



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

Members present:

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

Staff present:

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

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

TRANSCRIPT OF PROCEEDINGS

MONDAY, 20 AUGUST 2018

Brisbane

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The committee met at 9.33 am.

CHAIR: I declare this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. I would like to start by acknowledging the traditional owners of the land on which we are meeting today. I am Aaron Harper, the chair of the committee and the member for Thuringowa. The other members of the committee with me are: Mark McArdle, the deputy chair and member for Caloundra; Marty Hunt, the member for Nicklin; and Joan Pease, the member for Lytton. Mr Barry O'Rourke, the member for Rockhampton, will join us shortly. The inquiry was referred to the committee on 3 May 2018, and the committee is required to report to the Legislative Assembly on 30 September 2018.

This committee is a statutory committee of the Queensland parliament and as such represents the parliament. It is an all-party committee which takes a nonpartisan approach to inquiries. This hearing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind you that intentionally misleading the committee is a serious offence. Witnesses have been provided with a copy of the guidelines for witnesses, so we will take those as read. Hansard will record the proceedings and you will be provided with a copy of the transcript in due course. This hearing will also be broadcast live on the parliament's website. I ask that any media present adhere to my directions as chair at all times. The media rules are endorsed by the committee and are available from committee staff if required.

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

BROWN, Ms Karen, Managing Partner, TerryWhite Chemmart, Samford

WHITE, Mr Anthony, Chief Executive Officer, TerryWhite Chemmart

CHAIR: Would you like to make a brief opening statement in relation to the inquiry before us? Then we may have some questions for you.

Mr White: My name is Anthony White; I am the CEO of Terry White Group. It is the parent entity that acts as the franchisor for the network of TerryWhite Chemmart pharmacies that operate throughout Australia. I am here with Karen Brown, who is the managing partner of the TerryWhite Chemmart pharmacy at Samford. Although my parents are pharmacists, I am not. I am here with a very experienced pharmacist who will provide technical support as well. In terms of opening comments, I suppose I would like to just raise some of the key points from our submission.

There are four main messages that I would like to highlight. Firstly, we do believe that there is the potential for pharmacists to perform a much broader role in the community and that such would be facilitated by facilitating clinical tasks that are within the competency of the pharmacist where we can provide extended care options for consumers.

The second point relates to optimising immunisation in Australia. Vaccination services in Australian pharmacies have been very well received by customers who walk through the pharmacies. Expanding these services to cover all of the standard vaccinations, including all of the NIP services, has the potential to dramatically and substantially improve Australia's immunisation status, which would substantially improve and maximise benefits to all Queenslanders.

The third point I would like to highlight is that Queenslanders and Australians actually have some compromised access to certain medicines that can be safely provided by professional pharmacists. The rescheduling of some prescription medicines from schedule 4 medicines to schedule 3 medicines, in association with appropriate and substantial controls over the safe and effective way of handling those medicines, would also improve care for customers. Medicines for minor ailments to avoid Queenslanders unnecessarily presenting at emergency departments across

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Australia—that has been indicated in many Queensland Health reports—are a substantial opportunity, and pharmacists certainly have the competency and experience to manage that. Medicines such as oral contraceptives are a very good example.

The final point I would like to talk about is the benefit of a franchise system such as TerryWhite Chemmart. We support more than 450 independently owned pharmacies across Australia. This system allows pharmacy owners to focus on pharmacy clinical services more, allows them to access expertise that could not be accessed on their own individually and helps pharmacists focus on the better delivery of medicines to all Australians. This system needs to be recognised for the extensive benefits it provides in supporting pharmacists to perform their core role. It allows the pharmacist to focus more on those clinical tasks than they could if they did not have that support. They are our four main points. With your agreement it might be helpful for the committee to hear a few words from Karen as well.

CHAIR: We have received 210 submissions, and we have a lot of people here in the gallery who would probably have read some of those submissions online. I come from regional Queensland. As a former health practitioner for many years I know that pharmacists certainly make up part of the health continuum. There are ageing populations in areas like Clermont, where pharmacists make up part of that town's health continuum, and people have to go to the pharmacist for a range of things. This inquiry has brought out some interesting aspects in terms of scope of practice, and pharmacy ownership is the umbrella.

Before we get to that, some submitters have said that they do not want to see a monopolisation of the industry. They want to keep some tight regulations around pharmacy ownership, but under that umbrella there is quite a bit around scope of practice, particularly for pharmacy assistants. I would like to ask about minimum qualifications. As a health consumer, I think affordable health care is something that all Queenslanders want. We went to a pharmacy to receive our vaccinations as opposed to turning up at an emergency department or GP, as you point out in your submission.

The AMA and a number of other submitters from the medical field made the point that this is broaching on taking some of their expertise away, so it is an interesting space for us to delve into. I am glad that you are here as a practising pharmacist. I want to unpack issues around scope of practice and pharmacy ownership, but I will get to the key points. Do you think that pharmacy ownership should be regulated more tightly? Should we establish a pharmacy council within the state of Queensland? I might go to some of those questions first and then we will move on to questions from members. I know there was a bit in that.

Mr White: You had a few questions there. Maybe I can address the question in relation to the pharmacy council. I think that support for a pharmacy council would be very much encouraged, particularly if its charter and direction were focused around facilitating and fast-tracking some of the expansion of scope that Queenslanders are looking for. If it is a council that is bogged down in a lot of administrative processes that add a layer of bureaucracy over and above the current system unnecessarily with no benefit to the system, I would ask why there is a need for that to be considered.

I think the purpose of the council is very important. It could very much help with programs such as the rescheduling of medicines. The council would have a very good role in supporting Queensland Health and supporting the industry to ensure that the right standards are in place. I think that is the major emphasis around the role of the council. In terms of its most value, that is where I would see it adding a lot of value.

CHAIR: Do you think if a council were established its remit should be in regard to having control over the expansion of scope of practice as well?

Mr White: I think in terms of the control of the scope, the elements of that need to be worked through.

CHAIR: I know the Pharmacy Board of Australia has some position on that as well.

Ms Brown: I think with the council it is putting us in line with every other state. I am a proud Queensland and we normally lead the way—we did in vaccinations a few years ago—but I think we are behind in this space. Also it is about getting consistency across all pharmacies. I think from a public perspective it is even about having a list of all the services. People should be able to find a database that shows all the pharmacies that can vaccinate and all the pharmacies that can provide methadone, for example. A council would bring all that together and know that all of those pharmacies are accredited in the same way, have the same standards of care, have the same scope of clinic rooms et cetera, and that I think would provide very good public benefit.

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CHAIR: We will move later in the hearing to the scope of practice itself and minimum qualifications. We will move now to questions. Member for Nicklin?

Mr HUNT: Thank you for coming along. In relation to the establishment of a pharmacy council to oversee the ownership regulations as they currently stand, are there deficiencies in that currently? There are ownership regulations which are overseen by Queensland Health. Leaving aside all scope of practice issues and all the other things that we mentioned around the benefits of a pharmacy council, is there a benefit, do you think, in establishing a pharmacy council purely to oversee those ownership regulations as they currently stand?

Mr White: I think the current statutory declaration that the pharmacists provide in relation to the processing of changes of ownership is a substantial control. It is a very serious declaration. It stands in law. I am unsure as to whether there is a need for any more supervision than what is currently in place.

Mr HUNT: It would be fair to say that, in terms of this inquiry, the establishment of a pharmacy council is more to do with what may change as a result in terms of scope of practice than the other issues around this inquiry and nothing really to do with just the ownership regulations as they stand now.

Mr White: My view is that the most benefit that the council can provide is in supporting and facilitating the expansion of scope and utilising this extremely valuable resource that we have across Queensland.

Mr HUNT: In summary, is it fair to say, then, that if nothing else changes in terms of regulation then the establishment of a pharmacy council at this point in time would not be of benefit?

Mr White: I think the statutory declaration that pharmacists provide is very serious and a very good control and I am not sure that, if there is more bureaucracy and controls, there is an added value in doing that, but the scope of practice piece that the council could facilitate would be of value.

Mr HUNT: Karen, in your submission you outline a lot of the great work that you do in a local pharmacy.

Ms Brown: Thank you.

Mr HUNT: You feel that this type of service may be affected by a deregulation of any of the current laws. Can you explain why you think your service would be diminished and these things that you currently do you would not be able to do in a deregulated environment?

Ms Brown: It is not about what I would not be able to do. I think when you are locally owned, exactly like what I do at Samford, you are the true health hub of our community. You spoke about those regional communities. My passion is that we are so much more than dispensing medication, and I think we forget that. People just see us as sticking a label on a box. You can see the value in locally owned or pharmacist owned because we put the patient first. It is not about the profit, which it would be if it was deregulated. It would be the sweatshop out the back with the pharmacist just churning out scripts. The majority of our value now is out the front. At Samford we actually have three pharmacists on every single day so we are accessible and available. We are one of the most trusted health professionals. I am not the only one who does those kinds of things. We go over and above, outside those four walls, and absolutely make a difference to our patients' lives. I do not think you would ever get that in a corporate sense.

CHAIR: You said that you have three pharmacists on every day. What is your response to the AMA, which has concerns about going a step too far with the scope of practice? This is in treatment of people with cardiovascular, strokes, INR measurements, diabetes and some of those areas.

Ms Brown: I think we are extremely under-utilised and I think, as I said before, we are one of the most accessible health professionals there are. We do go to uni for four years as a health professional. I can only speak locally, but we have a huge rapport with our doctors. We actually run a health professional group. We meet regularly with them. We are such a huge referral base. We talk about flu vaccinations. We have done nearly 600 flu vaccinations at Samford this year. We make the most of that 15 minutes we are with our patient. I took a gentleman's blood pressure. He had not seen a doctor, in his own words, for 10 years. I did the flu vaccination and I said, 'While you're here, why don't we make the most of this opportunity,' and I did a health check on him. His blood pressure was off the charts. I rang the doctor and got him an appointment straightaway. The doctor rang me and said, 'Thanks for sending him down.' The patient came back on his blood pressure tablets and said, 'Thanks for making the most of that opportunity.' That is what we can do.

CHAIR: That is a good response. I read that. It is quite significant in terms of the people who just do not go to GPs .

Ms Brown: Absolutely.

Mr White: Absolutely. When customers were surveyed about flu vaccination in the pharmacies, the vast majority said that they would not have got it done if access through the pharmacy was not available. It is unfortunate that in the media there is a turf war between doctors and pharmacists. In practice, as Karen has explained, in the real world that is not the case.

Ms Brown: We have each other's mobile numbers. We ring each other on a public holiday and say, 'I need to sort out this for my patient. Can you help me?' I think it is blown out of proportion at the top level. At the grassroots we all have the patients' best interests at heart and we all share the same patients.

Mr O'ROURKE: The submissions we have received provide no evidence that establishing a pharmaceutical council authority in other jurisdictions has led to better outcomes. They are saying it does not improve the outcomes by having a pharmaceutical council. Do you have an opinion about that?

Mr White: I know that in other states where councils have been established the processing of transfers of ownership has been substantially delayed and for pharmacists who are wanting to sell their pharmacy it is taking an enormously long time. Other than that, I am unsure of whether they are successful in the other states or not. I suppose getting the brief for those councils is the core issue around it succeeding.

Mr O'ROURKE: Queensland Health is also not aware of any evidence that Queensland consumers of pharmaceutical services are disadvantaged compared to consumers in states or territories where pharmaceutical ownership of premises regulation is administered by the pharmaceutical council or other authorities. What are your comments around pharmaceutical ownership? Karen, you spoke about the work that you do directly with consumers, but if it was owned by a corporation, for example, and employing local pharmacists—do you have a comment?

Ms Brown: That is exactly what I said: it would all be about the bottom line and it would be about the profit margin. It would be one pharmacist on, out the back dispensing, churning out scripts and having less qualified people out the front. That is a huge disadvantage to the public. Then you question as well what kind of impact it would have if it was a matter of 'we want you to sell this product' or 'we want you to sell that product', whereas many times during a day I actually do not sell a product; I will tell them to go home and rest or go home and 'use this that you've got at home'. It is clearly patient first for us; otherwise, it would be profit first.

Ms PEASE: Thank you both very much for coming in. I just want to elaborate on what you were saying, Karen, with regard to a register of different pharmacies that might be providing vaccinations or the Methadone Program. Currently that does not exist?

Ms Brown: No. It would be up to the general public to search their local pharmacies. Just extending that, even with methadone, we will have people come in and say to us, 'Can I get methadone here?' I know the local pharmacy that does it, but that consumer would have no idea how to find out where a methadone pharmacy is.

Ms PEASE: Do you believe it would be a task of a pharmacy council to undertake those sorts of registers?

Ms Brown: Yes. I think when you are registering the pharmacy it would be getting all the pharmacies to outline their services and then the council would be able to maintain it. That is the kind of thing that stops people going to the emergency departments and all those kinds of things. We are in an era of simple—what is accessible, what is quick, what is easy.

Ms PEASE: Are you familiar with whether the pharmacy councils in other jurisdictions provide that information?

Ms Brown: I am not sure, sorry.

Ms PEASE: If a pharmacy council was set up, who would cover the cost? Do you imagine that pharmacists would as a membership body?

Ms Brown: No. I am not sure, sorry. I suppose whether it is on registration and we are paying our annual membership, I am not sure.

Ms PEASE: Currently you belong to a professional organisation?

Ms Brown: Yes.

Ms PEASE: With that professional organisation you belong to, do you pay fees?

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Ms Brown: With respect, I think probably what is similar at the moment is the quality care program, where you pay and then you get accredited for all the different aspects of your pharmacy. Then obviously as individual pharmacists we pay for our national registration and things like that.

Ms PEASE: Are you as pharmacists required to undertake professional development?

Ms Brown: Absolutely, yes.

Ms PEASE: What are those qualifications?

Ms Brown: It is a continuing education and it increases each year. It covers everything from face-to-face answering questions to, obviously, implementation back in the pharmacy. You can do it obviously at conferences or online and, yes, it is ongoing.

Ms PEASE: Do you have a requirement for your staff to undertake those—your pharmacy assistants and also your retail staff?

Ms Brown: Yes, I personally do, but I think that is something that needs to be looked at when we talk about scope of pharmacy assistants. In a lot of the really good stores all of our assistants do complete their training, but that is not compulsory. A member of the public could walk in to one pharmacy and speak to a pharmacy assistant who has no training at all or they could go to someone else who has done a two-year traineeship and has certificates and is paid appropriately.

Ms PEASE: As a franchisee of TerryWhite Chemmart, does TerryWhite Chemmart expect you and your staff to undertake professional development or is that outside the scope of practice for TerryWhite Chemmart?

Ms Brown: It is recommended. With pharmacists we actually run a master class at TerryWhite Chemmart. Then we run a retail forum, which is for our assistants. It is not compulsory, but the brand does support us. We have an iLearn platform, like an online college platform, that we can do continuous training on, and our assistants can do training on that as well.

Mr McARDLE: Thank you for being here today and for your submission. Under the current regime, Queensland Health is advised of any change of ownership of a pharmacy. Are you satisfied that those arrangements that are currently in place are doing what they should be doing—that is, ensuring that only pharmacists are the actual owners of a pharmacy?

Mr White: To my knowledge, yes.

Mr McARDLE: You have no evidence to the contrary, that there are issues or issues that have been brought to your attention that would question that?

Mr White: No.

Mr McARDLE: Can I take you to the documents that you filed and 'Matters for consideration' in your submission. Questions 12, 13, 14, 15 and 16 deal with the issue of a council. When I read the questions and the answers, it appears to be saying that you do not support a council. Am I wrong in that interpretation or are you limiting your answer to the registration or other issues associated with the council?

Mr White: I am sorry for that confusion. I am not saying that we are against the establishment of a pharmacy council, by any stretch of the imagination. It is around the importance of the statutory declaration that the pharmacists provide. I think that is very serious, and I just ask the question: does the council add any further value than what that statutory declaration provides already?

Mr McARDLE: At question 13 you ask, 'Would a council improve community outcomes?' Your response is, 'Unsure. Accordingly, unable to comment.' I am not quite certain how the answer you have just given the committee ties in with that question and answer.

Mr White: It is just that I am unsure of what the scope and the charter for the council would be, so it is difficult to answer that question.

Mr McARDLE: At question 15 you ask, 'What other viable alternatives should be considered to deliver superior community outcomes?' The response is, 'The current model has worked effectively for many years.' That seems to imply to me that we should keep the current model in place. Is that not right?

Mr White: It has worked very effectively. You can look at what customers reference in terms of the support and services pharmacists give in the community. I think it has worked very effectively. I just feel that the current model could be further evolved and provide further benefits to those currently being provided.

Mr McARDLE: If that is the case, then, what could a council do to further enhance the outcomes for the community?

Mr White: It gets back to this scope of practice piece and the support pharmacists can provide in relation to an extended piece of work around access to vaccinations. It is really that scope of practice piece that pharmacists can provide further support on. They are not being fully utilised.

Mr McARDLE: Could I—putting words in your mouth—indicate that education and advice by a council to pharmacists would be something you would say the council could certainly become involved in if one were established?

Mr White: I had not thought about that, to be honest. Yes, supporting that and facilitating the rescheduling of medicines, for example, would be a very useful exercise.

Mr McARDLE: There is always a question of a conflict of interest in relation to any board being established. It would be important, would you agree, if a council were established that the composition of the council is drawn from pharmacists, non-pharmacists and professional people outside of pharmacy?

Mr White: I think for this council and other councils—and speaking more generally with boards—a diversity of skills and talent is really important. Getting some good diversity in that council would be useful.

Mr McARDLE: Have you turned your mind to what the cost of a council might be?

Mr White: I have not.

Mr McARDLE: You talk about schedule 4 and schedule 3 drugs in your submission. I think you also referred to the eHealth record or the My Health Record in your opening statement. Would it be the case that a pharmacist would rely upon the My Health Record or the eHealth record to form an opinion?

Mr White: It would definitely be very helpful.

Mr McARDLE: Everyone is going to have one of those records. You can opt out and, as I understand it, it is wiped. Would you still be linking directly to the doctor, as you said Karen, by way of telephone call to make certain that what you were doing was in the best interests of the patient?

Ms Brown: Whilst I think the theory of the My Health Record is great, my biggest concern is that you will always question whether it will be 100 per cent correct. Have they added everything? Has this person not? Absolutely, they are the lines of communication. I feel that we as pharmacists are that central place. The number of times that a specialist will tell us that something has changed and we tell the GP, because they have not spoken to each other, is considerable. The pharmacist is really the centrepiece of so many ports of information coming in.

Mr McARDLE: The hub.

Ms Brown: Absolutely.

Mr McARDLE: Would it be a practice that you would require of pharmacists when they are making a change to a prescription or issuing a prescription that they contact the GP first, if they can?

Ms Brown: Absolutely.

Mr McARDLE: That would be part of any proposal going forward, from your point of view?

Ms Brown: Yes. I am very strong in terms of my position about the continuation of repeat prescriptions. I have an example at the moment. I have a GP practice that is closed for 10 days and I have a patient who has come in needing his blood pressure tablets. At the moment, I can only give a three-day emergency supply. I have a five-year history of him being on the same tablets from the same GP. Am I not in the best position to give him that month's supply, as opposed to sending him to a brand-new doctors practice, him going to the emergency department or, worse still, him stopping his tablets until his doctor comes back?

Mr McARDLE: What percentage of your clients would fall into that category?

Ms Brown: Maybe a couple every day. Sometimes it is actually just through laziness that they have run out. In those cases, it is just a case of calling the doctor. In this case, the doctors are closed for 10 days—and they are entitled to go on a holiday—and we are not in a position to give people what they need.

Mr McARDLE: I can almost see the relevant medical fraternities arguing in terms of where you are now, 'Wait on. I intend to do A, B, C and D when they next come in for their script.' It may not be on the health record. They are going to say that that is important as well. How do you counter that?

Ms Brown: That is fine. They are not there to do that right now, though; they are on holidays.

Mr McARDLE: No, not when they are on holidays but generally speaking. I am on blood pressure tablets and the doctor said to me, 'Next time you come in we're going to do A, B, C and D to make certain things are working out well.' How do you counter that?

Ms Brown: First of all, I do not think it is an extension of scope. I think it is where we are under-utilised. If it is changed, you are following a procedure. If it is that you want to offer a one-month continuation of a blood pressure tablet, they could say that we must take their blood pressure. We are quite capable of doing that. We could submit to the doctor, 'We did this. This was their blood pressure.' Next time they see the patient in a month's time to get their full six-month supply, they can conduct the following.

Mr McARDLE: Would you say that the regulation of ownership in Queensland is best left with Queensland Health but that there are other issues outside of that that could pass to a council, or are you saying they should all rest with the council?

Mr White: I have not considered that. I am unsure on how to respond. I will take leave on that, if you do not mind. I have not considered that at all.

CHAIR: For clarification—yes or no and then what the remit should be—should Queensland establish a pharmacy council?

Mr White: Yes.

CHAIR: Under what remit?

Mr White: Focus the effort on the expansion of scope and making sure pharmacists are properly utilised to help Queenslanders stay healthy and be well and deliver better health to all Queenslanders.

CHAIR: There were divergent views expressed by members of the medical fraternity with regard to education and training. Ms Brown, you said in your earlier statement that you could go to a pharmacy where a pharmacy assistant has had no formal training versus what you do in your particular pharmacy—and I commend you on doing that. I think there should be a base level of training. Some of the research that has been undertaken indicates that it is a certificate IV for a pharmacy assistant. We need to unpack what a pharmacy assistant does as opposed to what a pharmacist who is out the back dispensing schedule 4 drugs—

Ms Brown: We are out the front, not out the back.

CHAIR: Quite often when I walk into my pharmacy my pharmacist is out the back. I have complete faith in them. There is a relationship that you develop. You chat to your pharmacist. Concern has been raised about a minimum qualification. Should there be a minimum qualification if we as consumers are going to walk into a pharmacy and trust the advice? What should that minimum qualification be? You do a four-year course. For a pharmacy assistant it is currently a certificate IV.

Ms Brown: That is a two-year course. That is what I think the minimum should be.

CHAIR: Retail assistants—

Ms Brown: For a pharmacy assistant who is on the back counter with schedule medicine. Anyone who is handing out schedule 2 medicines or assisting with schedule 3 medicines should have a minimum certificate II in pharmacy assistant.

CHAIR: You talk a little about appropriate medicines and being able to do some scripts. Some people find it difficult going to their GP, as in the example you just gave. You talk about a range of medicine classes, from oral contraceptives to drugs for the treatment of migraines. I am interested in treatment of uncomplicated UTIs. Is this something that is common for pharmacists to see? How do you give that treatment for a common UTI? I thought you would have to do a urinary test. Do you just go on signs and symptoms?

Ms Brown: What I mentioned before is that it is about the quickness of things. You cannot always get into a doctor straightaway for things like migraines and UTIs. If we could give a three-day course of trimethoprim, they could get started. Most of time when it is prescribed, if it does not clear up then there is a sample taken.

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It is the same with migraines. It would be good if we could help a person on a Sunday morning at nine o'clock when their doctor does not open until Monday. It is those 24-, 48- or 72-hour things that we can assist with. I think that is where we are under-utilised. We are such a big scope for triaging. The general public does not even realise that sometimes.

Yesterday I had a lady who had her baby booked in to see the doctor for nappy rash in three days time. I said, 'I can have a look at the baby's nappy rash and I can help you right here and now. If it gets worse, go and see your doctor.' I think that is where we need to educate the public more on the role that we can play in that triage. They are going to the ED and those kinds of things when we could easily help.

CHAIR: Using the example of a UTI, you do not do a test until days later. What is the treatment? There are signs and symptoms. You think it is easily treated?

Ms Brown: Yes. Even with the morning after pill and things like that we follow strict guidelines and a checklist. It is quite simple. The morning after pill is a very good example of something that was descheduled. I could not tell you the last time I saw a script for a morning after pill because females just come to the pharmacy at all hours because it is quick. It is there. They do not have 24 or 48 hours to wait for the doctor's appointment. It can be the difference.

CHAIR: I thank you both very much for your detailed submissions and your appearance here today. It has been most helpful.

NISSEN, Professor Lisa, Head of School of Clinical Sciences, Queensland University of Technology

CHAIR: Good morning Professor Nissen. Thank you very much for appearing before us today. I found your submission quite good. You have done quite a bit of work around trials for vaccinations in Queensland. I will need to pull it up because it is electronic. I have put a lot of red around it. Would you like to make an opening statement?

Prof. Nissen: Thank you for giving me the opportunity to provide some feedback for the inquiry. The School of Clinical Sciences hosts the pharmacy discipline. We did not have to come far today, being located next door. We are one of the large providers of pharmacy students here in Queensland. We obviously have a great interest in having a very vibrant pharmacy profession, not just here in Queensland but obviously nationally and internationally.

From the point of view of our discipline, we have a great feeling that, with medicines being so complex and emerging as such a large player in the health sector, pharmacists are a great contributor to that complexity as medicines managers, which I will unpack a little as we talk more about scope. The discipline really believes that pharmacists should be considered as individual contributors to that system, rather than the buildings that we occupy. Often we are called ‘hospital pharmacists’ or ‘retail pharmacists’. We get considered as the building, rather than for the skills that we contribute to the system more broadly. Sometimes that prevents us from being where medicines are in the system and we get locked in a building rather than in the wider system itself. That is the context that we came to with respect to our broader submission.

Speaking particularly about the scope of practice, Queensland Health has a great position around expanded and extended scopes of practice for allied health professionals, and allied health in this case contains pharmacy. We do not always have a home, but in Queensland it is in the allied health document. It is important to understand that ‘expansion of practice’ means operating in the full scope of competency that you have, so it is not about adding things; it is about what you actually bring to the table as a health professional. An extension of scope often gets used interchangeably but incorrectly by people: an extension of practice is where you have to add things to your current skill set to be able to practice. Often they are things that are affected by legislation, professional turf wars and those kinds of system boundaries. Karen mentioned things that were probably good examples of those, where we can provide continuity of care for prescriptions and we can provide things in the medicines management space that is within our scope of practice currently, but we have legislative barriers and professional turf barriers that prevent us actually doing those. It is not about us not being able to do them; it is about the fact that the system prevents us from practising in that way.

For pharmacy, the really interesting thing is that, because it involves medicines, it actually collides with legislation, particularly with things such as the Health (Drugs and Poisons) Regulation that talks about the prescription or prescribing and medicines in the context of a communication or an order as a way of being able to get a medicine. That is a great example of a legislative barrier that prevents pharmacists doing things. Karen’s example is a great one around being able to continue a supply of medicine because we need a prescription, which is an order. It does not mean that we do not have the competence to do it and it does not mean that we will not communicate with the doctor; it just means we need a piece of paper because of the legislation.

From the research that we have done—the aspirin project that I referred to in our submission—we know that pharmacists have competency to cover a lot of pharmacist prescribing models, which, because of the nature of our practice around medicines, a lot of our scope of practice forms into things that are called prescribing models for pharmacy. Our competencies map to the majority of the prescribing competencies from the National Prescribing Service, and our ability to train pharmacists to meet those competencies is significant. Most of our professional competencies are already mapped to those.

It goes back to that expanded and extended practice. Mostly, models of practice internationally around dose adjustment, continuity of care, minor ailment services, the ability that we have already demonstrated here in Queensland around pharmacists prescribing—vaccination is a great example where we adjusted legislation to allow it to happen—showed that pharmacists can do these kinds of roles very effectively. It is looking at those core principles where pharmacists have existing competency but looking at where legislative and professional barriers are preventing us practising currently, more than looking at necessarily expanding practice beyond where we currently have competency, as far as addressing some of our turf wars.

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We agree that there is not a lot of consistency in what happens with assistants. The highest qualification is a certificate IV. They exist in both the retail and the health packages. That is also an inconsistency currently. Most of the hospital people do a different certificate IV than the people in community practice. In overseas models, North America and the UK made a decision to move technician training across to certificate and diploma training. They made a wholesale decision that gave people a timeline where they could shift across. Everybody had to move their baseline training within a certain period. We do know that if you use appropriately trained technicians you can improve the accuracy of technical tasks, as opposed to using pharmacists alone, and you can release pharmacists to do more clinical tasks.

It is really important that we talk about the technician work force. If we want pharmacists to do clinical roles and be where medicines are, you need an appropriately trained technician workforce. That is a great discussion for us to be having, because there are plenty of examples overseas of how you can do that. If we need to piece those two together, that is, use pharmacists more appropriately paired with an appropriately trained technician workforce—you cannot do them independently; they need to work together—then you can improve access, you can improve skill mix in your health workforce and you can improve medicines management in the community.

CHAIR: Thank you very much, Professor Nissen. I commend you on your submission, too. It is very detailed and we will break down some aspects of it. The core of this inquiry is to look at establishing a pharmacy council. If we use the horse-and-cart analogy, that would be at the front and behind it is the scope of practice. You have been dealing in this for some time, I gather. Should Queensland establish a pharmacy council? Secondly, if it did, should its remit be around educational standards, as you have just talked about, in terms of the certificate IV and the diploma? Do you think part of its remit should be to advise government on policy in setting standards for pharmacy and pharmacy assistants?

Prof. Nissen: No.

CHAIR: Why not?

Prof. Nissen: We have national bodies that look after those aspects, because the VET sector training sits within the VET sector training packages and they are national packages. We have national training. The board regulates our scope of practice and we have accrediting agencies nationally that look after those. They are national packages and they would be national programs. From an education and training point of view, I would not see that the state would have a separate view to a national approach to education and training. People practise across the border. We do not want to end up in a border dispute, like we have for other things.

CHAIR: Taking the scope of practice and parking it for a moment—and I appreciate your answer—what are your views on establishing a pharmacy council? I know that you did not really look into this in your paper, but do you have a view on establishing a pharmacy council in terms of pharmacy ownership?

Prof. Nissen: The comment that Anthony made about the transfer of ownership is kind of beyond our remit to speak about. Our assumption is that that part is something that has been happening in a legal process. The point that we have had interface with is more around the quality of businesses and how they operate, understanding that not all businesses are aligned to the guild and may sit under the quality care program. Our interest would be in having a way to ensure that there is a good governance and quality framework around how pharmacy operates in Queensland. With our QPIP pilot, part of our process was to ensure that people had an appropriate space for giving vaccinations, and that was not always consistent initially when people said where they wanted to give the vaccinations. I think you need to be able to provide quality places of operation across the profession.

CHAIR: From a governance point of view, do you think it is important to have a council?

Prof. Nissen: Yes.

CHAIR: You just talked about QPIP. My next question was—

Prof. Nissen: The Queensland Pharmacy Immunisation Pilot.

CHAIR: Can you unpack that a little? You led the way.

Prof. Nissen: It was not just me. It was a collaboration between the Pharmaceutical Society and the Pharmacy Guild, which was a fantastic demonstration of the profession operating together to lead a practice change. QUT and James Cook University collaborated to do the research evaluation of the pilot implementation. I happened to have two hats at the time: I was the Queensland state

president for the society and I worked at QUT at the same time. The pilot itself looked at the ability to have appropriately credentialed pharmacists providing, initially, influenza vaccinations in a community pharmacy. They were non-NIP, non-National Immunisation Program, so it was a fee-for-service program. In the second phase of that pilot we added measles, mumps, rubella and whooping cough. That was an expansion of the suite of vaccinations that were available and also we added a significant number of pharmacists to that.

We collected outcome information about adverse events. We were looking for the unintended consequence of adding a poorly skilled workforce. If you looked at the quotes from our good medical colleagues, people would die in the street if pharmacists were available to give vaccinations. They also said that we would be vaccinating people amongst the toilet paper and toothpaste, which was clearly not the case because they were in appropriately kitted out clinical areas. We collected data that showed that that was not the case. We did not have adverse consequences. We did not have people die in the street. I do not have the exact numbers, but to date hundreds of thousands of people have been vaccinated across the whole country.

CHAIR: Could you provide that data on how many people have been vaccinated since the project started?

Prof. Nissen: Yes.

CHAIR: Thank you very much. Finally, given the pilot program, do you think you can expand it to a younger cohort? I believe 18 is the minimum age at the moment.

Prof. Nissen: Currently it is 18. We have had some discussions with the Chief Health Officer about reducing the age and also increasing the number of vaccinations that are available. That has continued with the guild and the society having those discussions. My personal view, as has been discussed with the society and the guild, is that that could even be reduced to more than 12. In pharmacy, we consider that for those over 12 the dosing of medicines becomes adult doses. That would allow us to look at catch-up vaccinations for HPV. It would allow us to provide flu vaccinations for the super spreaders—that is, the teenagers. It would also allow us to cover a number of other vaccinations for catch-up programs for kids who miss them through immunisation programs. That would be the type of age group that would be most suitable for us to be pitching for.

Mr HUNT: I have some questions around scope of practice and training for pharmacists. We heard Ms Brown talk about the pharmacist's desire to be able to assist the patient in a more thorough way. An example was given where a baby presented with nappy rash. What training do pharmacists get in the diagnosis space? I guess that GPs have a wider scope of training in diagnosis and that their angst might be around pharmacists becoming overconfident with experience in diagnosing conditions presented to them that should be referred to a GP. Can you unpack for us the training around that diagnosis space when a pharmacist is presented with a symptoms?

Prof. Nissen: Yes. That is really a two-part question. The first part of the question is about clinical reasoning and clinical diagnostics. Pharmacists are trained in both of those things, so that is a process. That is the key consideration. You look at presenting symptoms and the onset, duration, nature et cetera of those symptoms, and that leads you through a process of coming to the point of whatever it is. Then the clinical reasoning is: could it be something else? Is this potentially serious and need referral? Pharmacists are trained in that as medical practitioners. It is part of their core business. Ours has a specific lens focus on how medicines play into those different conditions, but they train in cardiovascular disease, endocrinology—all of the major medical conditions—and through those processes our role usually stops at getting the prescription and how the medicines are part of that role.

Our specific area of diagnostics is currently in over-the-counter and minor ailment conditions as well as things related to chronic disease, because that is our general scope of practice. Pharmacists who practise in acute care facilities work in some of our major hospitals or other areas, and they apply that to intensive care, oncology et cetera. They apply that skill set to working in those other areas of practice. It is not different; it is just that application has been primarily around medicines related issues. For things like nappy rash, we train people in that in their second year. They learn how to look at different rashes and presenting complaints and work out what the problem is. They are able to tell that it is nappy rash and not foot-and-mouth and recommend the appropriate treatment. They are able to say, 'If it has not cleared up in three days you need to go and see the doctor,' and give the reasons why.

Mr HUNT: Keeping in mind the time, I will defer.

Ms PEASE: Thank you for coming in, Professor Nissen. If this has already been covered I apologise, but you spoke about the standard of service that is a priority for pharmacists. Given that this inquiry is all about some of the bigger players coming in and potentially wiping out community led pharmacies, do you have a position on that? Given some of the large organisations that are in play these days with pharmacies, is their role different from that of the community pharmacist?

Prof. Nissen: That is a very interesting question. There are different practice models of pharmacies. There are clearly the big-box pharmacies—for example, your Chemist Warehouse style pharmacies; there are others that have a forward pharmacy or a pharmacist in contact with patients as your first point of call; and there is a mixture in between. They are all models of practice of pharmacy, but what you want to ensure is that the pharmacist's interaction with the patient is a quality one, wherever that happens. Regardless of whether there is a pharmacy council in a state, the model of practice of pharmacy in this country is a mixture of all of those. That is my first reflection on the nature of the first question for the inquiry.

Ensuring that the patient interface with the pharmacist is good quality is our most important consideration—and that the environment that happens in is a good-quality environment. For us, it is a health environment and a clinical environment that is important. It is also important that it is one that patients would reflect on as a good experience.

Ms PEASE: You talked about nappy rash as an example. In terms of patient interface and intervention and engagement with the patient, I would assume that there is a fair amount of training with regard to medical training with pharmacies so they are able to engage with potential patients or clients?

Prof. Nissen: A good question back to you is: what do you think we train pharmacists to do? It is intriguing to me as an educator. I have one of my colleagues here, and we spend most of our time teaching our students to talk to patients and provide medicines management and care over four years of their degree.

Ms PEASE: Certainly. That would have been my understanding of it as well, but I just wanted to get that in the evidence. You talk about the technician, which is another term for the pharmacy assistant. I want to understand the difference with a technician's training. Obviously it is going to be shorter and different. A pharmacist would have to undertake a lot of training with regard to drugs and all of that sort of thing, but they also have to be able to engage clinically with a person.

Prof. Nissen: Yes. I think a good way to look at it is in terms of the medicines management cycle. I can table this for your information later if it has not been included in one of the submissions. There are multiple steps in that cycle, and at the middle of it is the patient. At each of the steps in that process a pharmacy technician can have a role in logistics and the system parts of that cycle, but it is the cognitive processes that are associated with that cycle that are the pharmacist's role specifically. If you take the logistical parts or the technical parts out of that, technicians should be able to provide those parts in the medicines management cycle. That allows the cognitive sides of that, so that clinical processing and judgement related piece around medicines. Making sure that I can look at you and take your clinical history and work out what your drug interactions are—that is the part you want pharmacists doing. You do not need pharmacists to stick labels on boxes, pull things off shelves, deliver stock and put together chemotherapy. Currently that is what we use pharmacists to do: technical and logistic roles. Would you like me to tender the medicines management cycle?

Ms PEASE: That would be great, thank you.

Mr McARDLE: Thank you, Professor Nissen, for being here. Just to clarify it in my mind, do you see a role for a council or do you think the current regime, with state and federal and other bodies, is sufficient to dictate the future direction of pharmacists and pharmacy assistants?

Prof. Nissen: I think the current system as it stands is fine. This is my impression, given an observation of other states that have a council and what happens in Queensland. The fact is that there is no difference in how practice happens in those states and this state and the way that pharmacies are operated. I do not see any difference.

Mr McARDLE: You would say that the outcome in New South Wales as opposed to Queensland is very similar?

Prof. Nissen: Yes.

Mr McARDLE: That is, there is a council in New South Wales and no council in Queensland but there are really no adverse outcomes either way that would warrant a change in either state?

Prof. Nissen: The practice is similar, yes—unless, as Anthony said, the charter was discretely different and we had some kind of operation, but then it would encroach on other operations for national groups like the educators or the board, so its purpose would have to be distinctly different to that of other groups.

Mr McARDLE: You would see a council as being another layer of bureaucracy that is really not required, given that we have several layers already?

Prof. Nissen: There are so many layers it is like a Sara Lee danish.

Mr McARDLE: Without the calories perhaps. Chemmart referred to schedule 4 and schedule 3 drugs given by either a pharmacist or a doctor, as the case may be. As I understand it, the right to immunise was only given after two years of intensive study by Queensland Health. It was not done overnight. There were tests done, there was data collected and the like; is that right?

Prof. Nissen: Yes, it was complex.

Mr McARDLE: Let us put it this way: no-one simply asked a question, it was ticked off and it could happen; is that right?

Prof. Nissen: Sort of. We are kind of caught a little bit by the fact that the bill has been in stasis for many years. The new regulation, as you would probably be aware, has been in stasis since we started doing the QPID pilot. After the first iteration of data, which was about 11,000 vaccinations, there was potential for—if the bill had been able to come through—a regulation change then. Because it had not and there were some changes afoot, we had to continue in a pilot framework because of the section 18 approvals. Because the bill continued to be in stasis, and not knowing when it was going to come out, we had to literally bite the bullet and make a regulation amendment at that point. If the bill had come in earlier we would have been able to make a change after a year. I think one point to make is that we should not necessarily always have to have Australian collected data to be able to make a decision about scope of practice. That is literally a waste of time.

Mr McARDLE: We are too narrow in our view of overseas data?

Prof. Nissen: Absolutely. Vaccination was a great example. The most developed systems, which are exactly the same as ours, had 10 years of pharmacists providing vaccinations—in the US it was 20 years—with no adverse outcomes. If we were able to literally say, 'Yes, it is possible to do this here,' one year later we could have changed it. The whole country came on board really quickly.

Mr McARDLE: Would you say that going from prescription-only schedule 4 to pharmacist-only schedule 3 should only occur after a detailed study is undertaken—

Prof. Nissen: No.

Mr McARDLE:—or would you move immediately to do that? If you would, what evidence would you use to substantiate that immediate change?

Prof. Nissen: I think what is being referred to there—and I think where we used the UTI example for trimethoprim—is a down-scheduling of S4 to S3, which is a broader category shift. That generally happens through the TGA application process. We have seen it with a number of items such as the PPIs and some of the pain medications. The migraine treatments, UTI treatments and others were down-scheduled from S4 to S3, or pharmacist-only. Emergency contraception did that. That is a category shift that does not require a trial. The S4 was not a category shift for the vaccinations. It stayed as a drug therapy protocol, so we treat pharmacists like any other vaccinator in Queensland. We are the same as community vaccination nurses, so we sit under a drug therapy protocol. It is still an S4 medicine.

Mr McARDLE: Chemmart referred to the move from S4 to S3 'in association with agreed standards'. Do you know what they would be?

Prof. Nissen: Yes. We have professional practice standards for S3 medicines. I think Karen referred to that when she was talking about emergency contraception. It says: 'Patient presents with this. These are the things that you need to go through as a checklist. If you have any of these red-flag items, you need to refer them to the doctor or other places. If not, proceed with these things. This is what you need to do.' It is literally like a drug therapy protocol for the profession, and the pharmaceutical society constructs those through a governance group.

Mr McARDLE: Are you able to table that document, please, just to clarify in my mind exactly what steps are undertaken?

Prof. Nissen: Yes. It is a national statement.

Mr McARDLE: In your own document at page 5 you refer to working in conjunction with medical practitioners to get the outcomes. What does that entail when you say ‘working in conjunction with medical practitioners’? Does that mean a telephone call before it is prescribed or subsequent to? How does that work?

Prof. Nissen: That is with emergency supply and script renewal?

Mr McARDLE: Yes.

Prof. Nissen: It can be both. The models they have in Canada are agreed beforehand. They say that you can renew a prescription under a certain protocol but you need to communicate what you have done to the patient’s doctor. You do not have to call them up and say, ‘I am going to do this right now,’ because, as Karen said, that doctor may not be available, but you need to communicate to that doctor what you have done.

Mr McARDLE: At page 6 in the second paragraph you refer to a study in New Zealand.

Prof. Nissen: The INR study?

Mr McARDLE: Exactly. Could you get a copy of that to the committee?

Prof. Nissen: Could you not get that document?

Mr McARDLE: I do not know. That is why I am asking.

CHAIR: I was going to ask the same thing.

Prof. Nissen: All right. I gave the reference to it at the back.

CHAIR: Yes.

Prof. Nissen: You could not get a copy?

CHAIR: This demonstrated improved clinical outcomes.

Mr McARDLE: Yes.

Prof. Nissen: Yes. I gave the references at the back.

Mr McARDLE: Sorry; my apologies for that. Is that only in relation to a particular drug or a series—

Prof. Nissen: Warfarin.

Mr McARDLE: Okay, so only one drug?

Prof. Nissen: Yes, which is a very high risk but commonly used anticoagulant.

Mr McARDLE: Yes. Is Harper the same Harper in the study in 2015?

Prof. Nissen: Yes.

CHAIR: Notwithstanding there was a Harper review, too.

Mr McARDLE: Indeed.

Prof. Nissen: Could you not get those references?

Mr McARDLE: No, I did not recognise that there was an index at the back, so my apologies for that.

Prof. Nissen: It was just BMJ open, so you should be able to download that.

Mr McARDLE: That focused on one drug only, not a range of drugs?

Prof. Nissen: Warfarin, yes.

Mr McARDLE: What was the outcome of that study?

Prof. Nissen: The primary outcome of the study was that they had less adverse reactions or outcomes from the Warfarin use—because the problem with Warfarin is that you can get people who bleed—and they got greater timing range, so they got tighter control of the Warfarin monitoring by having the pharmacist do it.

Mr McARDLE: Thank you very much.

CHAIR: How large was that study? How many people were in that?

Prof. Nissen: That is a good test.

CHAIR: We will get the information from that, because I think it is important.

Prof. Nissen: It was about 600.

CHAIR: Okay, because dose adjustment and monitoring of medications is something that the AMA has raised, and because Warfarin is an anticoagulant that is something that I was interested in.

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Prof. Nissen: It is a collaborative, so you do it in collaboration with the doctor but the pharmacist does the ongoing management.

CHAIR: That is an interesting study. I look forward to reading that. I have a question going to page 6 relating to pressure on emergency departments, which is something that I am very interested in. In the UK under the NHS they aim at—

... providing support for patients within the first month of starting a new medication. It has been delivered in >90% of community pharmacies since its introduction ... and covers ... hypertension, NIDDM—

diabetes—

COPD, and anticoagulation ...

Is there an evaluation? Are there any particular outcomes from that?

Prof. Nissen: The primary issue with that was that people with those conditions tend to have poor adherence to their medications, they have duplications of therapy and they may not continue their therapy post discharge, so these are commissioned services within the NHS. By having those services in place, specifically in the pharmacies—so for that follow-up—they were able to get better outcomes for those patients in that post-discharge period by having a directed service post discharge rather than just sending them into the wild.

CHAIR: Is that something that could potentially be established in Queensland, do you think?

Prof. Nissen: Yes, absolutely. There was a study done by Danielle Stowasser out of the PA Hospital in 2013 or 2014—and I can get that for you as well—that showed that post-discharge follow-up of patients can prevent hospital readmissions. That was out of the PA Hospital, so I can get you Danielle's study as well.

CHAIR: That would be good.

Prof. Nissen: It was a seminal piece of work for post-discharge follow-up.

CHAIR: Dr Nissen, thank you very much for your time and again for your detailed submission. I found it very valuable, as I am sure other members of the committee have. You did take some questions on notice. We need responses to those back by Friday.

Prof. Nissen: Friday is fine. I have written those down—so Danielle's study, the medicines management cycle and the professional practice standards. That is fine. I have a copy of the pharmacists prescribing for the board and the QPIP pilot, which I was not sure you were able to get copies of.

CHAIR: We will need to seek leave to table those. Is leave granted? Leave is granted. Thank you very much, Dr Nissen, for your contribution today.

Prof. Nissen: Thank you.

KING, Dr Stephen, Commissioner, Productivity Commission (via teleconference)

CHAIR: Good morning, Dr King. Dr King is author of the Australian government's 2017 report *Review of pharmacy remuneration and regulation*. Dr King, thank you for joining us this morning by phone. I am Aaron Harper, chair of the health committee, and you have all of the health committee members here and a pretty full public gallery. We are conducting an inquiry into the establishment of a pharmacy council and transfer of pharmacy ownership in Queensland. Dr King, I invite you to make an opening statement and then we will move to questions.

Dr King: I will keep my opening statement fairly short. As you have mentioned, I was one of three members of the independent inquiry into pharmacy regulation and remuneration. During that inquiry we did not explicitly look at ownership rules. As your issues paper notes, all of the states have ownership rules of some sort applying to pharmacies. We concentrated on issues that we could advise the federal government about and which the federal government could act on, so in that sense the views I will put here are my own. They are ones that my other panel members may or may not agree with. It would be up to them to judge.

With regard to my own views on the ownership rules, from my experience during the panel and during our hearings and our visits to pharmacies it struck me that the ownership rules might be an idea which is good in theory but is not working in practice. Perhaps I can just briefly explain that. In theory it is a good thing to have a healthcare practitioner directly responsible for the outcome of their patients, whether a GP, a specialist or a pharmacist. You want the individual who is providing the medical service to have, to put it simply, skin in the game as far as the patient's welfare and the patient's outcome is concerned. That is the way of maximising the health outcomes of consumers and making sure that they get the best service.

The underlying economics behind that are very simple. Most of us as consumers of health services are reliant on the expert knowledge and skill of health practitioners, so you want those health practitioners, to the highest degree possible, to be acting as our agents through their advice, through their recommendations of treatment, so we want them to be acting on our behalf as best as possible. We want to avoid conflicts there. A crude approach to that would be to say that one way is to have, say, an individual pharmacist who happens to do the dispensing or at least oversee the dispensing in a retail pharmacy setting also owning that shop so that if something goes wrong—if there are patients who are not well treated—then they suffer the direct economic consequences of that as the patients go elsewhere and choose a different pharmacist to dispense their medicines. That is the theory in very simplistic terms.

My background is not in health economics and certainly not in pharmacy, so the theory behind the ownership laws was one of the things that interested me on our trips around Australia—exactly how these laws were working, even though we were not explicitly investigating them. During our trips around Australia I became aware of a number of things about the ownership rules—and I will not concentrate explicitly on Queensland but speak more about Australia. Firstly, there are a large number of pharmacy owners who may best be categorised as absentee landlords. To the degree that the ownership rules are meant to bring the owners to have skin in the game, it seemed to be a very loose connection in the sense of talking to the shopfloor pharmacists. At a large number of chemists I would ask quite often, 'Who are the proprietors? How often do you see them?' An answer of 'never' or 'perhaps once every three months' or 'perhaps a couple of times a year' was a fairly common answer.

I want to stress that there are also some pharmacists where the owners are on the shop floor every day, so I do not want to suggest that this is a uniform outcome. If the aim of the ownership rules is to have the pharmacist as the owner engaged directly in that oversight facing the consequences of poor dispensing or poor service, there were some pharmacies—and, again, I cannot put a number on it but a significant number—where that just was not occurring.

The second element that struck me was—I will not call it gaming of the pharmacy ownership rules but certainly playing the rules as best as possible for the owner. For example, in Western Australia I was talking to one of the owners who came along to one of our sessions. This was an owner who had maximised the number of pharmacies they could own in Western Australia, in Queensland and in Victoria. I asked him, 'How often do you get to each of these pharmacies?' He said, 'Usually once a year I get to do a bit of a road trip around the various states'—and I think he lived in Melbourne—'to visit the pharmacies, but it is only about once a year.' If the idea is to have that very close connection through the ownership rules between a pharmacist and the patients who are receiving the medicines from that pharmacist, clearly—and this is just one example; there were other similar pharmacists—that is not what these rules are achieving.

Do I believe that the ownership rules should simply be removed? I think there are issues and dangers with a complete removal. There are transition dangers. I think we have seen some of the transition issues that have occurred in England, where they removed ownership rules and there was the professionalisation, if I can put it that way, of the ownership of pharmacies. They also allowed large new entries. The last time I looked, which was about six or seven months ago at least, they were in the process of trying to sort out an oversupply of pharmacies.

The second risk of removing the ownership rules, and I think the bigger risk—and certainly a significant risk in Australia—is vertical integration. One of the concerns that we found during the pharmacy inquiry was where you have, for example, GPs directly or indirectly having close connection with the profitability of a pharmacy—so a medical centre, where there was a pharmacy closely connected, renting space from the medical centre but, in a sense, the owners of the medical centre having strong incentives to have the prescriptions dispensed at the pharmacy and that then feeding back into the GPs and potentially giving the incentive. Again, I am not going to say that we saw that in practice but, clearly, the incentives were there for what I would call increased prescribing and potentially increased dispensing because of that.

I would be concerned if doctors were owning pharmacies or, quite frankly, pharmacists were owning doctors clinics. I believe that, in fact, there are some pharmacists who own doctors clinics, even though not the reverse. I would be concerned if individual drug companies moved down the chain towards pharmacies. There would be an incentive to suggest, for example, that the employees would be under pressure to make sure that the relevant owner's generic medicines were being used. That may not be the best generics or the cheapest generics for the customer. Again, it is acting against the customer's interests.

They are the obvious places that I would have concerns—doctors and drug companies. Other than those, I have not thought of any other areas where I would have problems and conflict. Obviously there need to be professional standards. Dispensing should always be under the direct supervision of a qualified pharmacist and that pharmacist's professional and ethical obligations would hold over the supervision of dispensing. I personally cannot see that having individual investors who are not pharmacists would lead to a change in incentives compared to what we see in terms of the absentee owners of some pharmacies today, particularly where those owners are maximising the number of pharmacies they own in various states. Let me leave it there and open to questions.

CHAIR: Thank you very much, Dr King, for your opening statement. You raised the point about pharmacies and medical centres. It is interesting that you do not have to be a GP to own a medical centre.

Dr King: That is correct.

CHAIR: The very core of what we are looking at is to establish whether we strengthen the legislation or look at it with a different view. You also made the point of the oversupply of pharmacies. Where were you relating that to?

Dr King: What has happened is that England—my apologies, I am drawing on my memory of material I read probably at least six months ago—deregulated the ownership. I am not sure to what degree they had location rules, but they certainly allowed the entry of new pharmacies in England. As I understand it, that has ended up having some very professional, well-run pharmacies coming in. Some of the larger chains have expanded. That has put a lot of pressure on, if I can say, older style pharmacies.

I have not looked at the studies, so maybe the customers have gained a significant benefit from that. I do not know. I would have thought that there would be pretty significant competition happening there and the more efficient pharmacies, the chain pharmacies that entered, would have probably been pushing down the prices for medicines. Again, that is a very difficult health system, so I really do not know about that.

I do know that around 12 months ago—maybe even a little bit longer—there was a very strong pushback in England because pharmacies were going broke. Many people consider that a community pharmacy is not just a retail outlet; they have a long-term relationship with their community pharmacist, particularly a well-run community pharmacy. There were issues in England about how to transition the market from what it had been to a market without the similar ownership rules but without, quite frankly, ending up with a lot of dead retail pharmacy businesses along the road. I think that is a problem. If recommendations go through in Queensland to change the rules to loosen them, the transition should be considered very carefully.

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CHAIR: Page 4 of your submission states—

Community pharmacy is a significant public asset. Australia's network of over 5700 community pharmacies and pharmacist workforce—over 20,000 in community pharmacy and 30,000 registered pharmacists—play an important role in our healthcare system and are a key enabler to the achievement of the NMP.

You will have to unpack what 'NMP' is. Your submission states further—

For many Australians, the community pharmacy network is the most convenient and accessible interface to the primary healthcare system.

The submission goes on to state—

... pharmacists hold a trusted role within our communities and act as a valued referral point for health and other local services.

Most of the 200 submissions that we have received make that point. Dr King, would you support Queensland establishing a pharmacy council to strengthen pharmacy ownership?

Dr King: By the way, 'NMP' is National Medicines Policy.

CHAIR: Right. Okay.

Dr King: On reading through your issues paper, it was not clear exactly what a pharmacy council would achieve or do compared to what the state department is able to do. If its base aim is to ensure or help ensure that the relevant ownership rules are complied with—whether they are the current rules, tightened rules or loosened rules—that is fine, except that it is not obvious to me why that cannot be done efficiently within the department. That may reflect naivety on my part.

If it is relating to the professionalism of pharmacies or pharmacists, that would seem to be something that really should be dealt with as a national issue. Certainly during our inquiry we came across ambiguous evidence of pharmacists who were not operating in an appropriate manner but being pursued. Certainly some were. We thought some of that pursuit could be a bit more vigorous. My situation is that I really could not see what the objective of a pharmacy council would be or what the benefits would be compared to just retaining the relevant enforcement role of the ownership rules within the department context.

CHAIR: Yes. Your submission does not go to scope of practice or any of the other aspects. I think the intent of establishing a council as we have seen established in other states and territories is to more strongly regulate pharmacy ownership. I come from a regional area. I have spoken with pharmacists. They think there would be a monopolisation—like a Coles or Woolies coming in and offering a cheaper service. You touched on some of that with regard to the experience in the UK. I am just looking at some of the numbers. There were 500 submissions and 381 responses. Did your review look at any aspects of scope of practice or was it mainly around pharmacy regulation?

Dr King: Yes. If I can respond to both points: the regional point and scope of practice point. I think our draft report probably had significantly more on scope of practice than our final report. They are quite separate documents. That was purely because we felt that, rather than doing what sometimes occurs—that is, you repeat most of the draft report in the final report—we would keep them very much as separate documents. This would be the view of the panel—and I am happy to say that it is the view of the panel: we viewed that the potential for increased scope of practice for community pharmacists could be significant. We viewed that as being to the benefit of consumers.

You will notice that one of our recommendations went to noting that, at the moment, at the federal level, there are very different payments by the federal government for the same service being performed by different practitioners. The example of influenza is an obvious case in point. One of our recommendations was that the federal government should remove that inequity. If the same service is being provided by an appropriate medical specialist, whether a pharmacist, a practice nurse or a GP, in an appropriate setting, whether that is a GP's office, a clinic or a relevant pharmacy that is set up to offer the privacy for injections, the payment should be the same in any of those settings. That was one of our recommendations.

More broadly, in terms of the future of pharmacy, the big asset of community pharmacy is its network. If there are a lot of community pharmacies in a lot of communities, that has an accessibility that is second to none in the medical system. Being able to expand the scope of practice, being able to offer consumers access to health professionals who are able to not just offer injections and do things related to medicine such as medicine checks but also potentially do things such as diabetes checks, diabetes management or more general checks for our chronic conditions, that would in general be a good thing. That is where our inquiry got to. We made limited recommendations in that scope, simply because it was getting very much to the edge of our terms of reference. From the top of my head I think we made only one explicit recommendation, which was on the payments.

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However, again coming back to a personal level, I think that is something that needs to be very seriously looked at. We have a lot of very bright, very well trained medicine experts in the pharmacist community. How are we able to best utilise what is a tremendous human asset to better serve our healthcare system? There will be debates about whether pharmacists are better placed or practice nurses are better placed. Obviously, at the moment there are debates about whether GPs are better placed. Should some ability to simply reissue a prescription or redispense a medicine be at the pharmacist level rather than the GP level for people with chronic illness? That is an important debate and it is a very important debate that we have to have in Australia.

Coming back to the regional issue, one of the things that we found was that the degree of competition is significantly less in rural and regional Australia than it is in urban Australia. If you look at the report you will notice that we use the \$1 discount as the proxy for this. We have PBS data showing the variance in the amount that people pay for their script medicine. Obviously, that is for general rather than concession card holder prescriptions for medicines under \$38. It is medicines where the pharmacist has a discretion as to how much they will charge the patient. We found a huge variation there. It is quite astonishing. The table is in our report. We found that, essentially, consumers in rural and regional Australia are paying more. In our opinion, and it is pretty clear from our recommendations, they were paying too much.

On the suggestion that competition can be harmed by changing the ownership rules in regional Australia, whilst I would not dismiss it I would say that competition is already being harmed in rural and regional Australia. It is not clear to me that removing the ownership rules would make it worse. To a degree, more efficient owners could come in and there would be an incentive to pass discounts on to consumers. Even under the current ownership laws, we have seen that some of the larger chains of pharmacies have a business model where they claim to pass on cheaper medicines to consumers. If that was the result, if more of those sort of operations got out into rural and regional Australia while maintaining appropriate quality, then removing the ownership rules may actually benefit competition in rural and regional Australia. There are still the location rules sitting there. Ownership rules will only do so much by themselves.

CHAIR: Thank you very much, Dr King. Just for clarification for anyone following the hearing, I referred to your submission but in fact it is not a submission; it is the Productivity Commission report to the federal government. We will move to questions and the member for Nicklin.

Mr HUNT: Thank you for that briefing, Dr King. I took copious notes while you were talking and I am trying to interpret my notes now. I note that you mentioned there are dangers in the complete removal of laws around ownership. You referred to England and a couple of issues there. I have written in capital letters 'oversupply'. Are the location rules in Australia sufficient to overcome that issue?

Dr King: The short answer is yes. If you removed ownership in Australia with the federal government's location rules remaining in place, there would be very close to zero chance of an oversupply problem coming out. Given the competition rules, there should also be very little chance of increased monopolisation occurring. Yes, I think that is a very good point. Given the location rules, there is little oversupply possibility if the ownership rules came out.

Also, one of the things we found—again, it is in our inquiry report—is that there has been monopolisation in some local communities already. There are a number of communities—I do not know of any in Queensland but I am sure they are there; we explicitly refer to Broome and Alice Springs—where small numbers of pharmacists have been able to form consortia, for want of a better word, or companies where they are the sole owners. As the community has grown, they have been able to gain the extra licences that have become available for pharmacists in those communities. We went to both of the communities that I mentioned. The community pharmacies were essentially dominated by the same group of small owners. Again, that is really quite anti-competitive. We made a very strong recommendation to government basically saying the ACCC should look at that and potentially force divestiture of some of those pharmacies, because it is just not serving the customer well.

Mr HUNT: Are the ownership rules around pharmacists only being able to own pharmacies basically causing a closed market in investment?

Dr King: In some communities it is effectively creating a closed shop, yes.

Mr HUNT: Comments were made earlier that if these ownership rules were relaxed it would create large pharmacies that are profit driven and not patient driven, and with a focus on other areas of the business rather than on patient care. Is there evidence of that in other jurisdictions, such as England, that have done this?

Dr King: Off the top of my head, the answer is no. I cannot remember reading anything that suggested, for example, in England there had been a reduction in patient care as ownership changed. I cannot think of anything off the top of my head. There was an implicit assumption in your question that the current ownership rules lead to patient focused pharmacies. I do have some concerns that that is actually not the outcome of the current ownership rules. I know that is the intention of the ownership rules, but when you have absentee pharmacists under these rules who are able to own five pharmacies in Queensland and another six, I think it might be, in Victoria and another five in Western Australia and they only visit them once a year, they are already profit-maximising pharmacies. It is not the outcome of the owner directly involved with the patient that I think the ownership rules may have been designed to lead to. I do not think that is happening now.

Mr HUNT: You mentioned some restrictions in relation to ownership, particularly doctors, for example, having a potential influence over the pushing of certain types of drugs or profiting from the sale of drugs that they are prescribing. Are you aware of any current potential for that in terms of pharmacists or doctors colluding in relation to the supply of drugs, incentives or commissions? Is that currently an issue?

Dr King: There is no formal evidence that I am aware of. There is a concern, but there is also a benefit in what I am about to say. We have seen the emergence in probably the last decade of more medical centres where you also have a pharmacy directly connected to it. I have been to one in Cairns where you walk through the pharmacy and there is a medical clinic at the back. The pharmacist who owns the pharmacy out the front would have a financial interest in the operation of the medical clinic at the back. Of course, that is a very convenient situation for patients, because patients who get a script are able to immediately walk outside and have their script filled. If they feel that the pharmacy out the front is not the best for them or may be too expensive, they can go to a different pharmacy. In fact, the one I am thinking of in Cairns Central has a Chemist Warehouse across the road. There are other options around there.

That is a model that is becoming much more common. I do get concerned that the pharmacists who own the clinic and the pharmacy clearly have an incentive to have doctors who will prescribe more. The reverse would happen, obviously, if the doctors owned it. They would have an incentive to write more scripts and try to make sure that they were filled by the pharmacy that they also owned. Medical ethics would push back against that and, hopefully, that would be enough to prevent incentives leading to poor practice. As an economist, my immediate reaction is that if you can stop poor incentives from existing then it is probably a good idea to do that, rather than to allow there to be poor incentives and just hope that professionalism avoids people following that path. Particularly with those vertical integrations between GPs who prescribe and pharmacists who dispense, I would prefer to see strong limitations on those sorts of vertical links.

Mr McARDLE: Dr King, thank you for your testimony here today. From what you have said, I take it that you believe that the restrictions should stay in place in regard to ownership?

Dr King: No. Actually, if I do a simple bottom line, I think the current ownership rules are ineffective. I do not think there is any evidence that I saw that an absentee pharmacy owner would be any different from an absentee shareholder, a cooperative owner or any other form of ownership structure. I think the ethical and professional role has to come back onto the pharmacist who is running the dispensary and overseeing the dispensary. That is the relevant point, to make sure that the ethics are there. That view is simply that the current ownership rules are leading to absentee owners at the moment who are interested in profit maximising; they just happen to be limited to people who also happen to have pharmacy degrees or be registered pharmacists.

It would be better to focus back in on the professionalism at the correct point, which is the point of dispensing. That is perhaps where a pharmacy council could have a significant role, to make sure that there are no explicit or implicit incentives within the pharmacy, regardless of who owns it, for pharmacists to behave in anything other than the customers' interests and then to make sure we avoid any obvious professional conflicts, such as doctors owning pharmacies or vice versa. I think that would be the better way to go.

Mr McARDLE: Is the current regime of ownership producing outcomes that would be corrected by allowing anybody to own a pharmacy? What is the evil that would be overcome by allowing ownership to be opened up to anybody?

Dr King: The answer is that I do not think there is any particular evil. If to a degree there is an evil, to use those words, it would be opening up rural and regional areas in particular to hopefully allow more innovative owners to come in, rather than to simply be the local small group of pharmacists who are there at the moment. To that degree it would potentially lead to a more competitive outcome

in rural and regional areas. In suburban areas, given the location rules that are in place, it could lead to an increase in efficiency in the sense that we did see some pharmacies, in urban areas in particular, running in very inefficient ways. Some of the practices that we saw—and I think we detailed some of these in our draft report—frankly, were eye-opening and unsafe. I would expect that professional owners would pretty quickly crack down on those.

I guess the second evil would be the degree to which some existing pharmacies or pharmacies that are owned by pharmacists are struggling and are starting to cut corners and do not have the management skills to be able to operate a good pharmacy. Perhaps that would be corrected. They would have a temptation to sell out to an alternative and more professional owner who would run the pharmacy better. That is perhaps the second evil that could be overcome. The obvious issue is the degree that the ownership rules were designed to have over the owner having direct skin in the game as a pharmacist that would be removed in pharmacies that were sold to non-pharmacy owners and my response to that is yes, but my experience is that that has already happened for significant numbers of pharmacies where the pharmacists are absentee landlords.

Mr McARDLE: Couldn't a lot of those concerns be addressed by a council in relation to efficiencies, training and the like, having sufficient skill sets themselves and funding?

Dr King: Yes. I do not think a council is needed for that. There is already the APS, the Australian Pharmaceutical Society. The guild is the representative of the owners and the guild is actually starting to introduce more, as I understand it, educative type functions. The APS, which is a broader representative body for pharmacists, has for at least the last four or five years been pushing very strongly programs to increase the business management skills of pharmacists and their ability to run pharmacies better and offer consumers a wider range of services within their pharmacies. I think that is already happening.

The pharmacy community itself has that incentive. I do not know that there needs to be a separate government establishment of a pharmacy council to do that, because the incentives are already there in the pharmacy community. The problem is that you can set out the water but you cannot bring the horse to drink, as it were. A number of pharmacists that we saw just simply were struggling on by. They did not seem to be interested in retraining. They were in some cases simply scared of a discount pharmacy setting up next door and them going bankrupt. We have seen certainly in urban areas some pharmacies going bankrupt because they are not being very well run. I do not know that that is the role of a pharmacy council, to summarise it that way.

CHAIR: Dr King, thank you very much. Your contribution has been beneficial to the entire committee.

JACKSON, Dr Shane, National President, Pharmaceutical Society of Australia

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

MEYER, Ms Jacqueline, Queensland Branch President, Pharmaceutical Society of Australia

CHAIR: I welcome representatives from the Pharmaceutical Society of Australia. I ask that you make an opening statement, after which we will move to questions.

Dr Jackson: Thank you very much, Mr Chair. Professor King referred to us as the Australian Pharmaceutical Society. We are the Pharmaceutical Society of Australia, the PSA. The PSA is the peak professional body for pharmacists, recognised by the federal government through our peak status. Our membership consists of over 22,000 pharmacists, interns and pharmacy students across the country. We are the largest pharmacy body in the country. We are a unified national organisation with state branches. Jacqueline Meyer is the state branch president and Mark Lock is the state manager of the PSA.

A number of the previous submissions and presenters today have talked about standards of practice. Our remit essentially is to focus on professional standards and practice, education and training of pharmacists and pharmacy assistants and essentially scope-of-practice fulfilment. I would like to table the following documents, which have actually been referenced today, and I think they will be quite relevant for the panel: the code of ethics for pharmacists, the national competency standards for pharmacists in Australia and the professional practice standards.

CHAIR: Leave is granted. They will be most helpful.

Dr Jackson: Those documents, essentially from a professional point of view, govern the professional practice of pharmacists. Previous presenters today have talked about professional practice standards and protocols for the provision of schedule 3 medicines. We are more than happy to provide the multiple documents that we have that govern all of the schedule 3 medicines and the supply of those medicines from a professional practice point of view.

I just want to make some comments about four areas before we go to questions: the ownership provisions, the establishment of a council, scope of practice and then, briefly, pharmacy assistants. That may well answer some of the questions of the panel.

Essentially, the PSA supports the ongoing provisions relating to the ownership of pharmacies by pharmacists. We believe that the current system promotes patient safety, promotes competent provision of high-quality pharmacy services and really helps maintain public confidence in the services delivered by pharmacists. Pharmacy owners as pharmacists are held to the same level of practice and conduct as any pharmacist as defined within the professional practice standards, our code of ethics, that are maintained by the society. Some of the comments that we have heard today by other panellists suggest that there may well be a deficiency in how those standards of practice are actually implemented and referenced potentially by legislation, but those governing documents are there for the profession.

Pharmacist owners also have obligations through the Pharmacy Board of Australia under the guidelines for proprietor pharmacists, which require owners to maintain an active interest and oversight into how the practice of pharmacy is being conducted in their pharmacies. We believe the arrangement of pharmacist ownership of pharmacies supports professional autonomy, objectivity and independence and also promotes public confidence in the services. We also believe that in the absence of evidence to suggest improved community outcomes for patients in Queensland in another ownership model, we do not support any change to ownership restrictions outside the current model that exists within Queensland.

I will make some comments now around the pharmacy council. Currently the Pharmacy Business Ownership Act is administered by Queensland Health. We recognise that other states have a state based authority or council that administers the relevant pharmacy ownership acts in those jurisdictions. We are aware that in other states the authority or council is also responsible for pharmacy premises regulation. The current Queensland legislation does not cover pharmacy premises regulation. Some comments previously today refer to a register, refer to a list of services, and we believe that that is a current gap in the legislation that should be addressed.

There are a number of ways in which a pharmacy business ownership act can be administered, as shown by the variation in the jurisdictions. We also note that pharmacy authorities and councils in other states produce reports related to the administration of the relevant pharmacy business ownership act. These reports give a level of transparency and also accountability in the administration

of those relevant acts and also give confidence, in our view, for the profession and the wider public that the administration of those acts is occurring in a way that ensures high standards of practice. We are not aware of such reports being made publicly available in Queensland.

Given that there is a lack of visibility as to the administration of the Pharmacy Business Ownership Act in Queensland, we genuinely believe that we would need further information regarding Queensland Health's administration of the act to provide guidance on whether the establishment of a council should be considered. However, if a council was to be formed, any duplication in the function of other agencies involved in pharmacy business and pharmacy practice should be avoided. Previous reference has been made today to national frameworks and national organisations, and we highlight that duplication is something to be avoided. From a governance point of view, we would need to make sure that there is a diverse range of industry and independent health governance experts involved in the membership of a council to ensure that appropriate and contemporary understanding of the pharmacy landscape is reflected.

From a scope of practice point of view, we would like to highlight that 230,000 Australians are admitted to hospital each year because of medication misadventure. That is about 50,000 Queenslanders each year admitted to hospital because, in our view, their health care did not involve a pharmacist more. Access to health care and medicines, especially in such a geographically dispersed population as Queensland, is a prime reason to look at pharmacists being used to their full scope of practice. We call this scope-of-practice fulfilment.

Patients have explained to PSA in a lot of the work that we have done with organisations like the Consumers Health Forum that they actually want greater availability of pharmacist expertise. They have described a spectrum of services that could be provided that relate to the accessibility of pharmacists and the pharmacist's skill as a medicines expert and as a primary healthcare provider. It has already been talked about today: access to tests, increased access to vaccinations, the ability to go to the pharmacist for care around common self-limiting illnesses—things like urinary tract infections and migraines—and also activities like pharmacists prescribing. Examples of pharmacists prescribing, which would mean that a pharmacist would enter into a relationship with a general practice in the care of a person who is taking medicines, are extending the life of the prescription and adjusting doses of a medicine so that the treatment goals are maintained. Only about a quarter of patients treated for high blood pressure actually achieve their treatment targets. It is those types of activities that pharmacists could do in conjunction with the patient's general practitioner. All of these health services fall within the current skill set and competency of a pharmacist but legislation and regulation are often the limiting factors.

In supporting pharmacists working to their full scope, PSA strongly believes that this should be underpinned by appropriate credentialing and training of pharmacists so that the public can have confidence in the level of training and the understanding that the pharmacist has in managing those key healthcare activities that patients want them to manage.

I would also like to table the following discussion paper, which we have titled *Pharmacists in 2023*, which the Pharmaceutical Society has released, which goes to the heart of pharmacists' scope of practice and what we want pharmacists to do as a profession and what patients want pharmacists to do in the future.

CHAIR: Leave is granted. Thank you. What was the outcome of that?

Dr Jackson: Consultation is currently occurring. It closes off on 7 September. To finish, we absolutely believe that pharmacy assistants play an important role in supporting the delivery of services performed by pharmacists. They are a fundamental supporting mechanism within community pharmacies. We also believe that, certainly in the public interests and actually in the public's expectation, there is a minimum level of training for non-pharmacist staff such as pharmacy technicians and pharmacy assistants who are working under the supervision of pharmacists and have responsibilities within that pharmacy. What we believe, however, is that there should be a national competency framework for non-pharmacist staff—so actually identify the roles and functions that we would like pharmacy assistants or non-pharmacist staff to perform in a pharmacy environment and actually map the training and the minimum requirements to that on an ongoing basis. This ideally is done from a national perspective. That framework would guide curricular development and minimum training requirements, as I said, and the framework would align with the key professional documents that I have tabled today, the professional practice standards, to ensure that they are all in alignment. I would like to thank the panel for the opportunity to give this opening statement. Mark, Jacque and I are happy to take any questions from the panel.

CHAIR: Thanks very much, Dr Jackson. It is timely to receive that particular paper. We will unpack that a little when consultation closes on 7 September. You raised a couple of points. I come from a paramedic background. We do credentialing each year. Paramedics have just come under national registration. I think Karen talked about some of the professional development standards earlier, but if there were a national framework across-the-board for educational standards and credentialing annually, would that extend to pharmacy assistants as well as pharmacists?

Dr Jackson: Currently the Pharmacy Board requires a certain amount of CPD. Pharmacists need to do that, in accordance with their learning plan. They need to plan the things that they need to do to maintain competence. From a credentialing point of view, if we have pharmacists doing these activities—vaccination, for example—there should be an appropriate training course and there should be a recognition framework for those types of activities so there is confidence from the point of view of the public that the pharmacist they are going to is able to do those services. If we are talking about full scope of practice, for some of the services we would expect pharmacists to do they may require an additional recognition or additional credentialing associated with those activities.

CHAIR: In your opening statement you mentioned medication errors—some 50,000 in Queensland. Do you have any data to support that? Where are we seeing that coming from, broadly?

Dr Jackson: Unfortunately, that is the tip of the iceberg. There was a paper published in 2015 by Libby Roughead, who is based out of the University of South Australia. We are doing some work with Libby now to update that data. That data is five years old. We are not getting any better at managing medicines, unfortunately, and that is only hospital admissions related to medication related problems. That is not presentations to the person's general practitioner. That is not presentations to the patient's community pharmacy because of medication related problems.

Like I said, it is the tip of the iceberg. That is widely published data. I am happy to provide that information. What we are seeing is that about one-third of those admissions are for elderly people, so 65 years and older. There are quite common medication related issues in older people because of multiple medicines, and often the system does not allow pharmacists to have greater responsibility—and with responsibility comes accountability in medication management—because we are not practising to our full scope. I think that is unfortunate.

CHAIR: Yes, you did mention that was because of pharmacists' oversight of that medication. We have an ageing population and a number of other barriers. To get to the heart of the matter, you talked to establishing a council. I take your point—an important point—about avoiding duplication. Broadly, do you support the establishment of a pharmacy council in Queensland?

Dr Jackson: From our point of view, we need information to say that the current administration of the business ownership act is not being done as we would expect and in comparison to other state jurisdictions which have a council. If the panel through this process identifies that that is not the case, then certainly we would be supportive of the establishment of a council to address those gaps. If there are not any gaps identified, then we would question the necessity of that. The heart of the issue goes to whether administration of the act is in accordance with what we would expect that administration to be and in accordance with other state jurisdictions through their administration through councils.

Mr HUNT: Dr Jackson, I have some questions around the ownership laws themselves. You heard Dr King talk earlier about the fact that somebody could own several pharmacies in different states and essentially is able to do that by being a pharmacist who may be an entrepreneur. I think you said that the act requires active interest and oversight. Firstly, is that active interest and oversight defined in the act? Secondly, is it overseen effectively in your opinion?

Dr Jackson: If I said the act I did not mean to say the act, I apologise.

Mr HUNT: I do know that you did—

Dr Jackson: What I believe I stated was that the Pharmacy Board, through its pharmacy proprietor guidelines, indicates that there needs to be active interest in the running of the pharmacy from a health service perspective.

Mr HUNT: There is currently no legislative requirement for them to do anything, other than be a pharmacist, to own whatever the regulation number of pharmacies in each state is?

Dr Jackson: That is my understanding.

Mr HUNT: Could you comment on the importance of having a pharmacist as an owner under those circumstances?

Dr Jackson: The Pharmacy Board guidelines are there to ensure that pharmacists have an interest in their pharmacy and follow the intent around pharmacist ownership of pharmacies to make sure that there is a professional practice process in place with the pharmacist who as the owner

ensures that the service delivery is focused on trying to deliver the best health outcomes for patients. We do not believe that there is anything wrong with the guidelines that we have in place. We do not think there is anything wrong with our professional practice standards. Often we just need to make sure that they are referenced appropriately and that the administration of those standards and guidelines is enforced in practice. If there are cases that pharmacists are not doing what they should do from an ownership point of view, then they should be held to account.

Mr HUNT: What are the consequences if they are not?

Dr Jackson: The Pharmacy Board can sanction individuals who are not performing in accordance with appropriate guidelines. If there is a deviation from what is termed 'accepted professional practice'—and accepted professional practice is referenced within multiple guidelines that the society is the custodian of—then, again, those individuals can be held to account through the Pharmacy Board.

Mr HUNT: It seems from what Dr King was saying that there is evidence of that occurring and it may be undermining your argument about pharmacy ownership. Are you aware of any reports currently to the Pharmacy Board about these issues and investigation, inquiry or action being taken in relation to these issues?

Dr Jackson: I think if Dr King has examples then he should report those to the Pharmacy Board. I am not aware of thorough investigations that are being done by the Pharmacy Board. That is probably a question best directed to them to see if there are any systemic issues. We are certainly not seeing any systemic issues with regard to that, to answer your question.

Mr HUNT: You see what I am getting at in terms of the picture being painted to us for the reason to retain the ownership laws is that connection with the pharmacist to the pharmacy and the community and that level of service. That is being undermined by other evidence we are hearing about the ability to own four or five pharmacies in each state and that that is going on. Is the Pharmacy Board aware of that or is anything at all being done about that situation?

Dr Jackson: I certainly take the point. From our point of view, if there are examples of individuals not practising in the way that we would expect—deviating from professional practice and not adhering to Pharmacy Board guidelines—then those individuals should be held to account because we do not want those examples, whether they be true or whether they be anecdotal, to be casting aspersions on the broader profession.

Mr HUNT: Would you expect that pharmacists becoming aware of these situations would be reporting them for the benefit of the wider scope of the ownership laws that you are advocating?

Dr Jackson: I do not know that I can answer that question, sorry.

CHAIR: Would the PSA be aware of virtual pharmacies—that is, establishing a pharmacy within the current location rules but not being PBS qualified or authorised or whatever the term is? A consumer can walk in there with a script that is electronically taken to another centre and authorised there and then goes back and they are dispensing. Is that a practice that you have heard of? What would your thoughts be of that type of practice?

Dr Jackson: My understanding is that that practice cannot occur under the Pharmaceutical Benefits Scheme. If that is the case, that would be against any approvals either by the pharmacy that has the approval number or the pharmacy that is acting as the agent for someone else. No, I am not aware of those circumstances and that would be against any legislative components in having a PBS approval.

CHAIR: I think we have asked previous submitters how many pharmacists in Queensland are PBS approved. I cannot recall it off the top of my head but there was a gap. I do not know if you have that type of data, but I think we have had that before.

Mr McARDLE: Dr Jackson, are you aware of any application through a state or territory in relation to registration of a pharmacy that has been denied because the structure involved in the application for registration does not fit with the relevant law of the state or territory?

Dr Jackson: Yes, I have heard of examples. The details of those I do not have, but I have heard of refusals.

Mr McARDLE: Can you indicate how many you may have heard of?

Dr Jackson: Not many—less than double digits.

Mr McARDLE: And that of more recent years than in years gone by?

Dr Jackson: Yes.

Mr McARDLE: Are they becoming more frequent do you think?

Dr Jackson: I cannot answer that. I suppose by reference to my previous comment the answer would be yes.

Mr McARDLE: Is it also a matter that there had been deregistrations as a consequence of an investigation by a state or territory body in relation to an early registration of ownership of a pharmacy?

Dr Jackson: I am not aware of those circumstances.

Mr McARDLE: Given your position and the PSA's position in the Commonwealth and also being an accredited body, you would be more likely than not to hear of concerns raised in relation to the structure of certain entities owning pharmacies. Do you have documentation or other records that would indicate that that is becoming more prevalent?

Dr Jackson: Yes. As a national organisation we have been made aware of individuals and organisational concerns around business structures. Whether they are becoming more prevalent is difficult to say, but we have been made aware of reservations around structures.

Mr McARDLE: Are they being prosecuted or investigated at the moment?

Dr Jackson: I will take a step to the side to say that our main focus is around the professional practice of pharmacists. Yes, we have positions on pharmacy ownership. When it comes to the technical aspects of purchases of pharmacies, we believe it is the regulator's responsibility to make sure that that is in accordance with the act. We do not go into detail trying to find out whether purchases of pharmacies are in accordance with the act, because we believe there are structures in place that should be doing that and should give the profession and others confidence that all those purchases are in accordance with what the legislation requires.

Mr McARDLE: If there are applications that are being questioned or perhaps even rejected, does that mean the current regime is not working effectively or is it a one-off scenario across a host of applications?

Dr Jackson: I do not know that I can answer that question. The administration of the legislation should ensure that those who are appropriate to own a pharmacy can own a pharmacy and those business structures that are not able to purchase a pharmacy. That is what the administration of the legislation should achieve.

Mr McARDLE: Are the matters you have told me about in relation to issues having been raised under a council and a state government based registration process or only one type?

Dr Jackson: Those examples that anecdotally have been raised with us?

Mr McARDLE: Are they across-the-board or focused under one heading?

Dr Jackson: Those issues have been raised in most states.

Mr McARDLE: I take it also from your submission that you need to be satisfied that a council should exist before you would endorse it but, more particularly, an analysis undertaken as to what a council should do as opposed to other state and federal bodies?

Dr Jackson: We see this as a bit of a tipping point. If there is information to suggest that the administration of the current Pharmacy Business Ownership Act is not in accordance with how we would like it to be administered, then we would be absolutely supportive of the establishment of the council.

Mr McARDLE: But you are not aware of any yourself?

Dr Jackson: No.

Mr McARDLE: Would the council have a larger remit than simply registration? Would it incorporate education, advice, scope of practice et cetera, if one were established? If so, is there evidence that you have that would substantiate that taking place?

Dr Jackson: The council should incorporate pharmacy premises regulation as well and it should perform the functions that were outlined by the initial panellists here today, Karen Brown and Anthony White, around the types of services that are available from those pharmacies. From an education point of view, I do not believe that that is within the scope of the establishment of a council. The council should be endorsing and monitoring and potentially enforcing through the administration of the legislation the existing standards that are available for the profession so that we can ensure that a pharmacist's practice is to the level that we would expect it to be and what the public would expect it to be.

Mr McARDLE: Thank you, Dr Jackson.

CHAIR: Thank you very much, Dr Jackson, Ms Meyer and Mr Lock for your contribution today. It has been most welcome for our inquiry going forward. I thank you for those documents as well.

GANCE, Mr Damien, Group Commercial Manager, Chemist Warehouse

CHAIR: Good afternoon, Mr Gance. Thank you very much for joining us today in what is an interesting space, which is an inquiry into the establishment of a pharmacy council and transfer of pharmacy ownership in Queensland. Could I ask you to make a brief opening statement and then we will move to some questions?

Mr Gance: Certainly. I am not sure how brief it is, but I will make a statement regardless. Firstly, I would like to take the opportunity to thank the committee for the invitation to appear and to assist with your inquiries. Whilst the committee has posed numerous questions in its published issues statement, those that I have chosen to respond to—both written and in this response now—relate primarily to pharmacy ownership.

As you would well know, pharmacy ownership laws currently mandate that only a pharmacist may hold a proprietary interest in a pharmacy business. Whilst I can appreciate the historical context and at least fathom the rationale for the introduction of these laws, I contend wholeheartedly that they have no place in a modern Australia. When these laws were introduced, times were different. At times, legislators may have been led to believe that these laws were necessary to ensure an equitable, universal, safe and responsible access to medicines. Whilst these ownership laws may have been well intentioned, what we have learned over time is that they are unnecessary and do little, if anything, to achieve these desired ends.

We have observed over the years that ownership laws in reality act to raise costs to consumers, prevent innovation in our industry and undermine the value of industry-wide investment. Restrictions on who can own pharmacies are unnecessary and constitute damaging regulation that should be reformed as a matter of urgency. I commend the committee for reviewing and considering the appropriateness or otherwise of these laws.

Regulation governing pharmacies, both national and state based, has been reviewed and re-reviewed many times in the past. Almost without fail, the primary recommendation of these reviews is a deregulation of both ownership and location laws, yet legislative inertia continues to prevail. I believe that one of the reasons for that inaction is a propensity for decision-makers outside of our industry to confuse the provision of primary pharmaceutical services with the proprietorship of what is a retail base. Those who passionately advocate for the status quo will deliberately attempt to blur this distinction yet, as the provision of primary medical care from a general practitioner is entirely unrelated to the ownership arrangements surrounding his or her medical practice, so is the provision of pharmaceutical care entirely unrelated to the ownership of a pharmacy. Under any proposed model that I would support in relation to pharmacy ownership, qualified registered pharmacists would always be at the heart of the professional pharmaceutical care which our patients derive.

Under the current model of a pharmacist, only pecuniary interest profits from pharmacy businesses are able to flow to a pharmacist. Under a deregulated regime, those same profits could flow to any proprietor. The primary societal benefit conferred on the Australian public through its engagement with retail pharmacy is in absolutely no way coupled with the ownership structures behind that pharmacy. Society is for the most part ignorant, if not indifferent, to the commercial structures that stand behind the pharmacy of their choosing. Where the final profits of any transaction reside, the public is not ultimately interested. The societal engagement and relationship with the dispensing and counselling pharmacist is a primary one. The Australian public forge a bond of trust and one of respect with the chemist who assists them with their pharmaceutical needs and in many cases, if not most, this is not the store proprietor. I suggest that the notion that pharmacist-only ownership results in a better calibre of owner is both misguided and misplaced.

It is similarly misguided to suggest that the corporate or non-pharmacist individual who may choose to own a pharmacy would be of a lesser moral character. Even the most cursory review of disciplinary proceedings brought against pharmacist proprietors today by any of the regulators that govern our profession show that the current ownership cohort is not without fault. We are not without failing. Just this morning I searched the website pharmacynews.com.au looking for any reports that I could find of pharmacist misadventure. In summary, on the flight over, this is what I found: a proprietor pharmacist currently being deregistered for selling fake Viagra to a children's hospital; a locum pharmacist caught stealing codeine and morphine from a hospital dispensary; a pharmacist owner having their registration suspended for defrauding the PBS—our taxpayer dollars—of over \$22,000; a pharmacist manager found selling phenazepam to a gym owner; and a proprietor pharmacist who inappropriately sold 143,000 OxyContin 80-milligram tablets. This small—and, trust me, by no means exhaustive—search done in fewer than five minutes highlights some of the inappropriate and illegal behaviour of pharmacists. All of those stories were published on this website in the last six months.

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Each and every one of these incidents shows a pharmacist plainly putting profits before health. Those pharmacists have shown a total disregard for not only good public policy and good patient care but also the law. Pharmacists are not holier than thou—and I am one. We are human and subject to the same failings and frailties as everyone else. Many—and, to be fair, probably most—of the current pharmacist proprietors are upstanding people—fantastic business owners—yet, plainly, some are not. The same could and would be said of any potential cohort of owners. Many will be great; others will not. The important thing is not whether you hold a Bachelor of Pharmacy but rather that you are ethical, responsible and of a high moral standing. Let me tell you that a pharmacy degree by default does not confer any of these traits.

The hurdle to be cleared to enable proprietorship should not be one of prior education, because simply being a pharmacist is neither necessary nor sufficient. Rather, the test should be one of a fit and proper person. A fit and proper person test is neither novel nor new. It is a well-established principle in many areas of the economy. The test could include a requirement to demonstrate appropriate upstanding financials and criminal, business and professional histories. I suggest to you that this is a far superior test in order to establish the appropriateness of a person to own a pharmacy business than a simple degree.

I have recently read various articles and submissions that advocate passionately for the status quo. These submissions endeavour to argue two primary points that I believe are both baseless and of little to no merit. One is that they suppose that those who oppose the current regulations—and I will put it kindly—are ignorant and misinformed. Secondly, they suggest that the current pharmacist ownership laws ensure that the retail proprietor pharmacist puts health care before profits. Both of those statements fail to stand up to even the most cursory analysis.

Firstly, opponents of the current overregulation are neither misinformed nor ignorant. I consider myself to be a well-informed industry expert and I have spent significant resource and time considering my industry and the issues that surround it. Secondly, to suggest that pharmacist owners put health care before profits is a statement of opinion, not one of fact. Further, it is opinion that is not borne out by any evidence that I have ever seen, including but not limited to the reported incidents that I spoke about earlier.

These articles espouse the virtuous nature of pharmacist owners and cite two primary examples of when a pharmacist is said to be putting patients before profits. These are when proprietor pharmacists open their doors early to assist their patients and when a proprietor pharmacist makes late-night deliveries of medicines to patients in need. These articles suggest, firstly, that it is the proprietor delivering these medications to patients and opening their doors early. I contend that that is entirely incorrect and that the proprietor of the pharmacy is not the person who opens early and is not the person who makes the late-night deliveries. I draw this conclusion through both my and my family's anecdotal and observational experience over the last 20-odd years in retail pharmacy as well as through some very simple top-line statistics.

It is estimated that we have 2,000 proprietor pharmacists in Australia today in 5,655 pharmacies. They cannot possibly do all of those late-night deliveries and early-morning openings. The more recent report by the Pharmacy Board of Australia shows that there are 28,065 registered pharmacists in Australia, which suggests a very high proportion—in fact, over 92 per cent—of all customer engagements, including opening early and delivering medicines late, are not with the proprietor but an employee. It is not the owner but rather the employee pharmacist doing this work. In a deregulated industry the same would occur, simply because it is good business practice.

It is somewhat disingenuous to suggest that these services of early openings and late-night deliveries are provided solely in the interests of the health of our patients. Whilst undoubtedly the service is in the interest of the patient's health, it is also purely in the commercial interests of the proprietor. It is simply good health care that aligns with good business. It is good business to look after your patients, because, as I always tell our managing pharmacists, if you do not then someone else will. If we look at the history of pharmacy proprietorship and the actions that are taken, it is a very proud history. It is a proud history of working for the betterment of the health of our communities but doing so for a profit. Pharmacists look after their patients because doing so is good for their business. Any business owner, pharmacist or otherwise, would quite simply do the same.

For the most part, profits and the provision of quality health care for our patients are congruent and aligned. It is most often profitable to do what is good for the patient's health. In the instances in which profits and health care align, such as late-night deliveries or opening early, pharmacists universally will choose this path. They choose to do what is best for the patient, because it is best for the patient—true—but it is also best for the business.

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When profits and patient healthcare outcomes diverge, proprietor pharmacists have been shown wanting and been shown wanting on many an occasion. If we consider the \$1 discount for PBS items, the vast majority of pharmacies other than Chemist Warehouse do not pass this on. Why? They do not because it is not profitable for them to do so. In a fact sheet published by the Pharmacy Guild of Australia just last week, they mention one and only one key role for pharmacists in our country, which is to support medication adherence and compliance. We all accept that patient medication adherence and compliance is fundamental to a patient's health outcomes. We also know that compliance is directly related to cost. More affordable medicine increases patient compliance and it increases patient adherence; thus, it is in the patient's absolute best interests to get their medicines cheaper.

CHAIR: Mr Gance, I am sorry to pull you up at this point, but we have only limited time for questions.

Mr Gance: I have about two minutes. May I conclude? I have flown up from Melbourne, so I would appreciate being able to finish.

CHAIR: I appreciate that. We can seek leave to have the rest of your statement tabled. Do you want to table the rest?

Mr Gance: It is one page.

CHAIR: Okay.

Mr Gance: Cheaper PBS medicines are better for the patient's health, but passing on the discount of \$1 is commercially suboptimal for pharmacy proprietors. Here is a single example where healthcare outcomes and patient outcomes diverge, and proprietors universally across this country have chosen profit. I know of many other examples where it could be argued that patient outcomes and profits are not aligned. In almost all situations, our current cohort of proprietors have chosen profit. When optimal healthcare outcomes align with good commercial outcomes, any proprietor, be they a pharmacist or an incorporated entity, will choose this common and aligned path. However, today, in the single example of PBS \$1 discounts, it is only Chemist Warehouse that passes on those \$1 discounts.

Lastly, if we are truly concerned with the proprietor's motivation to do the right thing or, to put it another way, to not do the wrong thing, the question boils down to this: who has more to gain by compliance and who has more to lose or to gain through noncompliance with the law? If a corporate proprietor owns 100 pharmacies and a material breach of practice would result in a failure of a fit and proper person test, would this risk keep the corporate proprietor in line? If failing the fit and proper person test results in an entity losing its rights to own any and all of the pharmacies, is the owner of 100 pharmacies more likely to act appropriately than the proprietor of a single retail store? Who personally has more to lose or gain: the CEO of a corporation or the proprietor of a single pharmacy? Who has the biggest societal risk? Who is more likely to act inappropriately with S4 and S8 drugs? Who is more likely to inappropriately dispense 143,000 OxyContin tablets: a pharmacist proprietor of a single store who is struggling under the weight of their mortgage or a corporate entity that employs thousands of staff, reports to thousands of shareholders and is responsible for maintaining the right to operate hundreds of pharmacies?

When this committee dispassionately and carefully considers pharmacy proprietorship, I am confident it will see that many arguments voiced by those in favour of the status quo are truly grounded in self-interest disguised as community care and that the arguments for deregulation are not only robust; they are very considered and very sound. I am happy to take your questions.

CHAIR: Thank you very much, Mr Gance. We have limited time for questions. There were some strong words in your statement that clearly come to the heart of what is going on in Queensland. We appreciate you coming up from Melbourne. You said that you have been in the pharmaceutical industry for 20 years. Did you start in a small pharmacy?

Mr Gance: As many pharmacists do, I come from a family of pharmacists. My father, my mother, my uncle and basically our entire friendship cohort are all pharmacists. I was brought up in pharmacy. My father had a business called My Chemist, which is a brand of retail pharmacies that trade primarily throughout Victoria. When I qualified in 1998-ish, I worked for him for two years. In 2000 I started Chemist Warehouse.

CHAIR: How large is the Chemist Warehouse chain in Queensland?

Mr Gance: In Queensland there are 80-odd stores.

CHAIR: You said that you employ a number of people in that area. The Victorian pharmacy council would have similar pharmacy ownership restrictions in terms of how many you can own—I cannot remember the number off the top of my head—per pharmacist. Your view is very clear that you do not support a council being established in Queensland; is that correct?

Mr Gance: We have not actually put forward a view on the establishment of a council.

CHAIR: Can I ask what your view is?

Mr Gance: I would be happy if a council was established and equally happy to continue to trade under the existing legislative arrangements.

CHAIR: Moving very quickly to scope of practice, you may have heard from other submitters today, particularly around pharmacy assistants and delivering health care more broadly. Do you support some of the views of having a national framework qualification for pharmacy assistants to deliver an expanded scope of practice? You have 80 stores in Queensland. Consumers would like to have confidence that they can go into a store and get qualified assistance, not just from the pharmacists themselves but also from whomever they might meet in that patient journey. What are your views on an expanded scope of practice in Queensland?

Mr Gance: I think an expanded scope of practice is a fantastic opportunity to alleviate stresses and strains upon the rest of the health industry. Pharmacists are well and truly appropriately qualified to have an expanded range of services that they can deliver. Again, I can only speak for Chemist Warehouse because my entire working experience is simply with them. We have a very exhaustive and extensive training program for all of our staff, based upon what you are saying: we want the customers to have confidence when they come into our stores and seek medical advice about any ailment that they have that our staff are appropriately trained, and not just trained in what they can deliver but also in a referral pathway through to the pharmacist.

CHAIR: Do you have annual credentialing, if you like, for your staff, including pharmacy assistants? You said that you have established training. What does that look like?

Mr Gance: It is fairly extensive. We have training for all the staff through an online portal, through which they have to continue their education and their training. We have local, store based meetings and then we have a face-to-face training meeting in every state and territory at least once to twice a month. We provide extensive written and, as I said before, online resources to enable them to up-skill.

CHAIR: You have a training oversight—

Mr Gance: We have a training department.

CHAIR: Maybe they could share what that is?

Mr Gance: We are happy to, by all means.

CHAIR: You can take that on notice.

Ms PEASE: Mr Gance, is yours a registered training organisation?

Mr Gance: Not at the moment, no. We work with the Pharmaceutical Society of Australia.

Mr HUNT: In relation to the ownership laws and the fact that at present it is restricted to pharmacists, that probably restricts the number of chemists that you can own. If those rules are relaxed, allowing big investment in, a flood of investment could suddenly come into that space. The angst there is around big companies owning bigger and bigger chemists, with bigger and bigger services and products, which would put pressure on the buying power of the smaller pharmacists. Being driven by price alone would remove the incentive to provide a higher level of service over time. Do you have any comments on that?

Mr Gance: I do. Firstly, there are lots of assumptions in what you have put forward. The pharmacy groups today are very robust and strong commercially, and they can buy fairly well. Say an alternative entity enters. For want of a better term, let us throw forward Woolworths because it makes the conversation easy. Woolworths is a pretty good retailer. As much as we like to bash them, they are a good retailer. If there is a commercial case that consumers want vaccination services, nurses, childcare nurses, wet nurses and midwifery services in the pharmacy that Woolworths owns, I actually believe that Woolworths is more likely to provide those services than a small independent proprietor. I think you would find you would get an expanded range of services and a better calibre and quality of delivery.

To suggest that pharmacists today exclusively believe that providing service to your customer is a good thing is selling every other retailer on the planet short. Chemist Warehouse thinks we are a reasonably good retailer. We focus on price, but we do not compromise on service. We provide more flu vaccinations, for example, than any other pharmacy group in the country. We provide more home

medicine reviews, or HMRs, than any other pharmacy group in the country. We are a low-cost provider, because we think that we can drive efficiency and we know that consumers are looking to save money, but there is no compromise on service; there is simply a compromise on price. Others could come up with alternative strategies.

The argument often voiced is one that I remember my year 8 debating coach telling me if anyone ever voices you know you have won the debate. That is the argument that 'if it ain't broke, don't fix it'. If that argument was true, we would still be talking on a landline phone. We would not have mobile phones. We would not have iPhones. We would still be in horse-drawn carts and we would not be driving cars. It is not 'if it ain't broke, don't fix it'; it is 'if you're not swimming, you're drowning'. We need to move forward to get to a better outcome and not simply suggest that the status quo is okay because a house ain't burning down.

Mr McARDLE: Mr Gance, thank you very much. I know that you came from Melbourne this morning and we do appreciate the time you have taken to come up here. To all those who were here from 9.30 this morning, thank you for your time as well. Mr Gance, Dr King made a couple of comments about his concerns about expanding who can own pharmacies. He referred to the UK example. I am not quite aware of the detail of that, but he tended to imply that people went broke because of it. He alluded to two things in particular: a risk of the doctor and pharmacy ownership becoming too cosy and, secondly, a link between drug companies owning pharmacies. In any arrangement there are always going to be outsiders, shall we say. When you say 'break the bonds', are there some constraints that you would put in place to ensure that ownership did not go to a point where it became a monopoly or, at least, created a concern for the community?

Mr Gance: Let us address the first one: medical centres and pharmacies not allowed to be owned. That is actually not true. Today, the ridiculous situation is that a pharmacist can own a medical centre. There is no reason they cannot. Legislatively, there is no issue. I can own a pharmacy—

Mr McARDLE: Let's go back to what he said. He said the pharmacist owning the medical practice and—

Mr Gance: That can happen today.

Mr McARDLE:—now an arrangement in relation to the medical practitioner owning the pharmacy. Do you not see any problem with that?

Mr Gance: If I can just finish my point, today the pharmacist can own the medical centre, so you can have the same ownership of the two businesses. The ridiculous part in my eyes is that the pharmacist can own the medical centre and the doctor can own the medical centre, but the doctor cannot own the pharmacy.

Mr McARDLE: So you do not think Dr King is correct on that point?

Mr Gance: I do not recall Dr King's—I am more than happy to look at it and take it on notice and reflect on it. I do not think Dr King mentioned anything like that.

Mr McARDLE: I do apologise. My notes indicate that he had a concern about that.

Mr Gance: I think Dr King was very clear in that he saw deregulation as a very good thing, but he had already been told it was not going to happen so he did not draw a conclusion. I may be mistaken about that.

Mr McARDLE: What about the pharmacy being owned by a drug corporation?

Mr Gance: I think there is potentially the need to legislate against that in order to ensure that you can have the correct oversight. Other than that, I have no issue with anybody other than—I have not given thought to who else could potentially be conflicted, but I think there is a definite conflict with a pharma company.

Mr McARDLE: I know that you talk about 'if it ain't broke, don't fix it'. I get all that; it is a wonderful saying. What is the problem with today's model here in Queensland?

Mr Gance: Today's model stifles innovation. It is very difficult—let me give you an example, if I could.

Mr McARDLE: Yes, please.

Mr Gance: It is a single anecdote but it is one that I think may enlighten you. My mother, as I said, was a pharmacist. She passed away 10 years ago. My sister is a general practitioner. She is the black sheep in the family—she did not do pharmacy—but we still accept her and love her dearly. When my mother passed away she was able to leave her commercial interests to me but not to my sister. That in itself sums up how this whole thing is nonsense. She is a general practitioner, she is a

fantastic individual and she would become a fantastic proprietor of a pharmacy, yet in my mother's final will and testament she gave my sister her jewellery and I got her business assets. It does not make sense. She would be a great pharmacist owner. Why do we have a piece of legislation which prohibits her from doing it? In fact, I will go as far as to say that she would probably be a better proprietor of a pharmacy than I am, but she cannot own it. Why?

Mr McARDLE: Thank you.

CHAIR: I have one final question. Many of our submitters—and we have received a couple of hundred submissions in this inquiry to date. I come from a regional electorate, although we do have a Chemist Warehouse up in Townsville.

Mr Gance: Two.

CHAIR: Yes, you do. You just opened one in my area actually. Many of the smaller towns, such as Clermont, Hughenden, Charters Towers and Ingham, wrote that they did not want the big Chemist Warehouse type establishments coming in and taking over those small towns. What is your response to their concerns?

Mr Gance: That concern has nothing to do with proprietary laws. I can easily show you, as we presented to Professor King—I think we got to about 400 emails from other regional and rural communities who expressly say that all they want is Chemist Warehouse to come to their town. Again, I am not in this state but I recall there was an article in the local newspaper in Wagga in which they listed the top 10 things they want for a town. No. 1 was Ikea, so we cannot quite tick them off yet, and No. 2 was Chemist Warehouse. We have petitions to many a local member in many a rural town advocating as passionately as I advocate against the regulatory environment. They write to me and I say, 'Look, Mrs Jones in Jonesville, I would love to open in your town. I appreciate you getting 55 signatures on your petition, but this is the law. I cannot open in your town because I cannot acquire a pharmacy business in your town.' The only way to open a pharmacy is to acquire one and actually I cannot own any more in Victoria. For every Ingham—and I know we are wanted there, so that is not a good example. For every example that you potentially can give me of a community who does not want a big, ugly yellow building, I can probably give you 50 who do, and we cannot get there because of these laws.

CHAIR: Mr Gance, thank you very much. You did take one question on notice. I think that was regarding your training—

Mr Gance: Training? I am happy to provide all of the materials.

CHAIR: If we could have that back by—

Mr Gance: I will just put you on to my training department; you can liaise directly with them. They know more than I do.

CHAIR: Mr Gance, thank you very much for your time to appear before us today. I thank everyone who has appeared before us today who has an interest in what is an interesting space going forward. It has been most helpful to hear from everybody today. I declare this public hearing closed.

The committee adjourned at 12.35 pm.