there are serious cases that can warrant a penalty—wilful, continual misconduct. Again, we are concerned not to criminalise the unintentional error, the well-meaning error.

Mr BATT: If a member of the community inappropriately hands over a schedule 8 drug to someone else because of a drug problem, as you say, I would think that a doctor doing that would be held to a higher standard than someone in the general community doing the same thing.

Mr Bowen: I accept that the standards on doctors must be high around this. The question is the appropriate process to protect the public. We say that it is initially to work out if this issue can be dealt with and fixed up without the need for a criminal process, because having that spectre of the criminal process may stop it from emerging in the first place and not provide the opportunity for that risk of harm to be avoided.

Ms PUGH: With regard to the self-prescribing, if people are looking to seek help, we are potentially talking about somebody with a dependence or even an addiction. What about those repeat offenders? How would you see them being dealt with if it happens more than once? I am sure doctors are just like any other member of the community: some of them are going to develop a dependence and further intervention may be required.

Mr Bowen: The Medical Board deals with cases like that. If it reached that point where intervention by a doctor's peers or oversight by the board has not been enough to stop them from that self-prescribing, it would then be a question of what is the appropriate way to deal with this. The board has existing powers to bring action to restrict a doctor's practice, seek a suspension of them from the practice or deregister them for a continuing problem that cannot be stopped to ensure the public is protected. It may be at that point that it would be appropriate for consideration to be given to that financial penalty under the legislation that Queensland Health will be provided with.

Again, a financial penalty for very inappropriate conduct already exists under the Medical Board's regulatory regime. We would again question whether that financial criminal penalty needs to be in this legislation when there is already something available in the appropriate circumstance for the Medical Board to pursue.

Mr MICKELBERG: I will continue with questions in the self-prescription vein. Can you give me some examples when self-prescription, be that for a S8 or any other S4 drug, would be required by a doctor?

Mr Bowen: Self-prescription in a sense of being required by them. It would be a rare situation where a doctor could not seek assistance from a GP. The problem when doctors do some self-prescribing of something like a schedule 8 drug is a problem of accessing that care. It might be because they are working so hard in the hospital system that they just cannot get to see a GP within hours. What we find as well is doctors are concerned about going to see the local GP for fear of being recognised as a doctor and having a problem or that perhaps their problem will not be dealt with in the right way because the doctor they are seeing does not appreciate the challenges they are facing in seeking help. That is the situation where doctors might be tempted into doing what they think is a minor self-prescription but can lead down that slippery path as things continue.

Mr MICKELBERG: I understand that and I appreciate they are issues, but I would contend that many of those examples that you just described could also apply to a wide section of society as a whole in other roles, not just doctors. What concerns me is that, if we allow doctors to self-prescribe at all, to be frank, particularly with regard to S8 drugs, surely that is, as you say, a slippery slope that some may take advantage of. I will use the example of a bank manager, crude as it may be. A bank manager cannot write out a loan for himself for a very good reason. He or she knows the processes and by virtue of the fact that you know the processes, you know how to work around the processes and it also exposes the individual and the entity they are working for to risk. In this case the consequence is even greater than a bank manager writing out a loan, yet we are letting doctors potentially prescribe themselves drugs, admittedly sometimes for entirely legitimate purposes. Where there is an alternative of embarrassment, or fear, or professional workloads, I think that same logic applies to a wide section of society. I struggle to accept that justification with respect to the consequence that will occur in the event that it goes wrong.

Mr Bowen: We accept the need for the right consequences and potentially serious consequences for doctors who do things like continuing self-prescription where that cannot be stopped. From our perspective, we need to move the profession away from self-prescription and try to make sure that that does not occur. What we question is the right way to do that and we look towards a 'let us have the Medical Board, as the professional regulator, deal with that first' approach.

Mr MICKELBERG: I understand. Linking that issue with the proactive checking point you made earlier—you talked about a hesitancy with respect to that proactive, call it compliance checking, and the potential requirement to do so and you talked about patterns of concern arising—how would those patterns of concern in the event of a doctor who is self-prescribing be identified other than through the pharmacist who may be dispensing, given they are the only other link in the system if we are not proactively checking the system itself?

Mr Bowen: We are talking about a question of what is going to be done around monitoring of the database. What are the practicalities of it? Certainly, patterns of concern need to be picked up, whether that is at the pharmacy level, a doctor's peers or by Queensland Health. The question is one of are the right processes in place to pick up the concerning prescribing patterns or will there be a focus at looking at one-off things to try to correct that? That is the concern that we have: that a doctor might feel that they are being watched and if they get one thing wrong they will be in trouble. It might be a matter of Queensland Health being clear or consulting with the profession around what is its intent around monitoring—`How is it going to be done to avoid any concern or fear that the regulator is watching every move I make and if I make one error I will be in trouble for that.'

Mr MICKELBERG: Do you think it would be reasonable—and I am asking for your opinion—for a monitoring regime, for example a computer based monitoring regime, to be proactively looking for patterns of behaviour across the entire system or do you think that that monitoring should only be informed by either witness information or concerning conduct?

Mr Bowen: I think it is reasonable to have some mechanisms in place for those who are monitoring it within Queensland Health to pick up those concerning patterns and not just have it that where it is a complaint they are made they look into it. The question then becomes: what is the threshold for a concerning pattern?

CHAIR: I will adopt a slightly different position for these questions. The medical industry itself has very well established and resourced bodies. Do they have a good record in identifying and rectifying patterns of practice that may be questionable or where doctors have placed themselves at risk? Is there is a relatively good record of self-policing, shall we say?

Mr Bowen: Yes, policing by the Medical Board and others.

CHAIR: Is it common to have those bodies integrated within the health system to assist with that monitoring and rectifying that behaviour?

Mr Bowen: Are we are talking about the role of something like a medical board?

CHAIR: Medical board, college of GPs, pharmaceutical association, for example. How well are they integrated within the health system to provide that oversight?

Mr Bowen: We think they are integrated quite well. The question would then be one of does Queensland Health, when the new regime comes into place, need to have certain protocols or memorandums of understanding with the Medical Board and others if there is an issue of do we refer it to the Medical Board or, if there an issue around education, do we engage the college of GPs or the other appropriate specialist association around it? We think there is a good system there that can be built on. It might just need some work in how it applies to this new regime.

Mr WEIR: I note that you have expressed some concern around treating practitioners and mandatory reporting. What is your concern with that part of the legislation?

Mr Bowen: There is an obligation on a doctor who treats another doctor or another registered health practitioner, if they believe that that person has an impairment that is not just a health condition of itself but something that puts the public potentially at risk, to report that to the Medical Board or, in Queensland, to the Health Ombudsman to take action as necessary. There has been considerable debate about whether misunderstandings or how that is framed is stopping doctors from seeking care because of concerns that, if they have a mental health condition, for instance, they will be reported to the board and their career will be put at threat. As I mentioned, there are misunderstandings around that, but it has meant a lot of work has been done to try to avoid those barriers to get the reporting threshold right. What we are concerned about is, if we add another layer of potential implication for doing something or having a health issue, it might be another one of those barriers. That is why we are concerned to make sure it fits in with the work that has already been done around mandatory reporting.

Mr WEIR: You believe that this legislation will make that more difficult?

Mr Bowen: I would not say that I believe it will make it more difficult; I am concerned that it could make it more difficult.

Ms PUGH: Back on the reporting issue, if we are not talking about imposing those criminal restrictions, what can we do to pre-emptively educate doctors? You have talked about the embarrassment of potentially being recognised. I do not know about everybody else, but I have certainly been to the pharmacy and GP and been recognised and it is a little bit embarrassing, but it is part and parcel of seeking health care as a female of child-bearing age. It is not fun, but it has to be done. What can we do to educate doctors that that embarrassment is sometimes part and parcel of seeking preventative and other health care and encourage them to do it anyway because it is the right thing to do for a number of reasons before it gets to the point where we need to intervene?

Mr Bowen: There is already some work being done by us and other similar organisations, colleges, the AMA and the Medical Board, around encouraging doctors to be proactive about their own health care, such as have their own GP and avoid self-prescription. The doctors' health service in Queensland provides a referral mechanism, as I understand it, if a doctor wants to find someone but does not know who to go to or is concerned about the embarrassment of going to the local GP or someone they know. The more work that can be done amongst these stakeholders the better. It may

be that it is a matter of engaging Queensland Health in that process. There is a strong body of people working towards having the point where a doctor can seek that assistance and there is not that reluctance, or barrier, or embarrassment as you observed there.

Mr MICKELBERG: I have a question with respect to the impact of this proposed legislation on premiums for doctors. I wondered if your organisation had considered or done any modelling with respect to the potential premium impact associated with the legislation as proposed.

Mr Bowen: We have not done any modelling around that. Our analysis of it so far has not raised any issues around that.

CHAIR: There being no further questions, that brings this session to a close. Mr Bowen, thank you very much. We appreciate it. Your sector of the industry is an important part and we are glad you were able to contribute.

VITELLI, Ms Marie, Policy Officer, AgForce

CHAIR: Would you like to make an opening statement? After that we will no doubt have some questions for you.

Ms Vitelli: I do have a short opening statement. Thank you for the opportunity to participate in this public hearing on the Medicines and Poisons Bill and the associated regulations. I represent AgForce Queensland, a member based state farming organisation for Queensland's beef cattle producers, sheep producers and dryland grain growers. We have over 5,200 producer and agribusiness members and our members manage approximately 40 per cent of Queensland's agricultural landscape.

Our interest in the Medicines and Poisons Bill is with the use of schedule 7 agricultural and veterinary chemicals, especially the vertebrate pest animal poisons such as 1080, PAPP and strychnine. The only medicines of interest in the bill are the access to animal antibiotics through the medicated stockfeed used in feedlots and intensive livestock production. Our main part is on the poisons side of the bill.

The proposed minimum training competency requirements in the draft regulations for pest management and poisons will impact on our producers and many of the fee-for-service providers for agriculture. This includes fencing contractors using insecticides to control termites in fencing or stockyard building, persons applying cattle tick insecticides, grain fumigators and some of our pest animal baiters and trappers. The Department of Health is taking a precautionary approach with community safety, although there have been very few incidents of human toxicity arising from producers using schedule 7 poisons.

If the parliamentary committee deems that these training competencies are absolutely necessary, AgForce recommends a long transition period of one to two years if this bill comes into force to enable producers and the wide range of agricultural service providers to acquire those competencies.

They will be itemised in the standards and the regulations, but we are aware of some of the proposed competencies. For some of these nationally recognised competencies, there is a real issue of accessing training in rural and remote areas across Queensland and also sufficiently skilled trainers for courses, such as for applied pest animal control techniques. We are aware that PestSmart, a national R&D body, is looking at some of the national competencies for vertebrate animal control.

The definition of 'regulated poisons' in the draft regulation includes schedule 7 substances. In Queensland, there are 90 schedule 7 substances in agricultural chemical and vet chemical use. Those are registered across 420 agricultural chemical products. It is important that the requirements for wholesale and retail supply for the schedule 7 products do not impede on agricultural production. One example is that the regulation states that the buyer must be authorised to buy these schedule 7 poisons. If a grain grower needed to purchase zinc phosphide baits, which is a schedule 7 poison, in wholesale quantities to control a mouse plague in their crops, what are the prior authorisation requirements and will the current proposal impede their ability to control, say, a mouse plague, which would require a wholesale supply?

With regard to the public register for holders of restricted schedule 7 substances or poisons, AgForce recommends that landholders can opt out of that requirement. Producers effectively manage the storage of vertebrate poisons on their farms. They are very careful with them and store them appropriately, as legislated and required. There is a risk that a public register could be misconstrued and used against producers, especially when we see the increased level of activists invading farms and sometimes when pet owners are quick to blame someone for the death of their pet dog if they suspect toxicity. A public register of producers with some of those restricted schedule 7 substances, such as 1080, PAPP and strychnine, could be misconstrued and that puts people at risk.

In closing, AgForce is aware that the major reform to the medicines and poisons legislation has been drafted over three years or more. AgForce commends the policy unit in the Department of Health protection branch for consulting with AgForce over the past two years. We have ironed out most of our raised queries and issues. I welcome any questions from the parliamentary committee pertaining to regulated agricultural poisons and medicated animal feeds.

Mr WEIR: Some of the issues that you have raised probably lie in the regulation.

Ms Vitelli: Yes, it is more on the regulation. Like a lot of legislation, it is the regulation that has the detail and you need to be aware of the impact of that.

Mr WEIR: You talked about training and competencies. You said that that needs to be done over a significant time frame. To an extent that happens now, but is it your understanding that it would be even greater under this new act?

Ms Vitelli: Yes. My understanding is that within the regulations now a lot of what we call fee-for-service providers, such as fencing contractors, baiting people and part-time pest management people working in rural areas, will have to have a general approval to use some of those schedule 7 poisons. They will need to do the two units of national competency, which is the use of chemicals and the storage of chemicals. That applies to a lot of fencing contractors, a lot of people who may be doing baiting and some of those people trapping wild dogs who occasionally use strychnine in the traps. If a dog is trapped and they cannot get back to the trap straightaway, the dog will pass away quickly. A lot of those people would not have been exposed to competency training requirements before. They have needed a general approval but they have not had to do those competencies.

We have a lot of people in the bush, maybe a lot of elderly people, who have been doing these things for a long time. They would need to be able to access that training if the regulations come in. The proposed standards underneath those regulations indicate those two units of competency. There are other people who will most probably need a pest animal control competency as well.

Mr WEIR: As I understand it, under this bill the storage requirements will not change. Is what you understand? Are you hearing anything different to that?

Ms Vitelli: No. All schedule 7 substances on farms still have to be securely locked up. The restricted schedule 7s have to be away from any food items. All of that stays the same. We are concerned that there will be a public register of who has restricted schedule 7 substances. That is what we are concerned about. I think it links more to the restricted schedule 7 medicines or other medicines where there have to be these public registers of who has those substances. We feel that landholders should be able to opt out of being on a public register. We have enough issues with people going onto farms.

Mr MADDEN: I can completely understand your concerns given the activities of certain people in the past year or so. My question relates to the practicalities if this bill becomes an act. How will life change for landholders who use schedule 7 chemicals and also people involved in vertebrate animal control?

Ms Vitelli: Currently the Department of Health has a process of general approvals if you do need to access 1080, PAPP or strychnine directly. That will continue, although I suppose the forms may change a little bit. Currently the requirement for competencies has not been there, even though there has been a big push that, if you are accessing those chemicals, you do need those competencies. There is a transition there.

Producers undergoing baiting programs through their council when they have the fresh meat baits and the rolled baits—they can also access some of the manufactured baits through council as well as resellers. That continues. As long as they have written authorities and processes come out through council, that will continue. On that side there are not too many changes, but anyone who does not have those two units of competency and wants to use those poisons will need to acquire them, under the current proposal.

Mr MADDEN: We have discussed education in a wide range of aspects today. Is that competency done online in modules or by reading literature?

Ms Vitelli: The current two competencies are offered by a range of registered training organisations. Many will do workshops, so it is a fee-for-service workshop. Some, including AgForce, have a registered training organisation component and can offer some of those online. It does mean that you have to have a level of literacy to be able to go through stuff. A lot of it is fairly general. You have to be able to write responses. If you are doing the online component, you have to demonstrate your competency before you can get that attainment. That is the main offer of that training.

The other thing we need and we have asked previously for is that some of our producers have what is called a commercial operator's licence, underneath the Queensland Department of Agriculture and Fisheries, where they most probably would have done precursors to those competencies many years ago. As long as they keep their licence up and pay their fee annually they retain that commercial operator's licence, which means that they know more than those two units of competency in delivering any pesticide. We would like to see that equivalence recognised, because of a lot of those producers would have their old competencies and they would not be considered valid now because the units that they would have got them under are obsolete.

Mr BATT: In relation to the public register, you mentioned that, because of their isolation, some producers are susceptible to having S7 poisons taken by someone who does not have a licence for them, if that information is public knowledge.

Ms Vitelli: That is a risk, but I suppose it is not so much about stealing the poisons. The concern is more in areas where a working dog or a pet dog dies and the owner thinks it has been poisoned. They will ask how that happened and who has that poison. If people in the community, other producers or land managers are aware that there is a public register, they might want to know who has that poisons. They can look up the register and might say that their neighbour or someone two neighbours away has that poison so he must have poisoned the dog. People will start to assume those things and we do not want that kind of misconstrued information. It could be nothing to do with the neighbour.

All of our farmers lock away the vertebrate poisons carefully. I do not think you will find there are many incidents of poisoning on farms or involving farm workers. We do not want that information to be made public. It is a bit like knowing what you might have in your medicine cabinet at home with some of the high-level schedule 7 substances. Would you like that to be on a public register so anyone can know what is in your home? You have to look at that. It is there. It is available. I am not saying that you should not have it on the register; just do not put it out on a public website.

Mr BATT: Definitely. I know that this comes under the regulation, but you talked about the definition of 'wholesale' and whether that should be a quantity or volume and those sorts of things. Can you go over that in a bit more detail? It is in your report, but what are the issues with that not being defined?

Ms Vitelli: There are more requirements for schedule 7 substances that are sold wholesale. If there is a good discount on a pesticide, a producer might buy three years supply in one year. Would that be considered wholesale? Often they can store it on their property, as long as it is not beyond the expiry date. Sometimes with their cash flows they will do that. We all sometimes bulk up on things. Does that put them into the wholesale category?

As I said before, if there was a mouse plague or a locust outbreak or something—we have had chickpea diseases before, where we have had to quickly put out a lot of fungicide. When you have large areas of crop or livestock to treat, sometimes our producers will be put into that category of wholesale. There are more requirements on the reseller too. There also needs to be more documentation around receiving those schedule 7s and within a few days information has to go back about that.

We want to know, in an agricultural sense, what is defined as 'wholesale'. Some of the big bulk containers hold 200 litres or 500 litres of substance. Paraquat or diquat is used as a defoliant in the cotton industry and other industries. They are bought in large amounts. That is common practice for producers, but I think it most probably falls into what the bill would perceive as wholesale. We just want clarification.

Ms PUGH: Like a number of submitters, you have recommended a transition period to ensure that all of your members are across this. Can you expand on how a transition period would help you and your members?

Ms Vitelli: There are going to be wide-scale requirements across a lot of users. As I said, there are 420 products that come under schedule 7 substances. I have a list if you require. It is all the technical names. There are a lot of insecticides and herbicides. Even some of the tick acaricides are in that category. It depends on the concentration of some of the compounds. Sometimes they are a schedule 5 if they are in a lower concentration. That will catch up all the people using those compounds.

Under the proposed regulations and standards, users will require those two levels of competency. Like everything, everyone is busy. Everyone needs to access the training. The registered training organisations—the ones that do good delivery—are out there, but they are going to be inundated. As I said, other service providers to the industry need it, such as licensed pest management technicians. In the rural areas, we have people who do not get pest management work all the time and most probably have other jobs, but they might do rodent control, termite control or cockroach control as a part-time job. They will all need this.

We need time because it is a new requirement. It is a bit like when they brought in the chainsaw licensing requirements. Everyone had to do chainsaw competency—I see some nods. People had been using chainsaws for years. It took a long time for people to do that competency. Please give us time. There has to be awareness. A lot of rural people do not even know about the proposed changes.

I hope the Department of Health or the government will help with that awareness and allow people to move over to the new requirements over a long period of time. You will not be able to do it in a year. I would suggest two years, if you could.

Mr MICKELBERG: In your submission you talk about the legislation prohibiting the advertising of various different drugs and you use the S4 prescription vaccines for animals, in particular three day sickness, as an example. What you have suggested makes sense. To summarise, you are proposing there be a specific carve-out for animal related prescription medicines in order to be able to increase usage across industry for the production effect. Is that a fair summary of what you are talking about?

Ms Vitelli: Yes, that would be terrific. We have had contact with Zotos before. They have a good vaccine available for the three day sickness that is spread by biting midges. It would be good if that could be promoted further and wider. They have tried to do that through the national regulatory body. Some of the restrictions on being able to advertise antibiotic medicines are impeding their ability to get this promoted further. We thought that for some of the animal medicines and vaccines it would be good if it were promoted through industry.

Mr MICKELBERG: I was trying to work out why it was a prescription medicine. I could not work it out. I assume AVPMA has a reason for it being a prescription medicine.

Ms Vitelli: Given it is a vaccine that is based on a virus that has been denatured, it comes under the S4 category of vaccines.

Mr MICKELBERG: There seems to a fair variation. Tick fever, for example, does not have a prescription medicine. You can order it via fax or email. That is just a comment. One issue that was not raised in your submission but was raised by the Pharmaceutical Society was the compounding of animal medicines. This may be a question for the veterinary body. What is your view on that? Do you have any concerns with respect to that?

Ms Vitelli: Yes. Over the last few years AgForce has been actively involved in the national harmonisation of the regulation and use of agvet chemicals. The Australian Department of Agriculture and Water Resources was championing that through a task force. They were talking with vets about vet chemicals. Compounding is a practice that only vets can do. They can make up their own concoctions to treat sick animals. AgForce supports that staying with vets. We trust their expertise. If there is not a medicine or prescription available commercially and ready to go, if they can make their own compounds to improve animal health or treat issues we are fine with that.

For any animals treated with these compounds there are requirements that have to be met. Vets can provide all of that information. For example, if the animals are going into meat production and have to be slaughtered, the compounding parts of the medicine or the vaccination may affect the withholding periods. The vets handle all of that. Sometimes people just have breeding animals—especially horses and so on—that need some of those concoctions if they are not available on label. That is fine, and we hope that can continue under the bill and regulations.

Mr MICKELBERG: I note that you talked about the fact that you have been consulted fairly extensively by Queensland Health, which is good—it surprised me, to be honest—and a positive.

CHAIR: We will take that as a positive comment.

Mr MICKELBERG: You have raised four specific instances that you would like amended in the bill. Did the department provide you any guidance as to why they were not incorporated, based on your previous consultations?

Ms Vitelli: We have been working with them over the last two years. We have had many meetings. They have invited us over. We have had what-if issues. We were initially talking about barter days and fee-for-service technicians. We have producers who help each other out—sometimes they are paid services. They realised that that was an area that they could accommodate into a lot of their regulations. Fencing contractors were going to be fee-for-service pest management technicians and would then have to pay the $300 fee and be subject to the extra requirements. The department said that they would put them under the general approval requirement.

It has been good. That is why our current submission to you is fairly short. There are still a few things that we would like further clarification on. Over the last two years there have been consultation drafts come out with the regulations and the bill, even though the last versions have changed a little bit. There has been a lot of liaison with the Department of Health policy unit.

We feel that for the Department of Health it is a precautionary approach. I know they are trying to protect the community and feel that there is a risk out there. We feel it is most probably overkill. The risk is not there. We feel as though producers handle their agvet chemicals very well. We understand, though, that for the community wellbeing it is probably where we need to go.

Mr MICKELBERG: These four instances you identified in your submission are differences of opinion; they were discussed but not resolved? Is that effectively where they have got to?

Ms Vitelli: We would like to see the parliamentary committee confirm with the Department of Health that they have considered those instances. I think they are taking on board some of those, but there are a few we would like a bit more clarification on through your process, if possible.

Mr WEIR: We know that most agricultural producers are time poor and hate bookwork. Have you identified any extra documentation, record keeping or expenses that would be incurred out of these changes?

Ms Vitelli: Yes. Doing the competency training is going to be a big expense at the beginning. Registered training organisations have to charge a fee. That is not going to be free. There is a range of fees. Fortunately, the Department of Health has recognised that that competency will be for life. There is no requirement to redo it. Sometimes some of the registered training organisations want people to keep their training up to date so they will do a five-year renewal. ChemCert, Smarttrain and even our training sometimes require people to renew. That is not a requirement for the Department of Health, which is good. It is a bit like a driver's licence. You do one test and you are competent. That stays with you for life unless something happens and you lose it. The same for those competencies would be good.

There is a little bit more paperwork required. A lot of paperwork is already required under the Livestock Production Assurance program—trace back and trace forward ensuring the use of agricultural chemicals, especially veterinary chemicals, or anything applied to livestock going into the food chain is documented and the withholding periods recognised. Landholders are already time poor doing all that recording. It will build on that.

There could be a few expenses with this. I feel for the service providers such as the fencing contractors. I think fumigators already have to keep a fair few records for grain fumigation. Currently the regulations do not apply to a landholder doing their own grain fumigation. There will be a bit extra to be done. There will have to be an awareness program. There will be a bit of pushback, as you would know. Producers will say, 'No, not more to do.' We will have to work through it.

Mr WEIR: There would need to be an awareness campaign with bodies like yours and the department.

Ms Vitelli: We are a member based organisation with, like government, limited and diminishing resources. We have to work together. I really think the government needs to lead that campaign. We will support it where we can and get the information out. It does need resourcing. Because it is government policy—government legislation and regulations—ideally it should help resource that.

CHAIR: There being no further questions, we will bring this session to a close. Thank you, Ms Vitelli, for appearing before the committee today. We do not have any questions on notice.

Proceedings suspended from 12.55 pm to 1.30 pm.

GRAHAM, Mr John, Queensland Representative, Australian Environmental Pest Managers Association

SAYER, Mr Philip, Technical and Training Manager, Garrards Pty Ltd (via teleconference)

CHAIR: Mr Graham, would you like to make an opening statement?

Mr Graham: The association has been involved with the pest management part of it from the start, which has been a very long process. Phil and I were involved back in 1999 when we rolled out for 2003, so we understand how long and slow the road is, but when we get there we hope to get there in a safe format. The association has some concerns that a big net has been thrown out over a big industry. Normally when a big net gets thrown out things slip through it, and as an industry we do not want to be part of one of those things that has slipped through.

As we are classed as users, we do not want to get tangled up in something that is too hard to follow through, because there is a big net without details being followed through. As a group we understand that we are at the bill stage and regulations will guide us and tighten things up, but if something is not right up at the front end it transfers through and regulations will not be able to pick it up or manage it in a cost-effective way. That is where we are very concerned. Licensing and regulations are key, but if the act is not right it is very hard for us to correct the bus when it is going the wrong way.

Mr Sayer: As John said, I am on the committee of the AEPMA as well, and I do go and physically see a lot of pest managers. I have seen over 200 this week in North Queensland for training sessions. There is concern about the incorporation of the Pest Management Act into the Medicines and Poisons Bill. There are always unintended consequences when something like a use is put into something that is really for manufacture and distribution. We are the only use industry, I believe, in the bill. We were not even mentioned in the minister's description of what the bill is to be about.

When you put a use into a manufacturers and distribution bill, things happen. The registers that are there are aimed at businesses. For instance, Garrards, the business that I work for, is going to be on the substance authority register and that will be at our business address, but each of the pest management technician's details—whether they are working in their own company or working for a large company—will also be on the substance authority register. Someone using the White Pages very simply would be able to go in, using their name and postcode, and find out where they live and their phone number and so on, whereas that would not happen for businesses that are set in a place like Garrards is.

There are other things that come through from that as well. The definition of a pest management business includes real estate agents. I do not know how that is at all possible. I know that Health has done it because they are trying to stop real estate agents from doing pest management activities. The definition of 'pest management business' is on page 182, the bottom line going up to the top, which states—

means a business in which services are offered that include pest management activities; but

Examples—

pest control services offered by a pest management technician or as part of property management services by a real estate agent

That is indescribable. How could that possibly even be there?

CHAIR: Mr Graham, one of your concerns is that you need to be licensed by both the Department of Health and the Queensland Building and Construction Commission; is that right?

Mr Graham: Correct, yes. Traditionally, we have had occupational licences for the actual users, our pest control technicians. There is no company licence required under the Health Act. Going back nearly 10-plus years ago, QBCC cast a net and threw it out and we got tangled up in it, so anybody conducting termite related activities has to be licensed by the QBCC as well. That is an impost back to business. They threw a big net out and we got tangled up in it as pest controllers, so now probably 50 to 70 per cent of our industry has to pay licence fees when they are doing nothing that is building or constriction related. That is why we are concerned about how these things go.

Obviously there is a cost back to industry of $1,000 to $1,500 per head or per company plus accounting fees to put your financials forward, and that is a big impost back to small industry, where the average user is a small family operator. The average business is a one- or two-man operation or a family operation with another family member. That is a massive impost when companies are only

turning over $150,000 or $200,000. It is wrong. That is where we would be like to be licensed by one organisation, not two. Then we would have a clear direction on who owns what and where the problems go and some true enforcement.

CHAIR: It seems to me that you do fall into both, because the termite protection that you provide is a crucial part of the building industry within Queensland, but at the same time you are working with chemicals that are equivalent to some we have talked about in agriculture and other such large chemical-holding entities. It is a case of being one of those businesses that perhaps does fit into both and you need to make sure you are working to standards in both of those streams?

Mr Graham: I think it is correct in one way, but that probably picks up from the building point of view or the preconstruction element, which is probably 30 per cent of the industry. There are too many people caught up in it because the technicality of a termite inspection gets landed in there, which is a lot of the bread-and-butter or retail work for a lot of our industry, so they have been cast under there. These could be houses that are 20, 50 or 100 years old. We are involved with Old Government House; how old is that? We have to comply with that. It is a hard enough gig as it is without being tangled up in something else.

CHAIR: In terms of the 30 per cent that are not involved in new building construction—the existing ones could translate—are there two streams within pest management, or do you have to do one or the other?

Mr Graham: Yes, pretty much. No, there are two streams in there. Our company is very diverse, but it is not economically viable for smaller companies to do certain parts in preconstruction because a lot of it is involved with high volumes, locations and spread out over a big area with clients and builders, so it is not representative of the industry. It is challenging.

CHAIR: One company could quite easily diversify into the other stream?

Mr Graham: There is no financial limitation or occupational obstacle to stop that, yes.

Mr WEIR: We heard about agricultural contractors earlier, but you are identifying that you have been specifically named in the legislation; is that correct?

Mr Graham: Yes, that is what we are concerned about, because obviously it is no different from being an ag user, to a certain degree. A lot of the chemicals are very similar or the same.

Mr WEIR: You talked about cross-border concerns. What are your concerns?

Mr Graham: There are national qualifications and structures for training and newness of competency. Each state wants its own rules, wants its own thing. For us to jump borders—for argument's sake, for us in Brisbane to work in the Tweed—we have to have a Tweed licence. Someone in the Tweed coming to Queensland has to have another licence, but there is no standard mark. We have to make an application and wait. Queensland Health at the moment takes three to four weeks to release a licence, so that process is slowing it down.

Victoria has a nice licence which allows border hopping. You just make an application and your qualifications are recognised, as long as you are not getting too carried away with the volume of work that you do. I hold a Victorian border licence. It is a nice, simple, easy transition. Someone coming from another state to Queensland has to jump through the hoops. We all have the same qualifications but unfortunately there are different recognitions, so it slows business down and it is another cost. It is not an easy process. I think everybody would be happy to have a form, fill it out, pay the money and move on and have their other licence recognised as the qualification. Unfortunately, it just does not work like that through the acts and regulations.

Even though there have been talks of national harmonisation for probably 15 years that I am aware of, we have never got any closer. In Western Australia they want a certificate III. Here we want five units of competency or three units of competency, depending on where we are. In Victoria it is different. It is all very hard. The idea of national harmonisation is not practical, but we have to look back to the cost. As an industry, we would like to see a high level of compliance with the pest management acts and regulations. We would love to see that. At the moment, there is a lot of noncompliance because it is just not practical. As an industry body we do not want to see noncompliance. We want to see the exception, and when that exception arises we want to see it slammed down and publicly hit down so we can promote it to try and lift the industry standard.

Mr MADDEN: Is there any equivalent licensing scheme that you are aware of where there is a national licence?

Mr Graham: There seems to be a lot more recognition for electricians and plumbers. Where it came through with the harmonisation it listed the trades. I do not know where we landed, but it was pretty much at the bottom of the heap. It is hard. The other trades seem to get away with it quite easily by recognition of their qualifications.

Mr MADDEN: There is a precedent in that regard?

Mr Graham: Yes.

Mr BATT: Mr Sayer, you were talking about incorporation of the Pest Management Act into the Medicines and Poisons Bill after it was split out of that in 2001. Do you know why that occurred in the first place?

Mr Sayer: The reason it was split originally or the reason it has come back in?

Mr BATT: Probably both, if you are aware.

Mr Sayer: Licensing started in Queensland for pest managers in 1976. It was included in the act then, and fumigation was earlier than that. In 1996 the Health (Drugs and Poisons) Regulation came out, and after that it was decided to split because the Health Act at that time included manufacturers, wholesalers and sellers. We did not fit then and I would argue that we do not fit now.

The Pest Management Act was created to demonstrate and recognise the status and significance of the pest management industry. Its purpose was to regulate the industry, and it is no different from plumbing and drainage and so on. Not all of our activities involve the use of chemicals. We do a lot of inspections in premises and so on and provide advice to clients, and it is not something that the Health Act of the past and the Medicines and Poisons Bill will appear to solve. In Western Australia, the MPTG Act does not include pest management. It is in the pesticides act over there. It just does not fit with medicines and poisons.

Mr MICKELBERG: Mr Graham, in your submission you talk about business registration and registration of the operating entity as opposed to the storage location of the chemical itself—the former of which is not contained within the legislation, I understand.

Mr Graham: Yes.

Mr MICKELBERG: Just to be clear, what you would like to see is a single registration of the business under the Department of Health and then the business being responsible for whether or not they employ appropriate accredited technicians; is that right?

Mr Graham: Correct. That would be the best avenue and it is also a better control measure. You have fewer people to control. You have organisations to control rather than individuals. The company would be responsible to make sure that the individuals are appropriately trained and qualified.

Mr MICKELBERG: Presumably, you would be supportive of some form of penalty if a business failed to comply with that requirement?

Mr Graham: We would love to see something that is enforced, yes. As I mentioned earlier, we would like to see a high level of compliance. With the last compliance program that went on two or three years ago, no result came out of it because the level of compliance was too low because the documentation and the regulations in the act did not cover it. A lot of the noncompliance was because it was never going to be compliant because the act and the regulations were written wrong. The big net was thrown out and some of the detail was blended and lost.

From our point of view, we would like to see a very high level of enforcement because that straightaway lifts the overall standard. It lifts our industry standard. It lifts our perception with the public and we do not see bad luck stories. We do not want to see negative advertising. We are heavily involved in biosecurity and food security and a lot of different areas. As Phil said, a lot of our work is not involved in putting out quantities of chemicals. The perception that we are spraying hundreds of litres around a house on a regular basis is long gone. We are out for a matter of litres. We are more targeted areas of work now. A lot of our work now, our growing portfolio, is just reporting on termites in houses or buildings or in the food security, food handling and food management areas. A lot of it is just reporting and management. We would like to see a very high level of fine and compliance because one will bring the other.

Mr Sayer: In all of the other states, the pest management technician is the person who is licensed and they are the person who actually goes out and does the job. Some states also license businesses. We have not really had this as a discussion topic at AEPMA at a state level, but I still prefer the individual to be licensed. The new act and bill are going to put more requirements on

businesses, which I see as good. At the moment, the vehicle can be supplied to a technician without signwriting, and if he gets picked up the technician is the one who takes the blame, not the business. That will be corrected along with a few other things.

It is the individual who goes out and actually does the job that can be very important in pest management. We work separately to each other in many cases but there is also responsibility for businesses, even to make certain that the staff keep up to date with things. I think individual licensing is still very, very important but perhaps there should be other safeguards put in as well on businesses. That is just a slightly different look at what John was saying.

Mr WEIR: I want to ask about the level of engagement you have had with the department in constructing this legislation. Have you had any input or consultation?

Mr Graham: We have been involved in consultation. We have meetings. Some are more frequent than others. There has probably been something every three to six months, I suppose. Things started off pretty good and then slowed down and we are at a bit of a mad rush now. There has been consultation but, unfortunately, I do not think there has been enough listening.

Mr Sayer: Certainly the department has taken on board quite a few of the things that we have been talking about. For example, at the moment we have to provide information to customers on paper as opposed to electronically. That has been remedied. When we went and did, say, a Tristar place where there were three levels of care of people, we were to provide information to every person who was there. Now it will only be the manager, and then they provide that information on. There are many things that the department has taken on board, but by combining us into this bill there are other consequences that we have not been able to work through.

We have asked that the real estate agent situation be taken out of the definition and that has not happened. There are other things like that. Although there has been consultation, I believe the better consultation would have been for us to be in a meeting between those who are proposing the changes and some of our public health unit people—the ones who actually see us face to face, the ones who officiate on the legislation now. That would be us all in one meeting. Instead of having little groups, as they have done in this, it should be down the stream—from head office, through to the people who regulate us, through to us—all in that one meeting. The public health units are very, very important in understanding. They are the link between the legislation and us, and I think they have been kept out of it pretty well.

Mr WEIR: I take it from that that you would like to see this engagement continue in the drafting of the regulations. You seem to have significant concerns in that area.

Mr Sayer: Yes, and I would like to see the public health units involved with us in these meetings, because they are the ones who are going to have to officiate on it in the future.

Mr BATT: Mr Graham, in your submission you said—

We are concerned that the new legislation does not go far enough in reducing the regulatory burden of industry and is less transparent than the previous legislation which was contained in one Act.

Is the act you are talking about the Pest Management Act?

Mr Graham: Yes. Things have changed, I suppose. We take two steps forward and half a one back. That is the hard part of it. It is quite hard. The paperwork is quite onerous on us—even with how Queensland Health over the last few years have changed their licensing on how they issue a number. We have technicians with 10- and 12-digit numbers for a licence that have to be manually reproduced every time they do something. Now we are going to electronic format, but how are we supposed to document things? Our organisation has had to change templates multiple times just so people can write a licence number which is part of the requirement.

Some things clear up; some things get a bit murkier. That is where obviously commercial reality comes in. As I said, the average business is a small, family run operation. We have to manage those people. We want the high levels of compliance from them. While it is nice and easy and simple, everyone is right. If we get embedded in other acts and regulations things may slip through—throw a big net, things get caught, things slip through—and that is what we are very concerned about.

We understand that the regulations will actually tighten it. If a little bit of the act or the bill is off course, the regulations can direct it and bend it, but it will not be able to make a 90-degree turn. It is very important, as Phil said, with the consultation that the regulation writing or management is handled through all parties being very actively involved so there are no surprises at the end of it.

CHAIR: As there are no further questions, I thank Mr Graham and Mr Sayer for appearing with us today. We do not have any questions on notice.

DWYER, Ms Sophie, Executive Director, Health Protection Branch, Prevention Division, Department of Health

GIBSON, Ms Eve, Acting Manager, Legislative Policy Unit, Strategy Policy and Planning Division, Department of Health

YOUNG, Dr Jeannette, Chief Health Officer and Deputy Director-General, Prevention Division, Department of Health

CHAIR: I welcome representatives from Queensland Health. You have heard a lot of the testimony today. I invite you to make a brief opening statement of about five minutes addressing some of those issues.

Dr Young: Thank you very much for this opportunity to further brief the committee about the bill and respond to those issues that you have been hearing about. As you are fully aware, this bill impacts on so many industries and professions. We have heard now from a broad range of stakeholders on a diverse range of issues. A significant number of stakeholders have been generally very supportive of streamlining the legislative framework through this bill and the draft regulations. A number of technical issues have been raised in submissions that relate to the regulation but do not impact on the bill itself. Drafting of these regulations is ongoing, and stakeholder submissions will be taken into account before finalising those regulations. Some of the issues raised with the committee that you have heard today fall into that category.

I would like to take the opportunity to briefly address some of the key issues that have been raised. We have heard from the Queensland Nurses and Midwives' Union today about their concerns with regulation of the aged-care sector. They raised concerns in their submission that the medicines and poisons scheme would introduce a new category of aged-care worker. To address this concern, it is proposed to prescribe this category of worker as an 'unregistered care worker' in the medicines regulation. The parameters of the authority for unregistered care workers to administer medicines in residential aged-care facilities will take into account existing Nursing and Midwifery Board of Australia standards, guidelines and frameworks and relevant legislation. These parameters will be determined in consultation with relevant stakeholders, including the QNMU and the aged-care sector, prior to the making of the regulation.

This approach will address the QNMU's concern that clause 51 of the bill, relating to agents and carers, would apply to unregistered care workers. Clause 51(2) provides that a person authorised under the act to supply or administer medicine does not fall under the carer provision, which is intended to apply to carers such as family members—for example, a parent administering medicine to their child. By authorising unregistered care workers in aged-care facilities under the medicines regulation, they will be carved out of the carer provision in the bill.

Unregistered care workers are a well-established part of the aged-care workforce. All Australian states and territories have legislation that allows trained and competent care workers to administer medicines in a residential aged-care facility in limited circumstances. This is supported by the Nursing and Midwifery Board of Australia's decision-making framework that helps registered nurses to decide whether it is appropriate to delegate a task to a support worker.

As outlined in Queensland Health's response to submissions, not including unregistered care workers in the medicines and poisons scheme would prevent them from administering any medication in residential aged-care facilities under any circumstances. It would also restrict how medicines can be administered in other sectors, such as disability services and respite care. There would be significant impacts on the viability of providing residential aged care, particularly in rural and remote Queensland. Requiring a registered nurse to administer all medications could detract from the nurses' other tasks in caring for the health and wellbeing of residents or cause delays in aged-care residents receiving their medication. These are also safety issues that must be considered.

Including requirements for unregistered care workers in the medicines regulation is an approach that balances clear and appropriate rules for these workers with the flexibility to respond to innovations in medication management. Many aged-care facilities already use dose administration aids to enhance patient safety. For example, to minimise the risk the resident will be given the wrong medication, the facility can have a pharmacist prepare individualised tamper-evident packs for each resident with the correct dose and time that the medicine should be administered. Queensland Health is also closely monitoring the Commonwealth Royal Commission into Aged Care Quality and Safety

and the Queensland parliament's [Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's inquiry into aged care, end-of-life and palliative care and voluntary assisted dying and any implications for the medicines regulation.

On another issue, the poisons, pest management and agricultural industry raised suggestions in relation to business licensing, pest management activities in primary production and the need for a regulation separate from medicines. These concerns are being considered and addressed as appropriate.

Several submissions commented on the compliance and enforcement framework for the scheme. One submission argued that offending behaviours should be dealt with through education, counselling or professional disciplinary proceedings rather than offences. A key purpose of the new legislative framework is to protect public health and safety. To ensure the legislation is robust in achieving this, it is necessary to include the option for penalties to promote compliance and enable effective enforcement.

Queensland Health will take a risk based approach to enforcement that uses the least punitive method first. Education assistance for people to voluntarily comply with the legislation will always be the starting point. If this is not effective, Queensland Health may issue a compliance notice. If noncompliance continues, the chief executive may need to escalate the matter and take administrative action such as cancelling the person's substance authority. Prosecution of offences would only be considered as a last resort where compliance is not being achieved and there is a continuing risk to the public.

Many of the submissions noted the technical nature of the bill and the need for consultation to finalise the regulations and develop departmental standards and extended practice authorities. Queensland Health is committed to consulting with all relevant stakeholders and professional bodies during this process. There was general consensus from stakeholders that there needs to be support provided to industry to understand and prepare for the commencement of the new scheme. Queensland Health is preparing a transition and implementation strategy that includes an awareness campaign, as well as guidance and education on specific areas of the legislation.

A number of engagement and communication activities are being considered, including working groups, forums, roadshows and webinars to ensure coverage across the state and for various stakeholder groups. This will be supplemented by information on the Queensland Health website and media releases. It is expected that a suite of toolkits and fact sheets will be available for individual elements of the new scheme, such as the real-time prescription monitoring and substance management plans. Queensland Health will also provide ongoing support and information to stakeholders following commencement. Thank you for the opportunity to address you about some of the key issues that we have seen raised during this inquiry.

CHAIR: Dr Young, on the issue of substance management plans, SMPs—and we have covered a lot of ground on that today—can you outline what oversight there is going to be for SMPs under this bill?

Dr Young: Initially we will be working very closely with stakeholders because this is a new requirement, although of course we are aware that a lot of people already have them in place because anyone who faces any accreditation process, whether it be through hospital accreditation, ACHSC or ISO accreditation, would already be doing something similar. We will work with people on whether they need to do more than what they currently have. We will be providing templates for people to use. We know that most of the industry is quite aware of these sorts of plans, how they need to be put in place and how they need to be managed.

CHAIR: You touched on the form and it is very similar to forms that are already in use. The plans that currently exist would be monitored now. How would the veracity of the quality of the SMPs be monitored by the department?

Dr Young: In some cases, as I mentioned, they are already part of accreditation processes and they would be expected to have them. In other cases we would monitor them when we are doing compliance assessments for other purposes, so we would ask to see them. Of course, if there were any complaints or any concerns we would ask to see them. Usually with these sorts of things we ask for a random sample so that we can keep a close eye on what is happening. We would not necessarily go and ask for every single plan to come to the department once a year or something like that. We would work through what is a reasonable amount to look at, to make sure that we are comfortable that industry overall has them in place.

CHAIR: In other jurisdictions where they have SMPs or an equivalent, is there role in the particular department—and you have talked about monitoring—to make sure that there is enforcement, lodgement or oversight? Does that happen in other jurisdictions?

Dr Young: It will be variable depending on what plans you are looking at and how people manage it.

CHAIR: Right across Australia?

Dr Young: Yes.

Mr WEIR: IT was another issue that was raised a number of times during the hearings, as well as the timing of the rollout and compliance with that. Do you have anything to add to that?

Dr Young: That is in relation to the real-time monitoring. At the moment we are working with our colleagues at a national level, particularly the Commonwealth, which has a lot of responsibility in terms of making the scripts available. We are working through all of that. Victoria has already started rolling out their system, so we have been working very closely with them as to how that then assists in what we are doing. We believe at this stage that we should be able to roll out our system by the end of next year, 2020.

Mr WEIR: How long was the rollout period in Victoria? Was it 12 months?

Dr Young: They started rolling out theirs towards the end of last year, I believe. They just started it and then gradually increased it throughout the state. We are quite dependent on being able to get some of the work that the Commonwealth has done because they have all the scripts, as you would imagine, that come through from the Commonwealth. Victoria piloted SafeScript in October 2018 and they believe it will be mandatory in early 2020.

Mr WEIR: That was my next question. You talked about the rollout late next year. Do you think everybody would be compliant by then?

Dr Young: We think we should be able to do that fairly quickly. Once we have the system in place, we are fairly comfortable that we should be able to have it rolled out and we are starting all of that education work now. Indeed, over the last two years we have been talking to all the relevant stakeholders that this coming. We have been engaging with them and talking with them about how it should work and what needs to be done. In terms of our industry here, medical practitioners, pharmacists and other users are quite aware that this is actually happening.

Mr MADDEN: To begin, I would like to thank you all for coming in today. My question relates to a submission by the Queensland Nurses and Midwives' Union, which I am sure you have already addressed. At the tail end of their submission they say that unregistered aged-care workers will be given legislative authority to administer medicines, but only in a case where the resident has been assessed as competent to self-administer. Can you comment on the requirement that a resident must be assessed as being competent to self-administer?

Dr Young: That is the work that we are doing at the moment, to work through how it is spelt out in the regulation. We will work through that with the nurses union and other bodies that have a role.

Mr BATT: With the real-time prescription monitoring, will it be both GPs and pharmacists who review and log that information?

Dr Young: It will not be for them to log the information, because it will be collected from other sources. It will be collected from all the scripts that doctors—whether GPs or specialists—write and then it will be collected from the data from pharmacists when they dispense it. At the moment, when pharmacists dispense any of these schedule 8 drugs they have to notify the department within seven days and we collect that information. However, it is not real time. By the time it is submitted to the department and the department puts it into the database, it is often about 14 days later. We have seen with a number of coroner cases and other situations that harm has occurred because of that delay. That is why we are moving to this real-time process, so that immediately a pharmacist dispenses the script it is in the database. Similarly, immediately a doctor writes out a script it is captured, so that any prescriber can see it in the database in real time. They cannot put any information into the database; it is for them to look at only. However, they can see any script that has been issued anywhere in Queensland.

We are working out with the Commonwealth whether we will be able to see scripts that have been put in place in other states, for instance through close links with northern New South Wales. That will be some future work that we need to do. A prescriber can see what has already been prescribed, whether or not it has been filled and they can also see what has been filled. They can see

that that individual might already have filled a script for a certain amount of drugs. The pharmacist can do the same: they can see what the scripts are and what has already been dispensed. It is about real time, so that all of that information will be in there immediately.

Mr BATT: The prescriber could say to the patient, 'You've had something prescribed in the last week, but I will still give you this one.' Then the pharmacist may say, 'You've had two of these prescribed in the last week,' so they are asked twice.

Dr Young: Yes, that is correct. They can then make a decision, 'You don't need another script because you already have one,' or, 'What happened to the script? Did you lose it?'

Mr BATT: In relation to the substance management plans, in the act are there any penalties for people who do not have them in place?

Dr Young: Yes, there are.

Mr BATT: As you said, the only way to find that out is if you get a sample or during an investigation where you might ask for it because they have not lodged them every 12 months with the department; is that right?

Dr Young: There are two parts to that. If you have a complaint or there is an issue or a concern, you can go and ask to see them at that point in time. We also do random audits and it may be picked up at that time.

Ms PUGH: In their submission, the Royal Australian College of General Practitioners talk about prescriptions outside of primary care, that is, outside the GP setting, specifically in the emergency room. They talk about the importance of all prescriptions being monitored in that setting. I am unfamiliar with the process around how medication is recorded in that setting. I clearly remember leaving a GP with a script in hand, but it is obviously a lot more muddled when you are leaving an emergency department for any number of reasons. Can you explain how those prescriptions or any medications that are given at that point might be captured in the new legislation?

Dr Young: More and more of our hospitals are actually prescribing under the PBS, under the same scheme that a GP would prebscribe under. Although we will not initially have some of that information, more of that will be included. Similarly, more of our hospitals are moving onto electronic medical records, with electronic systems in place for prescribing medications in the wards and for inpatients. Again the plan is for that to be included.

This will not all happen at once. Initially we will be rolling it out for GPs and specialists in their rooms, so that will be the first focus but, yes, there is every intent for this to roll out on all occasions. It will not only be schedule 8 drugs. We are including some schedule 4 drugs that are at risk of addiction such as diazepam—Valium—and a number of other drugs.

Ms PUGH: As you and the PSA have touched on, today we are referring to schedule 8 drugs but in the future there could be new drugs on the market that potentially have that same dependence-inducing quality. What provisions are there to ensure that those future drugs would be captured in the legislation?

Dr Young: That is very straightforward and easy to do. We have brought together a group of experts to determine the first list, and that group of experts is there to advise us when new drugs need to be added in time, so we have that process in place now.

Mr MICKELBERG: I want to address the issue of doctors self-prescribing and offence provisions contained within the bill. We have heard some testimony that they were unnecessary—and these are my words, not the words of the witness—and draconian in some respects and they might be a disincentive for doctors seeking help. What is the department's view with respect to the need for those offence provisions and situations where it may be necessary, if there are any, where a doctor should be self-prescribing because they cannot access another doctor, for example?

Dr Young: It is extremely important that everyone has availability of the best care possible and making decisions based on your own health and your family's health for any health professional is risky. It is not good care. The Medical Board of Australia has had that policy for many years. It is extremely tight about drugs of addiction, because it would be very easy for someone to harm themselves by prescribing those drugs to themselves, but it is actually broader than that. It is meant to be any care. There are not those same penalties for any care that you might provide to yourself, but for those drugs of addiction it is very clear, and that is true for every state and territory.

Mr MICKELBERG: Just to be clear, because obviously we do not deal with this regularly on this committee: the intent from an industry perspective is that individuals will not be self-prescribing effectively under any circumstances unless it is an emergency or there is some sort of time requirement where they cannot access other care. Is that the accepted standard?

Dr Young: I think it might even be a bit tighter than that, because they should be able to access other care. They should not ever have to be in the situation where they are prescribing, because by prescribing you have time. It is hard to say that there will never be a circumstance when that should not happen, but it is very unlikely that someone needs to prescribe for themselves.

Mr MICKELBERG: That is great. There were concerns raised with respect to the bill—and it is a regulation issue as opposed to the bill—capturing the non-S3 supply of pseudoephedrine and it was the view of one submitter that that was an omission in relation to the regulations. I note that you said that those issues are being addressed, but can you give the committee some confidence that that is either being addressed or you consider that it does not need to be addressed?

Dr Young: At the moment it is captured under Project STOP. I might see if either of my colleagues know what is happening with it.

Ms Gibson: I can talk generally about Project STOP, if that might help to answer your question. As Dr Young has said, S3s are going to be captured under that project. The Queensland Organised Crime Commission of Inquiry report provided that the Queensland government should look to mandate Project STOP to look at real-time reporting of those S3s and over-the-counter sales of pseudoephedrine. I understand that that particular database belongs to the Pharmacy Guild, so we are going to look to make some amendments in the medicines regulation that will require pharmacists to record sales of pseudoephedrine in a database, not specifically the Project STOP database necessarily to give them some flexibility. That will ensure that information is then available to other pharmacists across the state. That will capture those S3s that you are talking about in relation to the pseudoephedrine. Does that answer your question?

Mr MICKELBERG: Yes, I think it does. Just doubling back for a second with respect to the self-prescribing, one of the linked issues—and I think it may have been addressed by one of the other members of the committee—was with respect to proactive checking. From a compliance perspective with respect to the system, the view was expressed that that probably should not happen. I will not put words in that witness's mouth, but it was thought that effectively that was an overreach. I am keen to understand the department's view with respect to the need for particularly proactive systems type checking to ensure that patterns are identified and why that is important.

Dr Young: We do all of that at the moment; it is just a bit out of date. It is 14 days out of date, but at the moment we do regular reports checking whether people are prescribing inappropriately and checking whether patients are receiving above the expected amounts of drugs and then we work with their treating practitioners. We do all of that and part of that is whether people are prescribing to themselves, so we have all of those checks in place at the moment and we manage that. That will not be any different; it is just going to be a bit more timely.

Mr MICKELBERG: Just for clarity, that is proactive as opposed to intelligence led?

Dr Young: No, it is twofold. We do it proactively. We have a whole range of reports that we run on a regular basis and then we also do it reactively. If the Health Ombudsman contacts us about a concern that they have with a practitioner, then we will check that information, so we do both.

CHAIR: With regard to the issue of real-time monitoring, how many years worth of data or scripts are going to be kept in the system?

Dr Young: I apologise; I do not know that answer. It is a very sensible question. It will be stored from the commencement of the system and we do not intend there to be any historical limit on the records.

CHAIR: Thank you. That is clear. Also with real-time monitoring, many of the submitters said that 12 months would be okay and they thought that 18 months or maybe even two years may be more substantial for that. What has happened in other jurisdictions when they have brought in real-time monitoring? What kind of transition period did they use and were there any issues?

Dr Young: There has really only been Tasmania which introduced some real-time monitoring and that was a while back, although they did not give access to their prescribers and pharmacists. It is real-time monitoring for the department which then would use that information. I do not believe there was any large transition period for that because, again, it was essentially just better than what they were currently doing. Victoria, like ourselves, had been saying they were going to do this for a number of years, so I am not sure that there is a lot of transition, only because we have been saying for a number of years now—quite a number of years—that, once the technology enabled us to be able to do this, we would be doing it. The earliest we can do it, given what is happening at the Commonwealth level, is the end of next year.

CHAIR: Had the department considered 12 or 18 months as an alternative for a transition?

Dr Young: We have sort of gone longer than that now, because I personally have been out there talking to doctors and pharmacists that we are going to be introducing this and I think I started those conversations two or three years ago. We have had a long lead-up and in fact most people have said to me, 'Why is this taking so long? We would like to see it much earlier.'

CHAIR: I think it was more in terms of once the system goes live it takes people 12 to 18 months to adjust to it and making sure they are complying. I think that was the context of most of those suggestions.

Dr Young: Sorry, I have misinterpreted your question. Yes, we would not be penalising people for not using the information in the first 12 months. In the first 12 months we will be very much expecting people to use it as soon as it is available but working with people who have not.

Mr WEIR: Broadly, people are supportive of a register but some have expressed concern about the publishing of a register. Why would you need to publish a register? It was raised by the pharmaceutical people in that there was provision for the chief executive to keep and publish registers relating to substance authorities. It was raised by the Pharmaceutical Society and it was raised by AgForce and the pesticide management group.

Dr Young: I think these are registers about people having certain approvals so that people then can see—

Mr WEIR: Approvals and storage of certain poisons.

Dr Young: Yes, so they can see the people who have them so that if someone asks someone to come and do some work for them they can then, if they want to, go online and make sure that that person is appropriately qualified and has the appropriate approvals, so that is the idea behind it. It is no different to the fact that you can go online and make sure your doctor is registered and has the right skills to be seeing you, so it is a similar sort of thing.

Mr MADDEN: Mr Sayer from Garrads Pty Ltd raised an issue with regard to the definition of 'pest management business' in the definition section of the bill. The definition gives examples and the examples are—

pest control services offered by a pest management technician or as part of property management services by a real estate agent

It is just that last bit, the 'as part of property management services by a real estate agent'. He queried why that could be confused with a pest management business.

Ms Dwyer: The purpose of that definition is to make it clear that not only is pest management what you typically expect a pest management technician to undertake but also those who offer it as part of another business. There are examples where real estate agents may then also do their own pest management, and the other more common example is carpet cleaners which also offer pest management. The purpose of that definition is to say that the coverage is quite broad and one cannot do that work and say, 'Well, I'm only a real estate agent. I'm not undertaking pest management essentially,' and therefore it then obligates them to hold appropriate competencies and a licence.

Mr MADDEN: Thanks for clarifying that, Ms Dwyer.

CHAIR: We have a couple more questions, so we will extend the hearing by five minutes.

Mr BATT: Dr Young, in relation to the member for Condamine's question earlier about the public register, the query mainly from AgForce was that private people who have quantities of poisons are going to have to register on a public register that they have these poisons and they are concerned about others—their neighbours or whatever—knowing that they have these poisons because if something happens, say if a dog or whatever dies, they might think it was their strychnine or whatever it was that killed them.

Ms Dwyer: There are two parts to it. We keep a register and we are obliged to keep a register. That is part of the administration of the act as you would expect. With regard to the publishing of them, the chief executive 'may' publish rather than 'will' publish. I think that explanation of the risks of publishing certain information would have to be taken into account and can be taken into account in a decision as to whether or not you publish. Going back to the previous comment by the Chief Health Officer, where a pest management technician might be offering themselves as a service out to the community, it is possible for the department to publish who has a searchable licence. We take a lead in doing that obviously through consultation, but we take a lead out of how other registers of professions are handled like, for example, registration of doctors and other health professionals where it is searchable.

Mr BATT: Yes, it was to do with S7 poisons.

Ms Dwyer: Yes, it made sense. Just to clarify, telling people where S7s or restricted S7s might be has an issue associated with that.

Mr BATT: That is what we thought as well.

Ms Dwyer: Yes. That was understood.

Mr MICKELBERG: It is a bit like telling everyone where their guns are.

Ms Dwyer: Yes, exactly.

Mr BATT: Thanks very much for that. My question is in relation to the three-day supply of S4 medicines and possibly replacing that with the minimum standard pack. The gentlemen from the Pharmaceutical Society explained why that should be required and gave some examples of some illnesses that would require more than three days of supplies. I ask for your thoughts on that, doctor.

Dr Young: Yes. I do not think it is helpful if we have to break packs. That is not helpful at all—that is, that a pharmacy has to break up a pack—so we are doing some work looking at that at the moment. I agree with the Pharmacy Guild. I think that is a sensible issue.

Ms PUGH: Back to the real-time monitoring, you mentioned earlier about having that mechanism to add those in. What would that mechanism be? Would that be legislative changes or would that be adding to a list in a policy setting? How would we add additional medications in that are potentially dependency forming?

Ms Gibson: I can speak to the legislation aspect of it. That would be through the medicines regulation. We are intending to list the medicines that will be included in that database in regulation and that way, if it is determined that new or additional drugs need to be added to the database, it would just be simply through a regulation amendment.

Ms PUGH: Fantastic. Obviously, there has been a lot of feedback that all different stakeholders want to ensure that they have a long implementation time, and we have heard that there will certainly be that 12-month period to adjust. If groups of doctors or pharmacists wanted to start getting ready now, would they be able to start adapting to implement that real-time monitoring and start preparing early? Is that possible for them at all?

Dr Young: The IT system is not available, but currently at the moment the process is that they pick up the phone and ring a hotline and get that advice. So really, what they will be changing, instead of picking up the phone, they will be looking at an IT system. It is really about then understanding the IT system and how to use it. They all have IT systems on their desks that they use now for patient care, so I suspect it will not be a difficult process for them to adjust to. We will work with them and assist them and provide all of the training and the support they need.

Mr MICKELBERG: You mentioned that the real-time reporting will be dealt with at a GP level and then subsequently rolled out within the hospital system. Why did you choose to do it that way as opposed to the inverse, which the government controls—that is, emergency departments first to iron out the bugs that may exist from a systems perspective there and then impose that on private enterprise?

Dr Young: What we need is the scripts, and that is in place at the Commonwealth level and that is what has been done around the country. We want to do more than what other jurisdictions are considering, so at the moment this is really about community provision of schedule 8 drugs. Most people get their primary health care in the community, and that is where the focus for this is. We know that there is a role in what hospitals prescribe and that can transition when people go back into the community. That is why we want to engage, but it is a different process and it is different IT systems. In actual fact, it is about getting it right in the community before we add in the hospital data.

Mr MICKELBERG: Okay, but let us just say I am a chronic drug user and I go to the doctor. I then go to the pharmacist, who turns around and starts to push back by saying, 'Mate, you've been prescribed too much morphine,' or whatever it is, 'or S8 drug.' I then turn around and am going to go to the next most likely point where I can get my next support from, and that is going to be the emergency department. Do the different health services talk to each other to show that one provider gave Brent Mickelberg X drug on this day at this emergency department and then show the fact that I went to another health service? At the moment does that information pass along? Will that loophole be picked up?

Dr Young: It will in the future, but at the moment if you turn up to an emergency department their role is to fix up that one problem that is in front of them at that point in time. It is not to look at the ongoing care, so they would refer that person back to their GP. If they turn up with renal colic or they have had an injury, they will deal with that issue, but they will not go on to say, 'Yes, we've got to give you pain relief for the next six weeks.' They are two totally different settings.

Mr MICKELBERG: I have not been to emergency departments that often. Presumably, if they are admitted they will get referred back to a doctor if they have one or, if they are just an emergency admission and they do not get admitted, do they get referred back to a doctor, or do they just walk out the door?

Dr Young: No, they get referred back to their GP.

Mr MICKELBERG: Okay, and presumably that is where these sorts of things will get picked up.

Dr Young: Exactly, yes.

CHAIR: Thank you. The time allocated for this session has now expired. Thank you for appearing before the committee today. We have no questions on notice, so that concludes the hearing. I thank very much all of the witnesses who have appeared today and participated. I thank our Hansard reporters and our secretariat staff. The transcript of these proceedings will be available on the committee's parliamentary web page in due course. I declare the public hearing for the committee's inquiry into the Medicines and Poisons Bill 2019 closed. Thank you.

Dr Young: Thank you very much.

The committee adjourned at 2.36 pm.