



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 J Gilchrist (Assistant Committee Secretary)

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

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 7 SEPTEMBER 2018

Toowoomba

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The committee met at 10.30 am.

CHAIR: I declare open this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee. I start by acknowledging the traditional owners of the land upon which we meet today. I am Aaron Harper, the chair of the committee and member for Thuringowa. Other members of the committee with me are Mark McArdle, the member for Caloundra and deputy chair; Michael Berkman, the member for Maiwar; Marty Hunt, the member for Nicklin; Barry O'Rourke, the member for Rockhampton; and Joan Pease, the member for Lytton. Today's hearing is part of the committee's inquiry into the establishment of a pharmacy council and pharmacy ownership in Queensland. The inquiry was referred to the committee on 3 May 2018. The committee is required to report to the Legislative Assembly by 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 that takes a nonpartisan approach to inquiries. This hearing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind you that intentionally misleading the committee is a serious offence. Witness have been provided with a copy of the guidelines and 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. If there are any media present, I ask that you adhere to my directions as chair at all times. The media rules are endorsed by the committee and are available from the committee staff.

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

GAUHAR, Mr Adnan, Consultant Pharmacist, Diabetes Educator (CDE), Manager, Just Pharmacy Toowoomba

WHITTAKER, Dr Andrew, Just Pharmacy Toowoomba

CHAIR: I welcome Mr Adnan Gauhar and Dr Andrew Whittaker. This is a wonderful opportunity for members of parliament to come to the regions. We are starting in Toowoomba. I am from Townsville, and we are also heading to Townsville and then Cairns. We are doing some extensive consultation throughout Queensland on this important bill. It is important that we do hear from our pharmacists. I note that Lucy Walker from Goondiwindi is here. Thank you very much for your good advice on the coffee. We cannot start without good coffee. You have travelled a long way and I welcome you. We look forward to everybody's contribution to what is an interesting inquiry before us.

Adnan, would you like to make a brief opening statement? I understand you have had the Just Pharmacy for a little while. I will let you start with an opening statement before we go to questions.

Mr Gauhar: First of all, I also acknowledge the traditional owners of the land and pay my respects to elders past, present and future. I thank the committee for inviting us to put up this proposal. I would like to thank Andrew Whittaker for coming along and supporting us in providing this proposal. We are passionate in terms of the collaboration between GPs and pharmacists and increasing the scope of pharmacy practice and of pharmacists to provide early access to people who are looking for replacement programs or who have issues in terms of addictions and opioid dependence.

This proposal is based on the fact that a lot of Australians are dying from overdoses of opioid prescription medications. In fact, data released a few days ago shows that in Victoria overdoses from opioids have increased and surpassed the road death toll, which is amazing. It is really an area that is affecting communities throughout Queensland and, of course, Australia, but especially regional, rural and remote areas, where there is not much access available to save people from dying.

The Queensland opioid replacement program has been available for the past 40 years. It is one way of preventing early deaths. This is where our proposal involves expanding the role of pharmacists. Pharmacists have been involved in the program for the past 40 years, by monitoring Toowoomba

and providing support and medication to people who want to go on the program and change their lives. However, early access is very important to those people. At the moment we cannot get early access, because of the pressure on both the public and the small amount of private clinics. I can give you some data about that.

In Queensland, there are only 30 public clinics and only eight private clinics. There are only about 80 prescribers throughout the whole of Queensland. In the Darling Downs and South-West Queensland area, there are between four and eight prescribers who can start people on these programs. That is not enough. It why we have a massive waiting list and the Toowoomba alcohol and drug service is completely overloaded with people who are waiting to go on the program.

That is why the proposal involves expanding the role of pharmacists to initiate the programs from the community pharmacies, so that we can save people from early death. Those people come from all walks of life. They are people you will come across every day in your lives, whether it is your brother, your sister or anyone else you know in the community at the moment who has issues with drug dependency. With the drought kicking in, there will be an increase. You will see a lot of people with these issues.

Dr Whittaker: As Adnan said, the problem with a lot of the people who become dependent on narcotics, whether that is through IV drug use for recreational purposes or whether it is secondary to a therapeutic need that they have been taking narcotics for that has escalated, for them to get on the Queensland opioid replacement program is very difficult. There are only about three or four prescribers in Toowoomba. I essentially work very much part-time in this area. To a certain extent, it is not like I have a great passion to expand my practice in this area, but I see this massive need that is not being met.

There are a couple of important points about this. We are only talking about opioids. We are not talking about any other recreational drugs; we are just talking about opioids. I certainly know that in America the number of deaths related to opiate overdose far outweighs car accident deaths. That has been for a number of years now.

In the area of opioids, we have—I do not like to use the word ‘miracle’ drug, but in some respects I think it is a miracle drug. It is called Buprenorphine. The beauty of Buprenorphine is that it binds to the opioid receptors and prevents other opioids from biting into those receptors but gives a clinical effect as well, so it stops withdrawals from opioids. That is the first thing.

The second thing is that, even if Buprenorphine is used inappropriately—and almost certainly it always will be, because that is the nature of what we are dealing with, unfortunately—it is pretty unlikely that anyone can kill themselves with it. However, with other opiates, particularly fentanyl, oxycodone and morphine, it is very easy to overdose. It is very easy to kill yourself with them, basically. You hear it all the time with movie stars dying. All a lot of that is just opiate overdoses.

CHAIR: Can I pull you up for a moment, there. I do commend you on what you are intending to do. Obviously, you are one of the few pharmacists who provides that treatment in this area. The intent of this inquiry is to look at two aspects. I know you are tying in the expanded scope. One is pharmacy ownership and one is expanded scope of practice. Can I ask how long you have been established in Toowoomba?

Mr Gauhar: I have been practising in Toowoomba for the past 15 years. Andrew has been here for longer. I have been actively involved with opioid replacement since I started in Toowoomba through the different pharmacies I have worked in and that I own. Over the last 15 years, we have seen a massive increase in these sorts of drug related issues. We have seen people dying. We have also seen people making their lives normal after going onto the programs. We have come here to propose this because it is about the scope of practice and the collaboration that is needed in primary care practices between pharmacies and GPs—GPs such as Andrew and others—who are willing to provide assistance to people who are looking for help.

CHAIR: You have put a pilot proposal together. I suggest that would probably be a good proposal to send to the Minister for Health. Some of the funding arrangements for the addiction area may sit within the Commonwealth funding realm. I do not know enough about that; maybe you could inform me. I am not sure where the state plays a role in treating those people. Do you have any ideas on that?

Mr Gauhar: At the moment it is mostly given through the states. There is some funding available, but the Queensland Health service provides support to those people and the Queensland Opioid Treatment Program is from the Queensland government, which comes under the Minister of Health.

CHAIR: How do you see the expansion of scope of practice assisting your particular area of interest?

Mr Gauhar: That is what we proposed it for.

Dr Whittaker: Basically, what Adnan is talking about is that if someone wants to get on the program, as I was saying before, Buprenorphine literally keeps them alive. It is a life-saving drug. If someone gets on the program, they have to first find a GP who prescribes. They have to make an appointment. They have to transport themselves there. That might all sound fairly simple, but for a lot of those people it is not simple.

Adnan is proposing that essentially he captures these people. They can come to him as their first port of call and say, 'I want to go on the program. I have a problem.' He contacts me. We enrol them in the program. We would not do anything that would not be safe. Until they actually make an appointment to see me, they would go on daily dosing. The difference in this model to a normal model is that Adnan is the first port of call. That is where they go. They do not go looking for a GP. They say, 'This guy does opiate replacement. I will go to him. He will talk to a doctor. He will get me on the program. Then I dose. I build my relationship with him. Then I go and see the doctor at a later date.' My role then comes in.

The other thing that I would like to see happen is that, as soon as they walk through the door to go on the opioid replacement program, they also get diverted straight into Hep C screening. The guidelines for Hep C treatment is to get them on hep C treatment as fast as you possibly can, to prevent hep C being spread throughout the community. That is the concept of it.

CHAIR: Out of the 493 pharmacies that are currently providing the Queensland Opioid Treatment Program, how do you advertise that? How do people off the street know that they can walk into a pharmacy?

Mr Gauhar: It is not really advertised as much, compared to other services and things. This is where there are issues and impediments, both for pharmacists and GPs, to advertise these services.

CHAIR: Could that be done if an oversight body was established?

Mr Gauhar: It can be done by an oversight body or independent body, but this is about the scope of practice. We cannot say to those patients, 'If you come to the pharmacy, we will put you on the program.' We cannot do this under the current scope of practice. This proposal is that pharmacies are more accessible and pharmacists are accessible to these people. We see them day in, day out coming in and getting their medications, but we are limited in our practice to put these people on the program. This is why this collaborative process will be available if we go ahead—that these people will go on these programs as early as possible and initiate this.

Mr McARDLE: Are you saying at the moment that you have very limited scope of practice, that they cannot go on the regime through you until they see Andrew—

Dr Whittaker: Yes.

Mr McARDLE: And then it goes back to you.

Mr Gauhar: That is right.

Mr McARDLE: What you would like to do is have the right to start treatment early, then go to Andrew; is that right?

Dr Whittaker: I am still involved with the treatment.

Mr McARDLE: No, what I am saying is—

Mr Gauhar: What we are proposing is that we evaluate—

Mr McARDLE: If I come to see you, what is your job for me in your proposal?

Mr Gauhar: I will have a consult with you about your practices and go through a checklist which is available for these people. Then I will say to you, 'I will talk to my GP prescriber'—

Mr McARDLE: Which is Andrew.

Mr Gauhar: That is right. That will be available pretty much straightaway and we will initiate the program through Andrew.

Mr McARDLE: How is that different to what you do at the moment? I am the patient and I come to see you under the current regime. What happens?

Dr Whittaker: Adnan says, 'Here's a list of doctors. You need to make an appointment with one of those doctors. I'll see you when you've made that appointment.'

CHAIR: So your expanded scope of practice could allow you to do an initial consultation on a checklist. That unpacks it a bit more clearly.

Mr Gauhar: It is definitely in the proposal. It is already in there.

Dr Whittaker: It is not like it is not involving me; it does involve me.

Mr McARDLE: But it is an earlier start by Adnan in that process as opposed to, 'Here's your list. See you later. Come back to me later.'

Mr Gauhar: That is right, or if they go to their GP they will refer them to the ATODS, which will have a few months or weeks list and those people just lose their motivation or overdose in that period of time.

Mr McARDLE: That is the start of your enlarged scope of practice. Would you then also request the right to give medications without a script?

Mr Gauhar: We are not doing that.

Mr McARDLE: No. Under an enlarged scope of practice, would you like to have that right as well?

Mr Gauhar: No.

Mr McARDLE: It is just that the arrangement is altered at the start.

Mr Gauhar: Yes. We want a collaborative approach. We are not asking for a prescribing right to allow these prescriptions to be prescribed by pharmacists.

Mr McARDLE: You would always rely on Andrew to offer you the—

Mr Gauhar: That is right, because this is where the collaboration part comes in. We are not taking over anyone's turf. We are not going into this turf war or exceeding the scope of practice. We are at the moment currently proposing that there is a pathway available whereby these people can be enrolled by a pharmacist in a community pharmacy in collaboration with GP prescribers—

Mr McARDLE: So it sharpens the entry point.

Mr Gauhar: That is right, and early access. This is the key to it—early access. At the moment, the early access is not available and people are waiting for weeks and weeks. Even now, we just received a letter from Toowoomba health service ATODS that said that, if people who are currently on the program miss three days in a row for some reason—this is a part of current clinical guidelines—and they do not pick up their dose or get dosed three days in a row, we have to refer them back to the GPs or to their prescriber to evaluate them again. It does not matter what their reason was—whether they missed it deliberately or they missed it because they were sick.

Mr McARDLE: Thank you, Adnan. I do accept your comments.

CHAIR: Adnan, what you have unpacked before us already is the important role the pharmacists play in people's health care.

Ms PEASE: Thanks for coming in today. My question goes back further to that. What sort of testing is undertaken on one of your patients when they come in? Are there blood tests taken, or is it just a checklist to determine whether they need to go on the medication?

Dr Whittaker: They need to get clinically assessed. They have to make sure they are in withdrawal, and that is not particularly difficult to do. The reason is that if they still have narcotics on board and you give them Buprenorphine, there is a risk of a reaction called precipitate withdrawal where the Buprenorphine knocks the other opiates off the receptors and they go through a confined withdrawal time. Instead of being over a week, it is literally within two hours. It is pretty horrendous; I have seen it a couple of times.

We would certainly have to go through that, but it would not be a difficult thing to train a pharmacist up. There are just a few basic things there. What would be good then, and if we could initiate this by the pharmacist, would be to do a range of blood tests. What we are looking for there is any markers of hep C. That is the other important thing. I know I might be getting off the point a little bit, but if you can keep these people alive they will get better themselves. That is the whole point of the opiate replacement program—to keep them alive so they can sort their lives out later on. The other thing is that if you can treat them as early as possible with the hep C treatment, they are not going to spread hep C right through the community.

Ms PEASE: I appreciate that, but I guess what I am trying to understand is: if a community pharmacist is going to do the intervention work with that checklist, is there a blood test required before you start putting them on that?

Dr Whittaker: We could do that. That is something they could look at—

Ms PEASE: But is that a normal clinical assessment?

Dr Whittaker: No, I would not say that is normal. Pharmacists can do blood tests. It is just that they are not Medicare rebatable.

Mr Gauhar: We are not proposing that we will be doing blood tests. We can refer them—

Ms PEASE: I am just trying to understand what the current process is. Dr Whittaker said that if they are still having narcotics and they take the medication it can actually throw them into a withdrawal which would happen over two hours instead of the normal week. What is on the checklist to assist to avoid that happening?

Mr Gauhar: This is the checklist, which I have. This is the admission checklist which most prescribers use to admit people on the program. Andrew goes through this checklist. There is training available for that. This does not require any blood test immediately for them. It just requires a good, detailed history, which Andrew knows, and an interview before they are being prescribed on the program.

Dr Whittaker: You have the manual there.

Mr Gauhar: There is a whole manual there, and all the clinical guidelines.

Dr Whittaker: I am not expecting the pharmacist to overnight become opiate-prescribing doctors. I would not expect the pharmacist to do anything but ensure that the patient does daily pick-ups until they see their opiate prescriber.

Ms PEASE: With the patients who come in, are you required to report to the prescribing doctor if they are not turning up each day?

Mr Gauhar: Yes.

Ms PEASE: Does that happen on a daily basis if they do not turn up?

Mr Gauhar: It depends. According to the guidelines—and we follow the guidelines—if they miss three doses in a row, in consecutive days, we have to report it to the prescriber.

Ms PEASE: It is still quite involved already.

CHAIR: Do you do any vaccinations in your pharmacy?

Mr Gauhar: Yes, we do.

CHAIR: Do you think there is a role to expand the vaccinations to a younger cohort? Currently it is 18 years of age, I believe.

Mr Gauhar: I will recommend, based on my experience, that 16 and above can easily be included in the current guidelines. There will not be any issues with that.

CHAIR: How long have you been doing the vaccinations?

Mr Gauhar: From the last three or four years—since it has been available.

CHAIR: Have you had any adverse reactions?

Mr Gauhar: We have never reported any adverse reactions so far.

Mr HUNT: We are dealing with probably our highest risk, most vulnerable people here and life-and-death situations. You mentioned that there are only three prescribers locally.

Mr Gauhar: Four. One is inactive. Three are active and one is not as much seeing patients because of health or otherwise.

Mr HUNT: Am I correct in saying, then, that it is a fairly specialised area? Is there any reason there are no other GPs?

Dr Whittaker: The reason is—and can I be blunt—that people do not like dealing with drug addicts. They do not like them sitting in their surgery. I used to work a lot more in this area; I am more or less doing it part-time now. I have had some terrible patients come through, and I can fully understand how GPs would feel about that.

Mr HUNT: If I had a GP I had been seeing for 10 years and I suddenly spiralled into drug addiction and went and saw that GP, would they refer me to—

Dr Whittaker: In Toowoomba they would probably send you to ATODS.

Mr Gauhar: Yes, or they will ask you to see a private prescriber.

Mr HUNT: So they will not prescribe what you are talking about here?

Mr Gauhar: No.

Dr Whittaker: You can do it online now. You can go and do a training course.

Mr Gauhar: It is only one module you have to do as a GP. Before it was available through Queensland Health but it is—

Mr HUNT: So there is a qualification you have to have that GPs just do not have?

Dr Whittaker: The GPs just do not want to do it. That is basically what it comes down to.

Mr HUNT: I get that. I am trying to understand why there are so few. When you are dealing with life-and-death situations here with vulnerable people, would that specialised knowledge need to be had by the pharmacist? When we are expanding the scope of practice and they may deal with these people initially, what specialised care is there and what are the risks involved in that?

Dr Whittaker: Adnan is a very experienced pharmacist. He is probably pretty qualified already. I keep harping on about Buprenorphine, but the thing about this drug is that it is very safe. The worst thing you can do to someone with Buprenorphine is cause a precipitate withdrawal like I have described. Even though it is a very unpleasant couple of hours, most people will get through that fine.

Mr HUNT: Essentially, it is an urgent intervention until you can get medical care?

Dr Whittaker: Yes. It is all about trying to keep people alive until they sort the problems out. Stephen Cramb used to be our doctor at ATODS up here and I had a fair bit to do with him. He would always tell me this story that in Europe you could go to your local doctor and he would just write Buprenorphine like a normal script: 'Here you go. Here's your Buprenorphine. Off you go.' The controls are very loose on it. As you can imagine, it becomes a street drug pretty quickly because people take their script out and sell it and make money and whatnot. When that happened, the actual death rate from opiate overdoses decreased. They did not go up. More people were staying alive because people were using this drug instead of using oxycodone, morphine and things like Fentanyl. In a way, the more this drug is out there—obviously I do not want everybody shooting up Buprenorphine, but if you are going to shoot something up then it is a really safe drug to do it with.

CHAIR: I am mindful of the time.

Mr O'ROURKE: In regard to the scope of practice for pharmacists, are there any other activities that pharmacists could undertake to improve health outcomes for consumers without additional training and things like that?

Mr Gauhar: At the moment we have trained, qualified pharmacists coming out from the universities, which are very clinically oriented. They have a good, extensive four years of training, and then they do a year of internship at community pharmacies, which provide all these different types of services. They get exposed to all of these services, and then when they are ready to become pharmacists after five years they are well equipped in terms of dealing with day-to-day types of illnesses, acute illnesses, vaccinations and all these scopes of practices. Currently, certain of them are limited. For example, in Queensland we only have three vaccinations we can give out and only to 18 and above.

Of course, there is an area and we have seen it all around the world. I have pharmacist friends all over the world, including Canada, the United States and the United Kingdom, and they have a very expanded scope of practice in a community setting. We are talking about primary care settings where they can have a larger scope of practice to work and take the pressure off the GPs. This is done in a collaborative way—not in terms of overstepping their boundaries but within the scope of practice and providing help to the patients. It is a quality of care, basically.

Mr BERKMAN: Thank you both for being here. It is very important work and it is a really valuable insight into the role pharmacies can play in harm minimisation. You have touched on this already briefly, Dr Whittaker, but I go to the expanded role for pharmacists in the administration of Buprenorphine or other drugs. In your experience, are these drugs seen to have a recreational use? Is there a real risk of it—

Dr Whittaker: Yes, definite recreational use. I will not beat around the bush here. It is actually the preferred drug of use within prisons simply because the dogs cannot smell it. It is a synthetic opioid. Again, if they are not going to use that opiate, they are going to find another one to use. If they are going to use an opiate, they may as well use an opiate that is not going to stop them from breathing and die. I am not saying that we should be selling it in corner stores or anything like that—it is not like that—but it is a safer drug than the other alternatives. Like I keep harping on about, if you follow them long enough, these people will cure themselves. I have had people straight from prison who are

IV heroin users go on Buprenorphine and they are working within two weeks. It is quite incredible when you see that sort of transformation. That is why I get a little bit passionate about it. It is just a pity that this does not happen more often.

Mr BERKMAN: We are pressed for time, but I want to press a little further. Despite what you have said about the risks of recreational use, we have heard some evidence around the scope of practice expansion that goes to the existing provisions for emergency prescription by pharmacists—that is, that short-term provision of drugs where a script has run out. I guess I am trying to test how far you think a pharmacist's role might legitimately go when it comes to these kinds of opioid treatments.

Dr Whittaker: And I am hearing it. I think you would have to be pretty careful, to be honest.

Mr Gauhar: Yes.

Dr Whittaker: You could not just have anyone rocking down to the local pharmacist picking up some Buprenorphine, because I know exactly what will happen if you do that. If there is some sort of controlled way of doing that—

CHAIR: Is it a schedule 8?

Mr Gauhar: It is a schedule 8 drug.

CHAIR: It is a schedule 8 drug. That says it all.

Mr Gauhar: It is not easily accessible. It has a lot of the protocol behind it, so that has to be followed.

Mr McARDLE: We would certainly like to write to the health minister in relation to your testimony. In doing so, do we have your consent to provide him with your names and direct contact details?

Dr Whittaker: Yes.

Mr Gauhar: Yes, no problem.

Mr McARDLE: If we do not have those full details, could you tell the staff here perhaps your mobile numbers, if you are happy to give them? Talking to the chair, it does seem like something that might be worthwhile looking at.

CHAIR: Yes, I think it is very worthwhile looking at. I commend you on your work in this important space. It is useful information. We will also talk with the health department in our briefings and take your proposal as it sits in front of us up to the minister, just to highlight the issues raised today. Thank you very much for your information. Just before you go, did you have anything to table—the current checklist or any information that we can use? We will just need to accept it if you have forms there that are currently used.

Mr Gauhar: I did send it to Rob about the proposal and a copy of the checklist, but I can—

CHAIR: So we already have it?

Mr Gauhar: Yes, you should have. If not, then I can resend it.

CHAIR: If we already have it, that is fine. I thank you both for your time today. It was very useful information.

Mr McARDLE: Thank you indeed. That looks like a very worthwhile cause.

DUCKETT, Dr Stephen, Director, Health Program, Grattan Institute (via teleconference)

CHAIR: Dr Duckett, thank you very much for joining the committee this morning. We are in Toowoomba talking with pharmacists and interested parties to the inquiry before the Queensland parliament. Dr Duckett, I found the Grattan Institute submission very useful. We are challenged with the mobile phone, but we are doing our best to record you. I ask you to make an opening statement on your submission, please.

Dr Duckett: Thanks very much and thank you for accommodating me by phone with the technology challenge. The Grattan Institute is an independent public policy think tank. We have an endowment and so are able to speak and write independently. Pharmacy is one of the most regulated industries in Australia. It is regulated by both the Commonwealth and the state. The Commonwealth has responsibility for the Pharmaceutical Benefits Scheme and the Commonwealth as part of that has so-called location rules which restrict where pharmacies can be established. They also regulate the prices that pharmacies can charge for pharmaceuticals. The state, on the other hand, has a separate regulatory role—a historic role because the state obviously existed before the Commonwealth came into existence—and pharmacies are within the constitutional role of the states. The state regulation controls what pharmacists can do, who can prescribe what and who can own pharmacies and how many pharmacies they can own. That is what our submission is about—that is, the state responsibilities, not the Commonwealth responsibilities.

In our submission we supported the lifting of ownership restrictions because we think—although the evidence is a bit unclear about whether that would benefit consumers because different owners just might take higher profits—that competition in the industry through lifting of ownership restrictions has the potential to benefit consumers. The second thing we think is of benefit to consumers is to expand the role of pharmacists so that they can provide more services to consumers. Thank you.

CHAIR: Thank you very much, Dr Duckett. Just on that last point of expansion of scope of practice, did you look at any particular areas? We have had quite a few submissions and I am just trying to recall whether yours was around warfarin or any particular treatments.

Dr Duckett: What we did in previous work was look at what doctors do, especially doctors in rural Australia. We found that there is a lot of pressure on general practice in rural Australia because there just are not enough doctors. We looked at the sort of work doctors do and whether that work could be done in cooperation with the GP—not in competition but in cooperation with the GP—by pharmacists. There were things that we thought were very clear, and one of them is administration of a broad range of vaccines. I think that is already the case in Queensland. The second was being able to issue simple prescription repeats. Why does a person have to go back to the doctor every time they want a repeat if they have a chronic illness? Obviously they have to go back regularly—maybe every 18 months—to have a check-up and so on, but they do not need to go back to the doctor every time they need a repeat. We think this is something that pharmacists could do in conjunction with the GP. Thirdly, they could assist in chronic disease management. Obviously there are many people with chronic diseases who are on multiple prescriptions and who also need some monitoring on a regular basis. We think pharmacists could do some of that as well, improving access for consumers.

CHAIR: Dr Duckett, the AMA would argue against your statement of a check-up every 18 months. What would you say to their submissions directly opposing that type of arrangement?

Dr Duckett: Pharmacists have a four-year training in medications and they have a fair amount of physiology in that training. They have a fair amount of understanding about drugs within the human body and so on. What we are arguing is that they should be able to use that for the benefit of patients, and what we are saying is that this should be done in cooperation with GPs. For example, on the prescription repeats issue the consumer and the GP and the pharmacist should all agree and they should work together on this, because in many cases the GPs are overburdened and they are charging much higher fees. They are charging significant out-of-pockets in some cases. About 20 per cent of all general practice visits have an out-of-pocket, so we are saying that this is a chance to give access to people who need it by qualified professionals who are trained for this sort of thing and we should be using them much more efficiently than we are using them now.

CHAIR: I refer to the fact that 2.1 in your submission states—

Every year in Australia, nearly 1.3 million GP visits involve a vaccination to prevent a disease, with no diagnosis or other treatment involved.

That is interesting in terms of vaccinations. Did you have anything further to add in that regard? In particular, my question would be about lowering the age of vaccinations for pharmacists. Is there any thought on that? Currently it is restricted to 18 years of age.

Dr Duckett: My view would be that, as I said, pharmacists are well trained. In many pharmacies nowadays there are places for people to sit. The pharmacies are looking more professional and so they can give vaccinations. They can then say to the people, 'Sit down and we'll observe you to make sure you've got no reaction and so on,' and they can manage those reactions if they occur. I think the role of pharmacists in vaccinations should be extended to all sorts of vaccinations and we should be encouraging it, because it is very easy to just drop in to a pharmacy for a vaccination whereas with many GPs you have to make appointments a long time in advance which means that people often do not do that and so we are having fewer vaccinations than we ought to be having.

CHAIR: You mentioned in that point that international experience clearly shows that pharmacists provided vaccinations that are safe, and you have referenced 13 even though I cannot find it in the references.

Dr Duckett: Yes, absolutely. You can issue guidelines on these things, which is what that reference is about, and the evidence from overseas—Canada and the United States—is that patients like the convenience of pharmacy vaccinations.

Mr HUNT: Dr Duckett, just on the ownership side of things and relaxing or deregulating ownership, given some pharmacists are concerned about non-pharmacist owners improperly interfering with their professional work in pharmacies, do you have any comments around the risks of that? You make comment that a transition period must be slow. How that might look to mitigate those sorts of risks?

Dr Duckett: With regard to the evidence about interference, we already have legislation in other areas about pathology and diagnostic imaging providers, for example, not being able to interfere with GPs. There are other parts of the health system where this same issue has occurred or arises, and in those other parts of the health system it is not dealt with by saying, 'Only pathologists can own pathology companies or only radiologists can own radiology companies.' It is dealt with by addressing the specific problem of interference in clinical practice.

There is no evidence that I have seen anywhere that says just because a person did a pharmacy degree 40 or 30 years ago that means they are more ethical about not interfering in the work of the pharmacies they own than anybody else. If we think there is a specific problem, we should address that problem, regardless of who owns the pharmacy, because there is no evidence that pharmacists are more or less susceptible to interfering in the work of pharmacies that they might own, especially if it is owned by a corporation of which they are members of the board. The job of a corporation is to act in the interests of a corporation, so if we think it is a problem that corporations might try to interfere in the work of pharmacies we should address that problem—not through ownership, because there is no evidence that ownership will do anything about it. I forget what your second question was.

Mr HUNT: In relation to how that might transition. You put in your report about a slow transition.

Dr Duckett: I cannot hear that.

Mr HUNT: Sorry, Doctor. In relation to transitioning to that model, you have mentioned in your report about a slow transition. Can you comment on how that might look?

Dr Duckett: That totally broke up as well, sorry.

Mr HUNT: I am near the phone now. Is that better?

Dr Duckett: Yes, that is much better.

Mr HUNT: I asked in relation to your comments about a transition phase and how that might look.

Dr Duckett: At the moment in Queensland you can only own five pharmacies. I think there is merit in saying, 'Okay, let's have a staged implementation,' so you might have legislation which says we are going to increase it to 30 and then 80 and then lift the limit all up. Basically, what you want to see is the industry not having a buying frenzy overnight, which might diminish the value that pharmacists hold in their properties, but you also want to make sure the ACCC is aware that we are moving from a situation where there are limits on pharmacy ownership, as in the Northern Territory and the ACT, to a situation where there are no limits on ownership in Queensland.

There may be more competition issues that have to be addressed, and we want to make sure that the systems are in place. You could do it in a staged way like I suggest or you could do it in a way which says, 'We are going to introduce this. We are going to pass the legislation but it does not come into effect for another two years,' to allow all the systems to be in place for that purpose.

Ms PEASE: I refer to point 1.3 of your submission, that the ownership rules will inflate costs, and your statement that if we were to abolish ownership rules the cost of providing over-the-counter medicines would likely fall. Then you go on further to say that these savings would not be passed on and also that consumers would not necessarily automatically save. Those three statements that I have read out contradict each other.

Dr Duckett: You are exactly right. Thank you for that. The point is this: in theory we would expect increased competition. If there is relaxation of the ownership rules we would expect more efficient owners, if I can phrase it that way, to own more pharmacies. If you have a pharmacy owner who owns only five pharmacies, they may not have been able to build up the skills and knowledge about how to manage inventory, how to manage a pharmacy system. Even though pharmacies are now basically part of chains, you still have differences in the way different owners work. If you relax the ownership rules you would expect that a person who owns 10 or 20 pharmacies may be better at owning pharmacies than a person who owns five. That is an improvement in efficiency in the health system.

Then the question is: does that just get converted into higher profits or does that get converted into reduced prices for consumers? The evidence about that latter point is unclear. In many cases it just gets converted into higher profits for the owners, but we are also in a situation where, especially in the metropolitan areas, there is competition. In the Brisbane CBD, for example, there are multiple pharmacies and so there may be pressure for the pharmacists to compete. Especially if the ACCC says, 'You are not allowed to own multiple pharmacies within two kilometres of each other,' you are more likely to have competition that will drive prices down. The evidence is that you might have to make sure you are doing things to encourage that competition with the ACCC, rather than just relying on market forces to convert the efficiencies for ownership into benefits for the consumer rather than benefits to the owner.

Mr McARDLE: Thank you for your time today. I want to take you to 1.6 of your submission that refers to the Commonwealth government potentially making reward payments if there is a reform in ownership. To me that implies two things. There are a number of reports that already exist that outline the benefits of liberalising the ownership rules; would that be right?

Dr Duckett: Yes.

Mr McARDLE: I have a paper here somewhere that does touch upon them, but are you able to pinpoint a document that substantiates the claim that it would be better to liberalise than not to liberalise, outside of your own assessment?

Dr Duckett: I think there have been in the last two or three decades, even within Australia—that is setting aside overseas evidence—a number of so-called competition reviews in the pharmacy area. I think in each case they have all recommended more relaxation of ownership because of the potential for more efficient ownership. There was the Wilkinson review. I forget the name of all of them, but I think there have been two or three in the last three decades.

Mr McARDLE: Just to cut you off, I think there are so many that pharmacists do not bother filing submissions anymore. That would be right, would it not?

Dr Duckett: As I said, there have been a number of reviews and they have all basically said exactly the same thing.

Mr McARDLE: My concern is that reviews keep saying the same thing—it could be, it may be, perhaps it would—but no-one has come out and stated there will be a clear benefit. Is that also your view of the matter?

Dr Duckett: As I said, there is no evidence in Australia on that because it has not actually been done. You can make hypothetical judgements, as I have done, based on what we think will happen and we can look at what the overseas evidence is—and I have cited some of that overseas evidence in my submission—but obviously because it has never been done I cannot stand here and swear that there will be definitely a benefit for consumers. All we can say is that we think there would be and it would help improve competition which makes it likely that there would be.

Mr McARDLE: I do not doubt your conclusion. I am just trying to establish the basis or the facts that make that conclusion viable. The second point that comes from 1.6 is this: what are the reward payments that you refer to that in that point?

Dr Duckett: In the past the Commonwealth—even just recently, in the last three years—has said that it is in the interests of the Australian economy to be more efficient and it is in the interests of the Australian economy for there to be more competition in a number of sectors. They have in the past rewarded states for improving competition in some aspects of the public sector, such as in transport or energy. On the table, as I understand it, are reward payments for the pharmacy area. I think that is cited in the committee's discussion paper. In my view this is something that the Queensland government should be pursuing with the Commonwealth government.

CHAIR: Dr Duckett, thank you very much for your time this morning. It is never preferred to sit in a forum listening to the phone, but it has been beneficial for members of the committee to do that. Thank you again.

OWEN, Mr Chris, Pharmacist, Owen Pharmacy Group

CHAIR: Welcome, Chris. I much prefer face-to-face. It is not normal practice that we sit and listen to a phone. We try to do that as little as possible. Can you start with an opening statement? How long have you had your pharmacy? How long have you been practising?

Mr Owen: Thank you for the opportunity to speak with the committee today. I own two pharmacies. One is the Valley Discount Drug Store in Fortitude Valley in Brisbane. The second one is a Terry White Chemmart franchise in Highfields, which is just 10 minutes down the road from here. For me, at the very core of this inquiry is a very simple question: are the current regulations of the Pharmacy Business Ownership Act being upheld? Others have given evidence, as has Stephen Duckett, to the committee of the tenet of non-pharmacists owning pharmacies. Numerous committees have investigated this model and concluded that the best outcome for patients is for that to exist. This also has bipartisan, or tripartisan, support.

My evidence today will focus purely on the specific terms of reference that were given by the health minister. The issue at the heart of this inquiry is: is the Pharmacy Business Ownership Act in reality and intent being upheld within current protocols? To that I would say no. Should a pharmacy council be set up to monitor pharmacy ownership regulation and premises? Absolutely, yes. These two issues go hand in glove. The implementation of a council would certainly bring certainty to the government and to Queenslanders that the Pharmacy Business Ownership Act is being upheld as a legislative instrument.

I have concerns about how the department, without sufficient resourcing, has been able to achieve this legislative intent. I am not convinced that in Queensland this could be achieved without a pharmacy council as it is in other jurisdictions with a dedicated regulator. A council would have the expertise and the capability to properly scrutinise ownership structures. The nominated pharmacist must maintain proprietary and pecuniary interests of the business at all times. In recent times it is my belief that the legislation has been open to being gamed by nominating a pharmacist's proxy to pass the current approval processes of Queensland Health while they do not contain any true proprietary or pecuniary control in the running of their business.

A corporatised pharmacy is dangerous for patients. There is consumer research that shows consumers prefer a health practitioner to be the one that owns their business. Those who call for deregulation of pharmacy ownership seem to be motivated more by self-interest than public interest. Pharmacists have a professional responsibility and it is their registration and livelihood that is on the line. By their nature as pharmacists, they follow regulations and the community trust in their position is confirmed with public trust surveys.

Corporate liability versus individual liability is a key issue here. A non-professional company director can issue a profit driven directive to their staff without regard to professional conduct requirements. The cost of regulatory noncompliance is seen as a cost of doing business. The corporate veil must not be allowed to undermine patient safety, privacy or health outcomes. Personal liability is the key tenet of professional practice. Former AMA president Kerryn Phelps previously said—

But there are a number of warning signs and I think in particular the issue of where there's a clash between corporate profits and patient care, that's the area where I think we're going to see some concerning developments.

Just this week Dr Bruce Willett said in his comments to the committee—

Quite frankly, in general practice we have seen corporate models roll out and a more profit-driven ethos that tends to go with that. I think clinicians being directly responsible for the way the business is conducted actually lead to better outcomes and less conflict of interests.

There are groups operating in Queensland claiming to provide a franchise network, but there are valid questions as to where the proprietary and beneficial interests lie. They report to the Australian Stock Exchange about progress of their pharmacy expansion. It is a legitimate question to ask: are these franchisees actually salaried employees of this corporation and not bona fide proprietors as intended under the act? That is the question: have existing employees been used as pharmacist proxies to institute and operate a corporate model?

I run pharmacies under several franchises and brands and have never been an employee of a franchisor. They also claim to be running a franchise model or providing funding like a bank, but my bank lender has never directed me on product range, price, hiring or firing staff, payroll, paying the bills, record keeping or anything like that. They leave it all up to me. My concern is that under such arrangements all of the proprietary interest and control and the risk with this model is being held by the corporate franchisor, not the employee proxies who are pharmacists—a corporate who under

corporations law is obligated to put shareholders' financial interests first versus a health practitioner who is professionally obligated to put the health interests of their patients first. This is very dangerous for Queensland patients and their health outcomes. A pharmacy council would provide industry expertise to probe and test these ownership models to ensure their compliance with the act. Queensland is the only state without this level of governance.

To ensure cost-effectiveness, the majority of this would be industry funded, with the government contributing no more than the existing budget that is allocated to Queensland Health for this exercise. The balance would be covered by an annual licensing fee to ensure that each year these pharmacies satisfy the requirements of the act. Other areas a council would govern would be premises legislation as well as environmental health requirements and fulfilment of scope of practice.

The environmental health aspect is a very interesting one. Queensland Health did that as a centralised unit up until probably two years ago. Since then they decentralised it to the health and hospital services, which are a part of Queensland Health but decentralised. Until that happened, I and my colleagues did not have a review from the health department for about eight to 10 years. How is that in keeping with public safety? I would question that. Since the health and hospital services have taken this over in a decentralised approach, there has been some incongruous reading of the rules. This has led to some confusion between jurisdictions of the health and hospital services. I thank the committee for listening and I welcome questions.

CHAIR: Thank you very much, Chris, for your opening statement. I noted a couple of points there, particularly around the establishment of a council. You fundamentally said that the department is not performing its role in the way it is regulating ownership.

Mr Owen: I think they are under-resourced.

CHAIR: I am going to play devil's advocate here. When you say 'I think', what evidence do you have to say that they are not performing the role?

Mr Owen: Given the evidence of the approvals that have come out recently, it is my belief that we need a pharmacy council to be able to test whether they actually comply with the act. As far as I know, I do not think they would have the requirements to pass a pharmacy council's rigorous investigation of the model.

CHAIR: Have you read the Queensland Productivity Commission report?

Mr Owen: I have, and I did note that some of their assumptions may be challenged. I did note that the probity that they were putting into that council would not be at the same level that I would suggest would be required to adequately investigate these models.

CHAIR: There was a cost in the QPC report of \$7.7 million and \$11 million—there were a couple of models there—over 10 years.

Mr Owen: I broke that down. I do not know how much of the Queensland Health budget currently goes into this area, but for the 1,100 pharmacies in Queensland you would be looking at somewhere between \$650 and \$700 per pharmacy per year which I think is a quite reasonable expectation to ensure that the legislation is being upheld.

CHAIR: Do you think the council's role, if one were established, should look at ownership regulation?

Mr Owen: Most definitely.

CHAIR: What about all scope of practice?

Mr Owen: Most definitely.

CHAIR: Some submitters would say that the Pharmacy Board of Australia already has that role and the academia—

Mr Owen: The scope of practice role?

CHAIR: Yes.

Mr Owen: How the health department works currently is that I think it needs to have a body—Queensland is the only state without a body—to be able to provide independent evidence on those scope of practice issues. If you have, for example, Adnan's opioid replacement program, the only person who can give that evidence is directly to the health minister, as you have done—whereas with things of another nature such as medication continuance and simple UTIs, I think you need to go through a council. They can provide an independent analysis of that to the minister so that you are not relying on individual submitters as it exists in other states.

CHAIR: You can see the benefits of having an oversight committee that would tag into some of these things?

Mr Owen: Absolutely, yes.

CHAIR: In your opening statement you mentioned 'dangerous to patients'. I will get you to repeat that if you can find it. Can you cite better outcomes of having a pharmacy council established in other states compared to that? Whether you need to refer back to that or not, it does not matter.

Mr Owen: Sorry, what was the question?

CHAIR: I was wondering if you can unpack your comment 'dangerous to patients'.

Mr Owen: In my belief, and all through my opening statement, it is all about the corporates for the beneficial interests of the shareholder. They can issue directives. I will use the case in the UK of Boots pharmacy. They instituted some KPIs for their pharmacists. There was a case of a pharmacist who got severe depression and committed suicide. I think I included that in my submission.

CHAIR: Yes, you did. I remember the Boots case.

Mr Owen: This is the case where there is such huge pressure on these pharmacists that from a corporate level they are doing things that are not in the interests of the patient; they are in the interests of the corporate. At the end of the day they say, 'We pay the bills and you either do it or you don't have a job.' I think that is a dangerous path to trek. If you are not putting Queensland patients' health first then it should not even be considered.

CHAIR: Can you cite any evidence of better health outcomes of having a pharmacy council in other states?

Mr Owen: Without having any other jurisdictions that have anything opposed to pharmacist owned pharmacies then no, because I do not believe there is any evidence in Australia.

Mr BERKMAN: I want to start this line of questioning by putting out there that I sympathise with the inherent tension between corporatised health delivery and other more public delivery models. I want to go to the point you have made in your submission about the intent of the PBOA not being upheld. As I understand your position, that intent is the immediate hands-on engagement of a pharmacist owner like your own circumstance, for example, where you have two pharmacies. You can very easily engage with those two businesses in a direct way.

Mr Owen: Yes.

Mr BERKMAN: If that is the clear intent in your mind, the current arrangement does not necessarily seem to do that anyway, given that a single pharmacy owner is able to own close to 30 pharmacies across the country. It strikes me that a single pharmacist cannot have that kind of direct hands-on engagement with that many pharmacies nationwide. That kind of very large network of pharmaceutical ownership strikes me as being not necessarily terribly different from the sorts of arrangements that are in place under franchises.

Mr Owen: I think I understand where you are coming from. The difference between the corporate and the pharmacist owner at that particular level is his personal registration. He is directive to his pharmacist. He is directly responsible for any adverse clinical outcomes that happen in any 30 of those pharmacies. There are probably only a couple of groups in Australia that do operate in every state. I think you had at least two of them give evidence earlier this week. As I said, they are pharmacists. They do understand what their practitioners are going through. They do understand that if they give a directive it is their personal liability if they have any adverse effects, whereas as a corporate they sit behind a corporate veil. It is a limited liability company. You are only responsible to your shareholders. If they see it as a cost of doing business, then so be it. If it is a monetary fine, which is all you can do for a corporation—you could deregister some directors but they will probably get some new ones in.

Treading the corporate model is a very dangerous path. It could have unintended consequences. Other jurisdictions, such as America, have a very vertically integrated system. I understand that their public insurance works extremely differently to ours but they have a very vertically integrated system. It does not allow for individual practitioners to practise; they just get told what to do. For me, that does not ring true.

Mr BERKMAN: The distinction ultimately, if we get to the nub of it, is the personal liability—the consequences effectively falling to the single owner as opposed to a corporate franchisor.

Mr Owen: Absolutely.

Mr BERKMAN: In real terms, though, going back to the question of the intent of the PBOA versus the strict legal requirements, there will be a variety of legal opinion on all manner of things including whether or not certain recent transactions meet those legislative benchmarks around pecuniary and proprietary interests.

Mr Owen: Yes.

Mr BERKMAN: Again, I am looking to dig into actual evidence of health outcomes. What is the committee supposed to look to in terms of the on-the-ground health outcomes and how they are differentiated between the franchise models that are of concern more recently and what you say should have been the outcome of these ownership transfers?

Mr Owen: As I said, I can only give anecdotal evidence about the quality of care that you receive in a franchise model. Without going out on a limb, there are probably a couple that are operating as a corporate. To that I say that just because you do not get caught speeding does not mean it is not illegal. I think you need to be able to drill down. I think every pharmacist in Australia is AHPRA registered. They do have a requirement—they do need to meet a certain level. Whether that goes through a franchise model or an individual owner—I only have anecdotal evidence that they provide worse care. There is no document that I can point to.

At the end of the day, they are still a registered pharmacist so there is still a minimum requirement that they do need to meet. That being said, it is the ownership legislation that gives them the directives. For example, I pack Webster packs. I work in the valley and I do have a fair number of lower socio-economic customers. Last week a patient came to me and said, 'I don't have any money. Can you pack my medication but I cannot pay you until next week?' I do not know any Coles or Woolworths or any company like that who would allow you to take your milk and come back and pay for it next week, but I do that because I see the patient benefit. That is a personal experience that I have that may not exist in an otherwise corporatised world.

CHAIR: Is the anecdotal evidence that you were talking about from your experience at Boots in the UK?

Mr Owen: No. That is purely from Australia. I have never worked in the UK.

CHAIR: Sorry. I thought I saw that reference in your submission.

Mr Owen: No. The Boots reference was in my submission but that is a website link that I came across. It was from Pharmacists' Support Service, which is a depression type support network. That was where I saw that. I thought it was quite interesting to see the pressures of a corporate model and how they place pressure on their employees.

CHAIR: You have not worked under a corporate model, just your own?

Mr Owen: Correct.

CHAIR: I just wanted to clarify that. We are reading literally hundreds of submissions.

Mr Owen: I understand.

Ms PEASE: In terms of pharmacy ownership, I understand that the number of pharmacies individuals can own is up to five?

Mr Owen: In Queensland, correct.

Ms PEASE: I note that you have one in the valley and one up here at Highfields.

Mr Owen: Yes.

Ms PEASE: How do you spread your time?

Mr Owen: A general week for me is Monday and Tuesday in the valley, Wednesday I set aside for meetings, and Thursday and Friday in my Highfields store. I have store managers in both who are both well-paid pharmacists. I provide them with business guidance, clinical guidance or any assistance that I can give.

Ms PEASE: We talk about how important community pharmacists are to our community and how they play an integral role in providing alternative health care to people who may not be able to access it. If you have five pharmacies spread around all of Queensland, how are you as the person who owns those five licences able to ensure that is actually happening, that you are providing the best possible health care for your community?

Mr Owen: I suppose it is all in the systems. Whenever you talk about scale, you talk about systems. The benefits of having a franchise—for example, I have a Discount Drug Store and a Terry White Chemmart franchise. It is about putting those systems in place so that it takes the day-to-day responsibility of running those stores from an operational level away from people, from pharmacists. If you can concentrate on giving your direction to those pharmacists from day to day, I think that is the most important thing. At the end of the day, if I hold the licence I am responsible for what happens and everything in that store, whether I am there or not. There have been cases of pharmacy boards where there have been issues and then the pharmacist owner is the one who has been responsible for it because they have not given a directive. If you look at it in the negative, nothing is a problem until something goes wrong.

I would hazard a guess that five is probably the right number. If you go anything beyond five, I think it becomes difficult to have that personal responsibility. For example, I grew up in Toowoomba. I have been here since I was 12 and I still come back every week. Whether you have a pharmacy in Toowoomba, Charleville or Cairns, they are all accessible within a day. I am not saying you need to go to them every week if you have five. I certainly suggest that, if I were to do it, I would spend a couple of days in each place.

Ms PEASE: If you did have pharmacies dotted all over Queensland, how often do you think it would be appropriate to visit them?

Mr Owen: This is an extreme example: Brisbane, Charleville, Cairns—three pharmacies. We will make it even worse: we will go five, two in each rural place. I think if I had two pharmacies in Charleville I would spend a week out there, and if I had two in Cairns I would spend a week there and then I would spend a week back in Brisbane. At least once every three weeks to once a month would be a regular contact for me.

Ms PEASE: Thank you. I know that is very hypothetical. I am just trying to get an understanding around that ownership spread over the state. Geographically, Queensland is such a big state.

Mr Owen: I think you would need to do two or three days a month across each store. I think that is effective control, given you have the correct systems in place and you can have access and give directives to your employee pharmacists.

Mr HUNT: Given your submissions around suspicions that the act has been breached in terms of ownership under a franchise model and your comments about your own Terry White franchise model, can you unpack for us a little bit what you see as the differences in terms of having a franchise and the franchises that you believe might be breaching the act?

Mr Owen: A corporate franchise versus a non-corporate franchise?

Mr HUNT: I want to understand where you think this has been breached, where you have suspicions around the franchise model that is breaching the act.

Mr Owen: As it stands at the moment, I have suspicions and it is what I am led to believe, judging from my own experience in a legal circle. No-one has breached the act as yet. That being said, if you put an independent council in place with proper probity, industry knowledge and resourcing, you might get a different result.

I believe that a true franchisee is someone who is independent of the true franchisor. For me I am still responsible—I noted that one of the earlier submitters said that they have different units, payroll and ranging and that you can take them optionally. I would hazard a guess that no-one is not taking up everything in those models, whereas I have the ability to say, 'No, I do not know want that. No, I do not want that.' It is called third-line forcing. If they say to me, 'You must take this,' I say, 'No, that is third-line forcing. You can't force another business onto me.' I can choose what I need to take. The key to that question is: am I in control from the financial or control point of view? Yes, that is the difference in the franchises. Discount Drug Store, Terry White Chemmart, Amcal, Guardian—with all these pharmacies you have the control and you can take on as much or as little of the franchise as you want.

Mr O'ROURKE: What would you see being the make-up of the pharmaceutical board?

Mr Owen: The council?

Mr O'ROURKE: Yes, that council.

Mr Owen: At the very least an independent chair. I suspect you would need a pharmacy industry capable accountant to understand the models and a pharmacy industry lawyer. Then I think you would have some people from the general public and consumer groups and also you would have pharmacists, preferably retired, who have some knowledge of the industry. I do not think you would need any more than seven to 10 people.

Mr McARDLE: Thank you for being here today, for your testimony and your submission. I have to say that you started very strongly, with a very strong statement in relation to the act not being complied with by a certain type of corporate franchise arrangement. Is it true that this is simply hearsay; there is no real evidence?

Mr Owen: The only evidence they have is they have currently passed the ownership act as it has been regulated by Queensland Health. As I said before, just because you are not caught speeding does not mean you are not breaking the law.

Mr McARDLE: You have made the comment that the act has been breached. This committee can only act on evidence before it. It is important that if you do have that evidence you table it or you indicate that this is what you heard—and that is fine—that you believe that is the case. But you cannot table documentation or other documents of any sort to substantiate the claim?

Mr Owen: I do not have access to the franchise documents of these companies.

Mr McARDLE: That is fine.

Mr Owen: What I was going to continue to say is that Queensland Health does. I believe that if the probity is required—and as a parliamentary committee you could probably have access to those documents. You would be in a better position to tell me whether or not they breached the act. All I can say is what I know and what I have been led to believe.

Mr McARDLE: Thank you, I think that is right: what you have been led to believe. I accept that, by the way, too. I have no qualms about your absolute faith in that statement. You also made the comment that the corporate franchise arrangement is a dangerous arrangement. Again, let's go back to that arrangement as opposed to your arrangement. In all of those stores there is a highly qualified pharmacist operating, isn't there?

Mr Owen: Yes, there is.

Mr McARDLE: There has to be, otherwise they cannot prescribe.

Mr Owen: They are not prescribing; they are dispensing.

Mr McARDLE: They cannot issue; exactly. Is there any evidence that you can point to that there are worse outcomes from the corporate franchise model than your franchise model in relation to the health of Queenslanders?

Mr Owen: Beyond anecdotal evidence, no. The only reason I will say anecdotally is that the people who are employed in those corporate models, and judging by overseas experience—because we do not have any corporate models in Queensland apparently, or Australia for that matter. All I can give you is overseas inferences where the health of those patients is directly impacted by how happy a worker is to work for those people. I am not saying that they are going to be better or worse in terms of health outcomes, but I know that if you are working in a workplace where your KPIs are set and you are downtrodden and do not feel as though you are being valued by your employer—

Mr McARDLE: Is that happening here?

Mr Owen: Possibly.

Mr McARDLE: If a council is established, you want them to have the power of registration, I take it?

Mr Owen: The power to ensure the intent of the Pharmacy Business Ownership Act, the premises legislation, yes.

Mr McARDLE: If that is not complied with, that model or that individual will not be allowed to practise?

Mr Owen: I believe yes in—

Mr McARDLE: That is your—

Mr Owen:—the long term, yes; I believe they should be given a period of time to comply with the act. It will not be an overnight thing where you put your application in, you pay your fee and then they say, 'You're not compliant. Tomorrow you can't practise.' You obviously have to give them a period of time if they do not comply so they will be able to comply. I suspect they would not say, 'You don't comply today, but we need to ask for more evidence about why.' You need to prove to me that you do comply, not the other way around.

Mr McARDLE: In your mind, there is a corporate franchise model in Queensland that does not comply with the act at this point?

Mr Owen: I would say—

Mr McARDLE: Do not mention a name, just a yes or no. I am not asking you to go into details.

Mr Owen: As I am led to believe yes.

Mr McARDLE: Would that particular franchise model be a target?

Mr Owen: Target for what?

Mr McARDLE: Of the council in relation to registration?

Mr Owen: I think everyone is a target.

Mr McARDLE: The business ownership act as it stands has ticked off even that particular body that is not named but is referred to as complying with the act. Even though that had taken place, you would then require every pharmacist to go back and re-register with you, or just that?

Mr Owen: Everybody. I think you need an annual licensing requirement. If you sign a statutory declaration saying that you comply with this act, all the other premises legislation, the environmental health legislation—you comply with everything that is required in the state of Queensland—then everyone should be doing that every year.

Mr McARDLE: You also said that in a legal sense no-one has breached the act as yet.

Mr Owen: Correct.

Mr McARDLE: I am concerned about this—and with respect to you, Chris, I am not talking to you, per se. I am just concerned that, though the motivation is good, though the desire is good, I am picking up a sense of extreme hostility—not from you—that could translate into significant interference, negative outcomes and problems moving forward.

Mr Owen: With what?

Mr McARDLE: With regard to registration processes.

Mr Owen: If it is an independent pharmacy council there should not be any outside influence. As I understand it, the pharmacy council is to be independent of everybody.

Mr McARDLE: Who would be on it?

Mr Owen: As I said—I have already been asked the question—I suggest an independent chair, an industry—

Mr McARDLE: An independent chair? Not a pharmacist?

Mr Owen: Not a pharmacist, no. It could be a doctor, lawyer, GP—you name it. It could be you. We do not know.

Mr McARDLE: I do not think so, Chris!

Mr Owen: Maybe once you have finished—

Mr McARDLE: I know too many pharmacists.

Mr Owen: An independent chair and probably a lawyer.

Mr McARDLE: A lawyer? I like the idea!

Mr Owen: Then I would have someone who has industry expertise—an accountant and a lawyer who have that expertise. I would have some consumer groups in terms of general patients and I would also have pharmacists who are probably retired but do know the industry and do know the structures that are in place at the moment.

Mr McARDLE: You would want to unravel current approvals through the current act?

Mr Owen: We are not unravelling anything. Everyone needs to apply to make sure they meet the law every year.

Mr McARDLE: If they produced a document that gave a registration right as at 1 July 2019—that was given under the act earlier than that—you would not accept that necessarily?

Mr Owen: No, as I understand it, my licensing requirement would be that as of 1 July 2019 I comply with every piece of relevant legislation under Queensland law. I would do that again on 1 July 2020 and 1 July 2021—I comply every year. That is what I would do. You are not retrospectively taking away approval.

Mr McARDLE: Yes, you are.

Mr Owen: How?

Mr McARDLE: Because what you are saying is, 'I will accept it to a point. That already has been approved, but now I am going to ask you, despite the approval, to approve it again.'

Mr Owen: Everyone will be approving it again; it is an annual licensing requirement. You meet current legislation. Why would everyone who is not meeting the legislation have an issue with it?

Mr McARDLE: It is not a question—

Mr Owen: That is rhetorical, by the way.

Mr McARDLE: I accept that. It should be, by the way, too. I have a real concern that you would argue the point that, despite registration having been approved by a body, you would want to start that process over again, as opposed to new entrants.

Mr Owen: I am not picking up what you are trying to say.

Mr McARDLE: On 1 July 2019 and 2 July 2019, I am the pharmacist and I buy from Aaron. That is a new one. I see that is a process. That is right; you should look at that. I am concerned about retrospectively saying that up until 1 July 2019 pharmacy A was valid by law in this state and you are now saying, 'That no longer applies and we are going to make you jump through the hoops again.' That is what I am concerned about.

Mr Owen: At all times you should be compliant with Queensland law.

Mr McARDLE: But you are.

Mr Owen: As it stands—

Mr McARDLE: You are, because the act says so. You are saying, 'No, that's not good enough.' Is that what you are saying?

Mr Owen: I am saying that you should always comply—

Mr McARDLE: Are you saying that the current act is not good enough and you do not want to start all over again?

Mr Owen: I am saying that you should always comply with Queensland law.

Mr McARDLE: Thank you.

CHAIR: Thank you very much, Chris. I think we have run out of time.

Mr McARDLE: I enjoyed it, by the way, Chris.

CHAIR: You could tell that!

Mr Owen: Thank you for your time. I appreciate it.

WALKER, Ms Lucy, TerryWhite Chemmart, Goondiwindi

CHAIR: Can I start by thanking you on the record for coming all the way from Goondiwindi. To clarify, it was you who worked for Boots the Chemist. I commend you on your submission, which talks about collaboration, contributing and caring. I was really taken with the work you have done in your pharmacy, particularly the mental first aid training and the involvement in the beyondblue bash. I commend you for that. I have never been to Goondiwindi, but I have worked in some small rural towns in my previous career and I know the importance of collaboration and working together. With that, I welcome you here. As our final witness for the day, I ask you to make a brief opening statement before we go to questions.

Ms Walker: Thank you for giving me the opportunity to speak today. I would like to pay my respects to the traditional owners of the land on which we meet. My name is Lucy Walker and for the past seven years I have owned a pharmacy in Goondiwindi. Gundy is a 2½-hour drive west of here on the New South Wales-Queensland border. It has a population of about 6,000 people and is agriculturally based, though we also try to be a health hub for the region.

I have been watching the review with great interest, as I really love being a pharmacist and I care about the future of my profession. I have invested heavily in my pharmacy, from an automatic dispensing robot and a renovation to include two private consult rooms to having at least two pharmacists rostered on at any one time to ensure we can deliver the best health outcomes for my community.

Medicines are our speciality, from blister packs to staged supply and meds checks. We actively counsel our patients on their medications and provide additional services only if needed. I stock a wide range of medicines which may not all be profitable and have a high investment in stock to ensure that my patients can access their medicines in a timely manner.

In our consult rooms we have conducted over 800 flu vaccinations this year as well as many blood pressure checks, blood glucose and cholesterol levels. We have helped people lose weight, speak to their specialist via Skype and treat sleep apnoea with CPAP devices. I am an accredited pharmacist so I conduct Home Medicines Reviews. I work with the local GPs to educate our patients and help decipher what is happening in the home and then I make recommendations back to our GPs.

At our local nursing home I conduct quality use of medicine education sessions to our nurses on topics like minimising the use of antipsychotics in managing behavioural problems in dementia patients. My staff deliver medication to those in need for free, and out of hours the hospital, doctors, nursing home or optometrist will call my mobile so I can open up the pharmacy to access medications in need.

Our region is in drought so we have found our mental health first aid training has been utilised often, as we are having some pretty difficult conversations with our patients and we can refer them to care within our community. Our pharmacists set up the 'farmacist' model, to ensure we can direct our drought-affected patients to the financial and social services available. We have found patients unable to afford their medications so I personally help subsidise the cost with the farmacist account.

We work with our primary health networks in Aboriginal health services to provide free blister packs and medical devices to our Aboriginal patients. I am not aware of any big box discounters operating in a country pharmacy probably because I have to pay my pharmacist very well to work rurally and dropping the price does not always increase the volume sold because we have a finite population.

Our customers in Goondiwindi do want the lowest price possible with the best service, so I price-match and I offer the \$1 discount, which comes straight out of our bottom line, but I have direct competition too. There is another pharmacy right across the road from me.

I have an awesome team of pharmacists. I recruit early by speaking to uni students and trying to encourage them to go out west and I retain them by offering continuing education and a great professional working environment. I love my pharmacy assistants. Most have completed or are undertaking their cert III or IV in community pharmacy with the Pharmacy Guild. Please remember that many of my staff are part-time working mums juggling a lot and I am a small, rurally based business. They will need assistance to undertake further studies but they are really worth it.

My pharmacy and the people in it are an integral part of the Goondiwindi healthcare team. We are well trained, available and free—and appreciated too. Just yesterday I got flowers from a customer. The optometrist was away and he was suffering dry eyes and allergy eyes to the point where he was ready to hand in his licence, which is a big call when you live in the tiny settlement of

Yelarbon, which really does not have any services. I rang his wife to say thanks for the flowers and she said she could not believe how much better his eyes were and how he could do what he needed to do.

There are so many stories. A lady came into the pharmacy late on a Friday afternoon with symptoms of a UTI. I referred her up to the hospital straightaway but she could not go because she had her kids with her and it can take up to four hours to be seen. I told her to call the medical centre the next morning and get one of the emergency appointments. She didn't because she could not afford the \$40 out-of-pocket expense to see a doctor on a Saturday morning. She did go to the hospital when it got so bad on Sunday afternoon that she required oxycodone, a strong pain reliever, and she was diagnosed with a kidney infection. She was also required to go to the hospital again a few days later. I wonder what would have happened if I was able to supply her three days of Trimethoprim on that Friday afternoon to treat her UTI.

Our community will come to us first about minor ailments like a rash or thrush. We act as a triage service, as it can take up to two weeks to see your GP and they do not want to waste the hospital's time or their own unnecessarily. This brings me to my concern that the Queensland drugs and poison regulation's three-day emergency supply is not sufficient to ensure continuous supply of essential medications to my patients or the grey nomads who pass through my town. Farming families usually visit town once a week or fortnightly. It is becoming less often as the drought hits and fuel costs really add up. Say they run out of their antidepressant. To get a script that day they would need to go up to the hospital, and they do not want to clog up the system. They also like seeing their GP who they have a special relationship with. Continuity of care is important to the patient as well. Allowing a PBS quantity of the prescription would give the patients and the healthcare system in Goondiwindi the best outcome for all.

We work well together, and quite often socialise, with the other health professionals in town. We communicate, we attend local continuing education and we use technology like My Health Record to further assist us. The code of ethics of the pharmacist revolves around competency, integrity and care. Patients benefit from pharmacists owning pharmacies as our focus is care, not profit. The motto in my store is 'we care for ourselves, each other, our customers and our community'. Our customers in a rural community want to shop in a locally owned business because profits stay local and we utilise other local businesses like the local accountant, lawyers, printers and builders. They also know if there is a problem I am personally accountable for it. My house and livelihood are on the line and I will assist them in any way needed.

As a young pharmacist I worked in the UK for Boots the Chemist. While there were some positives in advance practices like initiating cholesterol-lowering medications and travel medicines, there were some negatives. Direction came from head office and the focus was on sales—three items for the price of two and sandwich deals. The focus was not on the health care of the patient.

Without a pharmacy council there is little requirement for a pharmacy to have particular standards in place for their premises—from the basics like having the pharmacist owner's name on the front door to what a consult room should look like. The Queensland Productivity Commission report highlighted some unpublished data from Queensland Health. Queensland Health inspected just 161 pharmacies last year. At that rate, a pharmacy would be seen every 7.3 years. Worse, the rate of compliance of those audits was only 41.8 per cent. In South Australia, where there is a Pharmacy Regulation Authority, published compliance data was 84 per cent. We need to raise the bar when it comes to minimum standards in Queensland pharmacies. A chain is no stronger than its weakest link and the 1,140 pharmacies distributed widely across Queensland can really help reduce the burden of chronic disease in our ageing population. We just need a more robust and transparent framework to apply it in practice. Please feel free to ask me any questions.

CHAIR: Thank you very much, Lucy, for your thoughtful and considered opening statement. Where did you do your training?

Ms Walker: I studied at UQ, so in Brisbane. I am a Brisbane girl. I did not grow up in the country, and I think that has been a positive because my expectation is that we should have really good health care. When you grow up in an area that does not have good health care, a lot of the locals do not realise what they are missing out on. When I moved out there I thought, 'They don't have this; they don't have that.' As a local business owner I can see there is a need and I can meet the need.

CHAIR: How long did you work in the UK with Boots?

Ms Walker: After managing a store in Brisbane I took two years off. I worked in the UK for Boots for almost a year. Then I did some locuming in hospitals in the UK and worked in Canada as a dispense tech for a bit and did a ski season. It was great to open your eyes to the world.

There are a lot of great things that are happening overseas in pharmacies. The PSA has said that Australian pharmacies are one of the most unusual pharmacies in the world. I have been doing a little bit of research because I was trying to get a Winston Churchill scholarship to travel around the world and see other practices around the place because my experience was almost 15 years ago.

CHAIR: That is quite a diverse range of experience that you have.

Ms Walker: Yes. I also used to work for Queensland Health at the PA Hospital.

CHAIR: You must have started when you were two!

Ms Walker: There is one more thing I did: I did education. I worked for the National Prescribing Service doing academic detailing and for the Medication Safety Unit doing education to nurses, so I have a breadth of experience. As part of the Health Workforce Queensland I used to visit all the rural areas around Goondiwindi.

CHAIR: We put to the AMA and some other submitters we had in front of us the other day that the UK has had 25 years of expanded scope of practice, and you would have experienced that.

Ms Walker: I walked into a UK pharmacy. I did do one month where I worked under supervision to another pharmacist, but there were no problems at all with me taking over those roles. I did not feel that it was beyond my capabilities. With the training we have had, there is so much more we could do. This is a great opportunity to say that pharmacies and pharmacists want to do more, so please help us.

CHAIR: You talked about the three-day emergency supply and used the UTI experience, and that was quite well articulated. With the three-day emergency supply, do you have a recommendation that it should be expanded to?

Ms Walker: I suppose doctors and pharmacists all use the same guidelines for treatment. We know the therapeutic guidelines of Australia—that is what we are trained on—and we know the protocols that are in place. All we want to be able to do is, if needed, help out in that environment.

Mr HUNT: Thank you so much for coming out today. It is really important on a couple of fronts.

Ms Walker: I would not miss it. Thank you for coming to Toowoomba. It is not really regional to me.

Mr HUNT: We are getting that regional perspective, which is fantastic.

CHAIR: You will get that in North Queensland.

Mr HUNT: I am looking forward to that too. We have had a lot of assertions about a corporate model leading to worse healthcare outcomes. You have the distinct experience in that space, because rather than just saying, 'We think this would be worse,' you have actually been in that situation and are able to give us direct evidence of that. Do you have any examples where the profit driven model that you were asserting did lead to worse healthcare outcomes for any particular person?

Ms Walker: There was a problem in Boots chemist when I was there. They were doing a big lead-up where they were looking at cholesterol-lowering medication. We had just been given the ability to hand out Simvastatin. The big KPI at the time was to check everyone's blood cholesterol levels and if appropriate start on Simvastatin. That is a good, noble thing to do, but that was the focus and the only focus because that is how they could make money for the patient. Instead of saying, 'Is Simvastatin the correct medication for this person? Will you be referring them back to the doctor? How are you going to collaborate? If they have high cholesterol, do they have other concerns that we need to look into?' the only point was getting as many people as possible on to this medication and keeping them on that—not looking at the overall picture and the wellbeing of the patient.

Mr HUNT: More specifically, do you have any examples where a health outcome was worse for a person because of the corporate model or the profit driven model that you are talking about? Do you have a specific example where there was a worse health outcome?

Ms Walker: Not that I can think of as a specific example.

Mr HUNT: On to ownership in general, there are other areas of health care that do not have ownership requirements. You do not have to be a radiologist to own a radiology. You do not have to be a pathologist to own a pathology. What is different about pharmacies in that respect in terms of health care and better outcomes for patients?

Ms Walker: I think we focus on the need of the community and the patient over profit. On a daily basis, like Chris said, we give out medication for free because they cannot afford it. When it looks like there is going to be a big flu season, we just buy in Tamiflu so we can give the stock to the patients who need it. We do not necessarily think of how much this is going to cost me to have this stock wait. It is actually, 'How can we help our community the best?'

CHAIR: How did you measure the cholesterol levels in the UK?

Ms Walker: The same way we now do it 10 years later in Australia, which is with devices, a blood prick. It was only a total cholesterol level at that stage.

CHAIR: Is that similar to glucometry?

Ms Walker: Yes.

Mr O'ROURKE: Thank you, Lucy. I have been to Goondiwindi a couple of times. I do understand the challenges for small rural towns in the provision of health services. That leads me to the question around medical practitioners and medical associations not supporting extending a pharmacist's scope of practice. The main point of contention is whether pharmacists should be allowed to independently prescribe medication, as opposed to a collaborative or prescribing model. What are your thoughts around that, particularly thinking around a smaller regional town?

Ms Walker: When we introduced flu vaccinations into Goondiwindi, I went and met with the local GPs and said, 'We're going to be doing this.' There was a bit of pushback. They were concerned about how they would know who has had the flu shot. Also, that is quite often a job that the junior GPs they get out there do, so they were concerned about how they would keep businesspeople coming through. Then someone said, 'Realistically, don't we just want people to have the flu shot?' We had to just go back to what was going to be best for the patient, so we worked around it. We make sure that every time we give a flu shot we put it into the national immunisation register, which they have access to so they know what is going on. Trust me, you still cannot get into the doctors. They still have enough appointments for their junior doctors.

Mr O'ROURKE: Are there ever occasions when you cannot get a hold of the doctor to get authority to prescribe things as such in town?

Ms Walker: Yes.

Mr BERKMAN: Thank you for being here. I have also been to Gundy. I know how far it is. It is always a memorable experience at the Wobbly Boot.

Ms Walker: That is Boggabilla.

Mr BERKMAN: Sorry, it is just not fair, is it! I want to touch briefly on the issues around the opioid treatments we were discussing earlier with Mr Gauhar and Dr Whittaker. Given there are so few prescribers in this region, how would you operate that at your chemist? If you do not have anyone in Gundy or nearby who can prescribe, what functional difference would it make in the pharmacy?

Ms Walker: The Opioid Treatment Program is difficult in Goondiwindi. There are a few patients on it and it is hard to manage because of the difficulty in continuity of care. I actually used to dispense up at the hospital for it. I can see that there is a need. I think pharmacists should practise within their scope of interest and their knowledge. I have worked in pharmacies where we have done opioid substitution programs. You develop relationships with these people. You see them every day. You know what is going on in their lives. There is that consistency of care. We are the medicine experts. If anyone knows about opioids, knows about withdrawal and knows about how we are going to manage these patients, it is us.

Ms PEASE: I have also been to Goondiwindi. Obviously you are very much keeping abreast of the trends and the changing times and you are keeping up with technology. Can you tell me what a dispensing robot is?

Ms Walker: We actually call our dispensing robot Spencer the Dispenser. He is German made. It is probably 2½ metres by five metres, right up to the roof. It can handle at least two or three weeks of stock in there. It automatically loads the medication, so I just throw the box of medication in and it sorts it away. We have three dispensing areas. If you walk into my pharmacy you come straight up to me, I scan your script and then right behind me pops the medication. During that process I can speak to you directly. I am not going out the back trying to find something. There is no barrier between me and the patient.

I did not lose a staff member; I have just gained more staff members. What I love about automation is that they are doing the jobs that we do not want to do. Spencer the Dispenser actually cleans the shelves for me. He does the stock management to the point of looking at expiry dates. We do not have to do a stock count because it does it. The right drug has to come out because the barcode is there. We double-check everything obviously ourselves, but it means we can have those systems and processes in place so we are available to do the meds check or help the patient with the flu shot. It is just one of those things. A lot of pharmacies have robots these days.

Ms PEASE: Who in your pharmacy uses Spencer? Do all of your staff use it or just the pharmacists?

Ms Walker: My pharmacy assistants will load Spencer.

Ms PEASE: When you say 'load', what do you mean?

Ms Walker: They will just chuck the medication in there, or the pharmacist will.

Ms PEASE: I guess what I am trying to go to is scope of practice and the training of the staff who are involved. You have pharmacy technicians, pharmacists and then retail assistants. In my community pharmacy, if somebody walks in and hands the retail assistants the script, that goes out the back to Peter. In your instance, would the retail assistants just scan that and then Spencer would do all of the work?

Ms Walker: No. In my pharmacy I usually have at least two or three pharmacists on the floor, so you can walk in and give your script straight to them. If we are busy in conversations with our patients, there is a schedules wall where you can get your S2 and S3 medications and that is where I have all of my trained staff members, my pharmacy assistants. If I am busy, my pharmacy assistant will take that prescription. With the medications, all of my staff members who deal with any sort of medication will be at least a certificate III or undertaking a certificate III in pharmacy management. I have a couple of junior schoolgirls who might come and clean some shelves and put away front shop items but that is about it.

Mr McARDLE: Lucy, thank you for being here today. We have all made statements about Goondiwindi, so mine is, 'Where is it?' I do apologise: I have been to Goondiwindi and it is a lovely little town.

Ms Walker: It is the best regional town in Queensland, as the *Australian* says.

Mr McARDLE: You have a fairly unique perspective. Taking into account the fact that Chris is also regional, you are perhaps more regional, if I can use that term, than Chris is. You seem to have a very close working relationship with the doctors in Goondiwindi and there is a good reason for that. I imagine you might be one of very few pharmacists in Goondiwindi and, therefore, it is a very important element to have a strong bond between the doctor and the pharmacist. We do not get that in Caloundra because there are so many doctors and so many pharmacists. You would have a very strong, loyal client base and therefore you would know quite quickly their history in relation to their medications and the like. Again, we do not have that in Caloundra as strongly as you do. You mentioned the My Health Record. Would that play an important part in going forward in your capacity to assist a patient with ongoing treatment?

Ms Walker: You are absolutely correct. I know my patient, their mother, their sister, their kids. I will socialise with them at the school. I am part of the community. The My Health Record has potential. It really does. We got straight on board and signed up. It probably has more need for me when there is a grey nomad—we have a lot of them come through—so that I can access their records. It has always been easy for me to ring up the medical centre and say, 'Can you tell me more about X, Y and Z?' but the My Health Record is the platform for the future if it is someone we do not have that strong relationship with. There are two pharmacies in town. People are pretty loyal to one or the other, and I have good history from them.

Mr McARDLE: Also I take it the doctors and you speak on a professional basis regarding your clients?

Ms Walker: Absolutely.

Mr McARDLE: That may not take place in Caloundra or Brisbane or other major areas.

Ms Walker: I think it happens everywhere. I really do. I would not say that just because I am in a country area we have a better relationship, but I must admit that tonight is the start of the Goondiwindi Medical Muster and I will be there with them.

Mr McARDLE: Say hello to them from us. The reason I say that is: is it easier to enlarge the scope of practice in a regional area given your intimate knowledge of patients and the volume, as opposed to a place like mine in Caloundra? My concern is that if you really do not know the patient all that well—and I am certain that the guild will tell me that they take every step to ensure that they do—to me it seems a simpler or a less complex process for you than it would be in a major area.

Ms Walker: That might be the case. As a pharmacist I worked in Brisbane. I managed a store there. We know our customers everywhere. Say with a flu shot, do you really care if you know the pharmacist injecting it or do you want to make sure that when you walk in and have your flu shot you

are in a premises that is suitable and the person who is giving it is well trained and is following the right protocols? Whether it is in a regional area or whether it is in a metropolitan area, I think that is where we can help everyone.

Mr McARDLE: You would say it is a fairly level playing field?

Ms Walker: Yes.

Mr McARDLE: You mentioned the three-day supply. Is that a Commonwealth government matter or is it a state government matter?

Ms Walker: It is an interesting thing. We can currently continue dispensing contraceptive pills and cholesterol-lowering medications for one month. What is interesting is that when that went national Queensland was very slow in passing the legislation so that we could do it in our state. You have heard evidence already about how they are looking nationally at pharmacists having some sort of—I will not say prescribing, but continue dispensing and that sort of thing. We need to have it set up so that once those processes have happened correctly or we want to do trials with people like Lisa Nissen it can become law.

CHAIR: Just to clarify, that was the contraceptive pill and cholesterol management?

Ms Walker: Yes, cholesterol-lowering medications.

CHAIR: That you can now dispense?

Ms Walker: Can currently do.

CHAIR: That was slowed by legislation.

Ms Walker: Yes, here.

CHAIR: I will not ask which year in case it falls back to our side!

Mr McARDLE: You also answered a couple of questions from my colleague the member for Maiwar, and you supported the operation proposed by Adnan and Dr Whittaker about opiates; is that right?

Ms Walker: Yes.

Mr McARDLE: Would you mind, when we do write to the health minister, if we gave him your name and number as well as a supporter of that principle?

Ms Walker: I am for anything that advances and helps patients. I do not know the proposal in detail, but I am always happy to give my perspective from what happens in a regional area.

Mr McARDLE: That would be quite good, actually.

CHAIR: That brings the hearing to a close. Thank you, Lucy, Adnan and Chris, for your contributions this morning. All were welcomed. I think I can safely say on behalf of the entire committee that we have gained quite a bit from today's hearings. I thank Hansard. None of this happens without our secretariat staff. Rob Hansen and Rod Bogaards are doing an enormous amount of work back in the parliament collating the information. I want to say thanks to everyone involved.

The committee adjourned at 12.35 pm.