Speech By

Michael Berkman

MEMBER FOR MAIWAR

Record of Proceedings, 14 February 2019

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

Mr BERKMAN (Maiwar—Grn) (3.28 pm): I rise to speak on the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee report, *Inquiry into the establishment of a pharmacy council and transfer of pharmacy ownership in Queensland*. The background for this inquiry stretches back many years to the implementation of the health practitioner regulation national law, after which Queensland remained in the unusual position that the Health department retained responsibility for the regulation of pharmacy ownership. Some years later this arrangement was dragged back into the spotlight by a fairly controversial series of acquisitions of pharmacies by franchisees of the Ramsay Pharmacy group and concerns aired by the Pharmacy Guild of Australia about whether these franchise arrangements comply with the ownership restrictions.

Skipping over the detail, as other members of the committee have, the central tenet of the ownership restrictions is the requirement that pharmacies are, in effect, owned and controlled by pharmacists. The pharmacy industry is no stranger to complex franchise arrangements that must satisfy the ownership requirements. We are all familiar with the biggest franchise names. The face of the industry has changed pretty significantly with the advent and expansion of what are commonly described as big box pharmacies. They all operate within the same framework.

Without wanting to sound flippant, this inquiry at times felt like a parliamentary mediation of what was fundamentally a dispute between commercial competitors. Key players seemed largely concerned about whether the acquisitions by Ramsay franchisees were lawful and whether the department had made an error in allowing these transfers. The department maintains that the transfers were all lawful. With the assistance of the Queensland Audit Office, the committee saw no sound basis to conclude otherwise. However, there is an apparent need for better processes and controls to ensure compliance and transparency in the administration of elements of the Pharmacy Business Ownership Act. This need is reflected in the committee's report.

The inquiry also considered the fundamentals of the ownership restrictions, which are unique. For example, we might make the comparison to ownership of GP clinics, which are not similarly constrained to being owned by GPs. Much of the evidence from pharmacists themselves sought to make the point that pharmacy owners are fundamentally better equipped to put the interests of their customers first, whereas under an alternative deregulated model that allowed corporate ownership profits would take priority.

We heard a lot of anecdotal evidence about this and various examples of pharmacists going the extra mile to meet the needs of their customers. I have no doubt as to the dedication of these pharmacists to the needs and wellbeing of their customers and I absolutely accept the general view that people are capable of acting with compassion and humanity in a way that companies are not.

The contrary position put by some witnesses was that the role of the dispensing pharmacist is the critical factor in patient outcomes rather than the ownership structure. Indeed, this is to an extent already demonstrated by the countless absentee pharmacist owners who play very little if any role in

the delivery of services and customer outcomes under the existing ownership regime. The evidence to this point was essentially all anecdotal and the committee had real difficulty identifying empirical evidence to support either position. In the wash there appeared no compelling reason to reconsider or change the pharmacy ownership restrictions.

In considering the possible role of an alternative regulator for the ownership regulations, the inquiry came to focus heavily on the scope of practice, as we have heard. The position we heard from nearly every practising pharmacist and academic working in this space was that pharmacists are currently not allowed to practise at anywhere near the full scope of their training or capacity.

It seems maybe self-evident that it is a good thing if a pharmacist can provide a wider range of services and treatments so people can avoid an unnecessary trip to the GP, but we heard evidence that there are risks inherent in any change that would limit or reduce the primary care patients currently receive from their GP. The AMA and the Royal Australian College of GPs raised these concerns and described how incidental visits to a GP for simple matters like a repeat prescription may provide an important opportunity for GPs to identify and address other healthcare concerns. The balance between convenience and comprehensive primary health care warrants a cautious approach to the expansion of scope of practice. This is also, I believe, reflected in the committee's report.

In conclusion, the evidence did not ultimately justify a new pharmacy council taking full oversight of ownership regulation, but, in addition to the improved processes recommended, there is clearly an opportunity for a new advisory council to support the department in its administration of the ownership regulations and provide advice on other matters including scope of practice.

I want to take a moment to thank my fellow committee members, all submitters and witnesses to the inquiry, the Queensland Audit Office and the Productivity Commission. As has already been said, we really need to give special thanks to the committee secretariat—Rob Hansen, Rod Bogaards and James Gilchrist—who shouldered an extraordinary workload at that time while we were also in the thick of the inquiry into the Termination of Pregnancy Bill. It was no mean feat. I commend the report to the House.