C O R R E C T E D T R A N S C R I P T

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

LEGISLATION COMMITTEE

Inquiry into the role and opportunities for community pharmacy

Melbourne — 25 June 2014

Members

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Mr N. Elasmar	Mrs A. Millar
Mr A. Elsbury	Mr D. R. J. O'Brien
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Substituted members

Mr S. Leane for Mr Viney

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Participating members

Mrs I. Peulich

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Witnesses

Mr S. Goma, professional services manager, and

Mr A. Tassone, Victorian president, Pharmacy Guild of Australia.

Necessary corrections to be notified to secretary of committee

The CHAIR — Good evening, everybody. I declare open the Legal and Social Issues Legislation Committee public hearing. Tonight's hearing is in relation to the inquiry into the role and opportunities for community pharmacy in primary and preventive care in Victoria. I welcome Mr Stan Goma, professional services manager, and Mr Anthony Tassone, Victorian president of the Pharmacy Guild. Thank you both very much for coming before us this evening. We appreciate your time.

All evidence taken at this hearing is protected by parliamentary privilege. Therefore you are protected against any action for what you say here today, but if you go outside and repeat the same things, those comments may not be protected by this privilege. Tonight's evidence is being recorded. You will be provided with proof versions of the transcript within the next week. The transcripts will ultimately be made public and posted on the committee's website. I invite you now to proceed with your presentation to committee members of around 10 minutes, which will then be followed by questions from committee members. Thank you again on behalf of the committee for coming before us.

Mr TASSONE — Thank you. On behalf of the Pharmacy Guild both Stan and I would like to thank you all for the opportunity to present to the committee regarding the inquiry into the potential roles and opportunities for community pharmacy in an expansion of its role in primary and preventive care.

Overheads shown.

Mr TASSONE — With regard to community pharmacy, I think it is important to take some time to quickly point out what community pharmacy is. Community pharmacies are located all across Australia and Victoria. There are approximately 1300 in Victoria and over 5000 across Australia. They are the traditional chemist shops that you may see in retail strips or in shopping centres, both large and small, or co-located in medical centres. Each and every community pharmacy is supervised by a registered pharmacist by law. Furthermore, each and every community pharmacy in Victoria is licensed by the Victorian Pharmacy Authority, which is a statutory body that reports to the health minister here in Victoria, and its mandate is to protect the public — that is its core purpose.

Part of the guidelines for the licensing of community pharmacies is that they all have a private and confidential counselling area, and some pharmacies actually expand this to even be a formal consulting room. This is a really important point for the public to be aware of in terms of pharmacies' capacity to take on these professional services or an expanded role that might need that extra care and confidentiality.

Pharmacists continually rank highly in terms of ethics and honesty in Roy Morgan surveys — they have never ranked below third and they are currently sitting at second — and a range of other credible studies have put pharmacists high in satisfaction ratings for the care that they provide and also the overall satisfaction for return visits.

What you basically have with a community pharmacy and the pharmacists who work within it is an accessible and highly trusted service with a high satisfaction rating from the public. Community pharmacy is actually the most frequented primary health-care destination across Australia. Last calendar year there were approximately 300 million patient visits to community pharmacies. Community pharmacy is the most frequented but also the most accessible primary health care destination in Australia.

With all that in mind we at the Pharmacy Guild strongly welcome the inquiry into community pharmacy and we feel it is very timely. Currently we feel that community pharmacists are potentially underutilised with regard to their skills and competency. There is a good workforce capacity to be able to take on extra roles and responsibilities to meet a community need. In a recent Health Workforce Australia report, *Pharmacists in Focus* of March 2014, it was found that there is not any undersupply or failure to meet demand in any metropolitan or rural or remote region across Victoria, and that cannot be said for all health professional groups. The point is that pharmacists have a great opportunity to reduce the burden across the broader health professional and health-care team.

From a state health-care perspective it is going to be a challenging time going forward, with the recent federal budget being handed down. There will be a strain on hospital health-care funding, and pharmacists can play a pivotal role in terms of not only being the most accessible and first port of call but also being able to prevent hospital admissions and prevent hospital readmissions after someone has been discharged. It is estimated that

approximately 2 to 3 per cent of all hospital admissions are associated with a medicine-related event, most of these being avoidable. This accounts for approximately 230 000 hospital admissions per year and $1.2 billion of estimated cost to the health-care system. This is from the Australian Commission on Safety and Quality in Health Care report from last year. This is up significantly from 2008, when it was 190 000 admissions and $660 million of estimated cost. The problem is getting worse, and pharmacy is here to play a role.

There are a few areas we would like to go through as part of this short presentation in terms of the potential roles and opportunities. The first is immunisation by pharmacists, focusing initially on adult influenza. The second is medication management services, and the third is screening and risk assessment. With regard to pharmacists carrying out immunisations, I would like to quickly let you know about the overseas experience. In overseas markets pharmacists are currently undertaking influenza vaccinations in the pharmacy setting. It has been happening in the USA since 1994, and since 2009 all 50 states of the USA have allowed pharmacists to conduct influenza vaccines. It is also happening in a number of other markets, including the UK, New Zealand and Canada. Due to the accessibility, high trustworthiness and competency of pharmacists, this has resulted in an increase in vaccine uptakes — so more of the population is being vaccinated — there is a decrease in overall illness, a decrease in absenteeism from work and a decrease in hospital and other health-care costs, and these are all providing a great benefit to the community.

The Pharmacy Board of Australia recently found that immunisations and vaccinations are within a pharmacist's competency, but there just needs to be some additional training and some appropriate guidelines put in place for pharmacists to abide by. The Pharmacy Board is the national regulator mandated to protect the public as well. It is not a bunch of pharmacists regulating other pharmacists out of self-interest; it is there to protect the public. That is an important endorsement from them as to what pharmacies and pharmacists are able to do. The current situation in Australia is that, prior to this year, there have been a range of nurse immuniser and nurse practitioner-led influenza clinics across Australia, and that has been happening for a few years now. There were over 16 000 people vaccinated across pharmacies run by the Terry White pharmacy group in 2013. The logical next step is for pharmacists to be able to do this.

In the current environment there is an immunisation trial being conducted in Queensland as a collaboration between the Queensland branches of the Pharmacy Guild of Australia and the Pharmaceutical Society of Australia, in conjunction with James Cook University and the Queensland University of Technology. Eighty pharmacies are participating in the Queensland immunisation trial, and over 10 000 adults have been immunised to date as part of that trial. Approximately 25 per cent of them have been walk-ins without an appointment; they have just come into the pharmacy and had the immunisation conducted. Convenience has been cited as a significant reason for that. Thankfully there have been no significant adverse events reported through this trial. There have been some concerns amongst some commentators in the media about pharmacists' ability to deal with adverse effects and whatnot, and significant reactions to the influenza vaccine. The medication used to treat severe allergic reactions like anaphylaxis is called adrenaline, and pharmacists keep that in their pharmacies as part of their core business. Moreover, pharmacists often have a first-aid certificate, and would actually have to stock adrenaline and hold a first aid certificate if they were to be conducting these types of services.

Another initiative conducted through pharmacists, and it is going to be rolled out more broadly in time is the ability to report directly to the Therapeutic Goods Administration for adverse effects and reactions. We are going to be the first health professional group that is going to be able to report directly to the TGA when there is an adverse event. We take a lot of pride in that and we feel very strongly equipped and committed to be able to facilitate the service for the public benefit. The results of that trial will be published later this year, and we look forward to seeing those results. The Northern Territory jurisdiction already has legislation for pharmacists to be able to give the influenza and measles immunisations, but pharmacists have not yet started to administer them. There is a range of professional support that will be able to facilitate pharmacist-led immunisation services when they come into play — all going well and all things being equal — and that includes the quality-care pharmacy program, which is an ISO accredited program, a quality assurance program operated through community pharmacies. Over 90 per cent of pharmacies are accredited. It is a voluntary program and there is a range of protocols and procedures that are in place to deal with rolling out professional services, including something like an immunisation service or a screening and risk assessment service, which I will discuss shortly, and to help facilitate training around that.

In terms of medication management and other initiatives, pharmacists are medication experts. They are the experts in medicines and in ensuring patients take the right medication in the right way, at the right time and at the right dose. Some of the particular initiatives that will be able to assist the broader health-care system with patients revolve around post-acute health care. What that means is that when someone is discharged from hospital or changes settings within the health-care system, a pharmacist can provide a medication reconciliation service. That means the pharmacist checks that when the patient is discharged or moved to another setting, the medication the patient has is correct, taken in the right way and is as intended. A study from the US found that when someone transitions from one setting to another, there is an approximately 70 per cent discrepancy rate in the medication lists, and about a third of those errors results in someone going back into hospital or back into another form of care. This is highly preventable and highly costly to the system. We feel that pharmacists, being medicine experts, can play a significant role in making sure people do not end up back in hospital or in other forms of care.

We will go into more detail about aged care in the home in our submission. This is the concept of the medical home that is emerging in the US. It is about keeping people in their homes for longer by giving them home-delivered medication services, services such as arranging medications and dose administration aid. I can hand this around later if you like. It sets out medications by times of the day and days of the week to make it much easier for people to take their medication appropriately. Approximately 50 per cent of people do not take their medication appropriately, and that is a high non-compliance or non-adherence rate which creates a significant risk to the public ending up in other forms of the health system by not treating their conditions appropriately.

Other initiatives that the pharmacy guild feels that community pharmacists can play an important and emerging role in relate to harm minimisation. Opioid replacement therapy has been around for quite some time in terms of buprenorphine and methadone administration services. Community pharmacists can play a role in terms of facilitating greater recognition and support for that to ensure that those services can continue, because it is an effective treatment for opioid and heroin addiction. It has been found that for every $1 you invest in needle and syringe programs, there is a return of approximately $4 in terms of preventing other downstream health-care costs. Between 2000 and 2009 that was approximately $1.2 billion — a very significant return.

Minor ailment schemes. What that means is the ability to support a pharmacist and recognise their role in helping to treat minor conditions or minor ailments in a community pharmacy setting without someone having to go to a hospital or an emergency department — higher, more extreme and more costly parts of the health system for something that can be dealt with in that community setting. Examples of this could be eczema, a urinary tract infection or a mild ear infection. These things are happening overseas at the moment, particularly in the United Kingdom and Canada. Those countries are supporting pharmacists to do this, and it is reducing health-care costs in the system.

A recent study found that up to 15 per cent of all GP consultations involve a minor ailment. With the possible introduction of a GP co-payment as a federal budget measure, it is more and more likely that patients will make the choice to go to a community pharmacy as their first port of call, which is a logical step. They could also go to an emergency department to get their medical needs met, but that is not what we want from a cost efficiency point of view.

Lastly, with regard to prevention and early identification of chronic diseases and other conditions, pharmacies are an accessible point of care to be able to monitor and screen for potential risk factors around conditions such as heart disease, stroke or diabetes. This could be done through readings of high blood pressure or cholesterol and through monitoring blood glucose levels. This could lead to early identification for people who may not otherwise see the doctor. They can be referred to the appropriate health professionals and get treated early. Stroke is one of the biggest killers in Australia, and the single most significant risk factor for stroke is high blood pressure. It is easily detectable and easily preventable, and pharmacy can play a significant role in that — being accessible, being trusted and being competent.

In conclusion, ladies and gentlemen of the committee, I would like to thank you again for the opportunity to present. We feel the community pharmacy has an important role to play, and we feel this inquiry has an opportunity to fully utilise pharmacy to its greatest capability. We look forward to helping with any of your questions that you may now have.

The CHAIR — Thank you very much, Mr Tassone. Mr Goma, would you like to make a comment to the committee before I open up the session for questions from the committee?

Mr GOMA — No, I have no particular comment. I am happy to assist Anthony with any questions you may have.

The CHAIR — Thank you very much; we appreciate that. Thank you very much for your presentation, which was very thorough. I realise that I had given you only 10 minutes, so you got through an enormous amount of material in that time. Thank you for that. You have highlighted some areas where you feel that pharmacy can play a greater role in the delivery of care — specifically medication management and other initiatives, as you have highlighted in one of your last slides. How do you think those initiatives should be paid for? Do have a view on that?

Mr TASSONE — When you ask how they should be paid for, are you asking whether it should be an incentive practice payment scheme or — —

The CHAIR — I am just asking for your view. For instance, regarding post-discharge medication reconciliation, is it a given that a pharmacist would undertake that or is that something that should be factored into the individual's health care and billed as such as a separate item? Have you got a view on that?

Mr TASSONE — It is difficult to formally say whether some sort of practice payment and reaching particular criteria is the best way of paying for a particular professional service or whether a fee-for-service-type mechanism is preferable. It depends on what we are discussing.

Unfortunately with post-acute care it is not always a given that a pharmacist will be able to do all of those duties to the best of their ability. What can happen in practice at the moment is that a patient might be discharged from hospital. Mrs Jones comes into my pharmacy and gives me her medications and I try to sort them out. I ring the doctor and say, 'Dr Smith, Mrs Jones is in my pharmacy'. I go to work through the medications with Dr Smith, and Dr Smith says, 'I did not know Mrs Jones was even in hospital. What are you talking about?'. This can lead to a lot of inefficiencies in the system, and it can decrease patient outcomes.

Through a recognise and remunerate model through a community pharmacy, the pharmacy can act as a concierge for that transition from hospital into the community and be able to make sure everything is in order — that a dose administration aid is set out and that the doctor is equipped with all the required information to be able to transition that care. That could be on a fee-for-service-type model, but I have not had the opportunity to fully model that at this point.

Mr LEANE — I have two questions, and maybe if there is time I will come back with another one, if that is okay. In your submission you indicated that there is an opportunity for pharmacists to be the first port of call to reduce the burden on the broader health system. The concern around that for your members is that if they are in a situation where they are the first port of call for someone with some sort of ailment, the liability is on your members to correctly diagnose someone and decide on the action they need to take to remedy that particular ailment or health concern.

Mr TASSONE — To help reassure your concern, that happens each and every day in community pharmacies right now. The opportunity loss is that because there is not a systemised and standardised way of appropriately remunerating and recognising what pharmacists do, this may happen opportunistically or not to the full extent of care that the patient can experience. There is the opportunity for patients to receive the most optimal treatment for that minor ailment without a pharmacist necessarily quickly screening them and quickly referring them onto a doctor or another health-care provider as a triaging role. Pharmacists are highly competent, and part of their core business is that triaging-screening role. They are able to refer a patient on when something is more serious, but they can treat things that are on a minor basis. In the minor ailment schemes overseas, it is about giving pharmacists a greater capacity to be able to treat those minor ailments that are not serious enough to warrant a complex examination.

Mr LEANE — Would it need to be determined what falls under the heading of a minor ailment and a minor health concern?

Mr TASSONE — Yes. When you say would it need to be determined, are you meaning a particular condition or particular ailments?

Mr LEANE — With the reference we are looking at — and you have hit on it very well as far as a chance to reduce the burden on the broader health scheme through more that community pharmacies can do — one of our recommendations is that this should be endorsed and encouraged more. So how do we nail down and alert people to what a minor ailment could be without going into an area that could actually not be a minor ailment?

Mr TASSONE — With regard to that, the pharmacy board provides a significant amount of guidance as to what is considered within a pharmacist's competency as they manage the registration of pharmacist practitioners as part of the national scheme. The pharmaceutical society, which is a professional body within the pharmacy industry, is a body that sets out a range of codes of conduct and professional guidelines to abide by. For want of a better comparison but just to try and give an illustration, emergency contraception — commonly referred to as the morning-after pill — was once upon a time a prescription-only medicine. It was down-scheduled to become over the counter, and pharmacists were able to counsel patients who sought it and screen whether it was appropriate or not under a governing set of guidelines and protocols developed by the pharmaceutical society.

In certain instances where it was not deemed appropriate we would refer them to a general practitioner, and that has been happening within community pharmacies for a number of years now. I am not saying that emergency contraception is a minor ailment, but I am just trying to demonstrate that that is a service that was once solely with general practitioners and now community pharmacies are handling it quite adeptly.

Mr LEANE — Just briefly touching on the harm minimisation in your submission and the opioid replacement therapy and needle and syringe programs, is that currently occurring in some community pharmacies in Victoria as we speak?

Mr TASSONE — Yes.

Mr LEANE — Are you saying that a better outcome would be more community pharmacies actually supplying that service, if not most?

Mr TASSONE — Currently — and I will refer to my colleague, Stan Goma, in a moment — approximately 45 per cent of community pharmacies are supplying the service, and we feel that through appropriate recognition and remuneration, getting more pharmacies encouraged to participate and provide that valuable service eases the workload on those currently doing it. It also captures those who may not have access to opioid replacement therapies, whether it is in a rural or remote region or a particular suburban area where they currently do not have ease of access. It captures those who need the service.

Mr GOMA — I agree with what you have just said. Ultimately, with the right kind of incentive and support we will hopefully see a lot more pharmacies being willing to provide that service because at present, particularly in Victoria where we have a community-based model, the existing number of pharmacies that provide the service — which is around 40 per cent — is probably still under where we need it to be. What we are arguing is that with some better incentives we would see more pharmacies being willing to provide that service in the community.

Ms HARTLAND — I have four questions, and I will try and make them really brief. Following up on the issue of methadone dispensing, can you talk about the barriers that stop chemists being a dispenser?

Mr TASSONE — They could be highly subjective and many and varied. It might be a perceived excessive regulatory burden from a compliance perspective, it could be fear of what the potential clientele could bring to their business or it could be a lack of understanding of what the benefits of the program are. Just anecdotally through my own experience, with regard to speaking with pharmacists and proprietors, once they learn more about the evidence base behind opioid replacement therapy and the difference it can make in people's lives, it can change their point of view.

Mr GOMA — Again, going back to what I said earlier, at present we have about 40 per cent. There was a training program, which I am sure our colleagues from the Pharmaceutical Society of Australia will talk about, which we hope will result in a greater number of pharmacies being willing to provide the service. But we do

know, for example, that at the time of starting the program there is a cost involved in setting up the system in the pharmacy, and even though at present we have an arrangement where the patient pays for the dispensing of methadone, it is fair to say that many pharmacies would be reluctant to start providing the service because of the initial cost of setting up the service.

If there was an incentive, that would assist. Particularly in the initial setting-up phase, we would see more pharmacists being willing to start the program. As an example, if you decided to provide the service, you may need to purchase a pump and a larger safe in which to store the methadone, so that is an initial cost that the pharmacy needs to meet. If there is no incentive, that become a barrier.

Ms HARTLAND — On the Northern Territory example you gave of influenza, that was really obvious, but I was interested that you only listed measles. Are there no other immunisations being done?

Mr TASSONE — Not by pharmacists. Those examples listed were legislative changes that allowed pharmacists to deliver an immunisation. It is for influenza and measles currently in the Northern Territory. The pharmacy guild is not necessarily opposed to further immunisations being given by a pharmacist, but at this point in time that is what has been legislated for in the Northern Territory.

Ms HARTLAND — Is there any reason why it was only measles?

Mr TASSONE — Are you referring to measles, mumps, rubella? Is that what you mean? Or other — —

Ms HARTLAND — Some of the other vaccinations that could occur. I was just intrigued as to why it was only the one.

Mr TASSONE — It has only been legislated for the influenza vaccination and measles at this point. I am not sure of their intentions to expand the ability for pharmacists to deliver vaccinations, but that is what they have legislated for at this point. Currently pharmacists have not commenced doing that, whereas in Queensland there is actually a trial being undertaken where pharmacists are physically delivering an influenza vaccine in a research setting.

Ms HARTLAND — On the screening issue, I could understand all of the screening except for the bowel cancer screening. How does the chemist screen for bowel cancer?

Mr TASSONE — It is the distribution of bowel cancer screening kits. It is an actual take-home kit. I was considering whether I should have included that one, but I am glad you asked. It is a take-home kit, and pharmacists are a distribution point. It has been found that when pharmacists are a distribution point and have an ability to describe and explain how to use the kit, there is a greater uptake and utilisation compared to not-for-profit groups such as a Rotary club, for example, sending out kits in a non-targeted or strategic way.

Ms LEWIS — Most of these services would be for people coming into the pharmacy to receive them. Is there any potential for some of them to be home-delivered in terms of medications and things like that?

Mr TASSONE — Yes. Services regarding particularly medication review and medication management services can be delivered in a patient's home. There are currently programs that are federally funded that are doing that at the moment, but there is the opportunity at the state level to target specific types of patients who are particularly at risk or have just been discharged or who have a particular condition such that they can be delivered as an outreach by the pharmacy into the patient's home. The 'medical home' or 'aged care in the home' concept is one that is an example of that. It has been demonstrated in the United States to significantly reduce other health-care costs, hospital admissions and readmissions and to delay transfer into aged care through the pharmacist's involvement.

Mr O'BRIEN — You might have touched on this in your presentation, but could you just explain to us how you would consider that community pharmacy initiatives could further contribute to primary and preventive health care in rural and regional settings?

Mr TASSONE — We did not get the opportunity to expand on it much today. The Grattan Institute report highlighted pharmacists as an underutilised resource in rural and remote areas, particularly around telemedicine initiatives whereby pharmacies as a health hub could provide resources for medication advice but also be a

contact point. They could possibly be able to facilitate appointments with specialists in metropolitan regions through the use of technology from a pharmacy setting. That is happening increasingly at the moment through various initiatives, but with appropriate recognition and remuneration support that could be happening in a more standardised way.

I am from the rural area of Mildura and there are increasing initiatives in that area. Currently patients have to undertake overnight visits to Melbourne or Adelaide to visit a specialist, but through the use of telemedicine or other appropriate technologies they can have an appointment or a consultation with a specialist from the pharmacy setting. Also the pharmacy can be an accessible health professional in regard to being a medicine expert et cetera. Pharmacies do that in any case at the moment. They are able to be the first point of contact for medicine advice to ensure that patients are taking the right thing in the right way.

Mr O'BRIEN — Your guild represents both community pharmacies and pharmacies attached to hospitals?

Mr TASSONE — No, we represent community pharmacy owners, not hospital pharmacies, but there is a group called the Society of Hospital Pharmacists of Australia that primarily represents hospital pharmacists.

Mr O'BRIEN — I just wanted to understand your recommendations. It seems logical to me that a lot of the initiatives you advocate for and which are sensible could be trialled, firstly, in the hospital setting where you have the ability to refer more complex cases, to pick up Mr Leane's point on diagnosis, to doctors. But at the same time I understand the need for community pharmacies, particularly in rural areas where there are no doctors at all.

Mr TASSONE — That is right.

Mr O'BRIEN — I just wanted to know what recommendations you would suggest we make if we were to look at trialling this initiative for both hospital and community pharmacies, particularly in rural areas.

Mr TASSONE — I think a minor ailment scheme would make sense under the conditions I referred to earlier where there are no doctors in some rural settings. If they could go to a pharmacy and get certain conditions attended to and treated in the first instance, that could assist people in those areas. There could be research studies done with a particular hospital, whether that be in a metropolitan or a regional setting. We will talk about it as a regional setting at the moment. It could be done as an interface so that when someone is discharged and they need to be monitored in the community, and a specialist only attends that regional hospital once a month, through the pharmacy there could be some sort of consultation or discussion using technologies whereby the patient is attended to by a specialist via a virtual consult from the pharmacy setting.

There could also be wound-care services whereby a patient who might have chronic diabetes or another condition where wound care is a significant component of their ongoing management could be facilitated in receiving that care from the pharmacy setting with dressings and appropriate chronic management without having to go back to a hospital setting per se.

Mr O'BRIEN — Are immunisation nurses something you are prepared to work with? Are you saying that immunisations could be done without the need for immunisation nurses in a community pharmacy setting?

Mr TASSONE — That is something we support. We feel that pharmacists are able to do that.

Mr O'BRIEN — Without the immunisation nurse? I just want to be clear.

Mr TASSONE — Yes, for influenza that is our first choice. But in saying that let us take the notion of paediatrics and of children being immunised. Pharmacies could be a primary health-care setting for a nurse immuniser to do children's vaccinations. As part of our submission we are not advocating for pharmacists to be doing paediatric or children's vaccinations as part of the national immunisation program, but we certainly would not be opposed to a nurse practitioner immunising from a pharmacy setting to help facilitate that service in rural and remote locations.

Mrs MILLAR — In terms of reducing the burden on the broader health system, I am interested in your view on pharmacies issuing medical certificates for employment purposes and the likely uptake of that service in a community pharmacy setting.

Mr TASSONE — Since the introduction of, I believe, the WorkChoices legislation in the 2000s, pharmacists can issue medical certificates. From my own experience and those of my colleagues this has not been a service that has been taken up significantly. I believe part of the reason could be that for some public sector-employed individuals and some in private enterprise their conditions of employment require a medical certificate from a particular health professional and pharmacists are not recognised as being able to do that.

Pharmacists through their area of competency and because they are recognised by the Pharmacy Board of Australia are able to provide medical certificates for those minor ailments we discussed earlier, so that if someone was experiencing a gastro bug or a cold or flu, something that could be easily identified by a pharmacist, it would be within their area of competency and professional obligations to be able to write a medical certificate for that person. However, I believe some of the employment agreements in place at the moment provide a barrier to the public being able to do that and there is not a great awareness amongst the public that they are able to seek out a pharmacist to provide a certificate.

Once again, if we can reduce absenteeism from work and if we can expedite people being attended to by a health professional, especially in rural and regional areas, I think that can only be a good thing.

Mr ELASMAR — In your briefing you said that more than 50 per cent of pharmacists have a private consulting room. I am talking about pharmacists and immunisation. At the same time doctors have expressed concerns about patient safety. There are two parts to my question. Firstly, why would people go to pharmacists and not to a doctor, and secondly, what is your response to the doctors' concerns?

Mr TASSONE — People would be more likely go to a pharmacy because of its accessibility. There are more of them, they are open longer and they are easier to get into. Unfortunately, like many Victorians, I find it very difficult to make an appointment with my own GP. Due to their significant workload there are delays in getting in to see them. People have busy lifestyles and families have a lot of commitments in running their household and whatnot, so having something that is accessible, has extended hours, is trusted and people are satisfied with I think is the main reason why someone would go to the pharmacy.

With regard to responding to the medical profession's concerns, all I want to say is that anything that we have put in our presentation today and will put in our submission is not about turf wars and not about self-interest; it is about community benefit. It is about what will benefit the community. Will they get what they deserve from a Victorian health system? At the pharmacy guild, we will only advocate for the things that we strongly believe that pharmacists can do. We do not want to overpromise and underdeliver. That is a disservice to Victorians. It is about what is in their best interests.

Mr RAMSAY — I have a couple of questions, (a) and (b), if I may. Some of it has been covered, but I want to get down to the basics of how the process works if I seek a consultation with a community pharmacist as against a GP. I go to a GP, get bulk billed and pay nothing through Medicare. If I go to a community pharmacist, I am not sure how the payment works. Can you explain that to me from a comparative point of view? My second question is pretty much along the same lines as Mr Elasmar's. What is the reaction from the AMA in particular? What are the legislative barriers to pharmacists being able to perform certain vaccinations? You talked about the Northern Territory legislation and that the Queensland legislation has to be changed or has been changed. Is there a requirement for change here in this state for you to be able to perform those procedures? So there is (a), (b) and (c).

Mr TASSONE — In terms of seeking a consultation with a community pharmacist, for the most part, if not on almost every occasion, a pharmacist is providing their advice at no charge without an appointment. Whether that can continue into the future and is sustainable may be questionable. We feel that this inquiry is an opportunity to look at how that can be more structured and standardised to deliver greater outcomes. So pharmacists are doing it at no charge on an ad hoc, opportunistic basis at the moment, but within the scope of what they have been given to do. With greater scope, there are greater opportunities to deliver greater outcomes, and that might require appointments and a more structured approach in that regard.

With regard to the AMA, can you repeat your question about addressing their concerns? Could you repeat part (b) of that question?

Mr RAMSAY — I was just wondering what their reaction was in relation to your broadening out the services that you are providing to those who seek them.

Mr TASSONE — It is interesting. If you spoke about pharmacists performing vaccinations, the AMA's opposition to that particular initiative has been well documented. They say to pharmacists, 'Where are you going to do it? With the toothpaste and the toilet paper?', trivialising the community pharmacy setting as a health-care destination. I have pointed out that there are private consulting rooms and whatnot. They have pointed out that we cannot handle the cold chain. We do have fridges and cold chain protocols throughout our whole community pharmacy network. In fact our fridges are accredited by an ISO quality care accreditation program. Their cold chain is not. They say, 'How would you manage adverse reactions and anaphylactic reactions?'. We store the medications to deal with that as part of our regular stocks. They say, 'How would you report adverse events and whatnot?'. We have the direct reporting capabilities that other health professionals do not have. I feel that we have been able to directly address many of their concerns.

On the flip side, if you were to speak to the AMA about initiatives such as the post-acute setting in terms of transition of care and medication reconciliation when patients go from one point of care to another, I would be confident that they would be strongly in support of it because they recognise the difficulties there are at the moment, and the inefficiencies and the ability to make sure that someone does not end up in hospital or be readmitted to other points of care. I feel that some of the things we have demonstrated today they would be in support of because they see the benefit.

With regard to the regulatory impact, there would be a regulatory impact here in Victoria for the influenza immunisation. It is in regard to pharmacists' ability to supply that particular medication. There would be a regulatory impact. I can take it on notice and provide greater detail as to what specifically that regulatory impact would be, but I can say there would be one. Do you have any other — —

Mr GOMA — We have been in discussions with the drugs and poisons regulation section of the Department of Health to work out what might be the way forward. But at present the position is that the Queensland trial is in place and that will hopefully provide some additional information on some of the concerns that may need to be addressed prior to making the legislative change in Victoria. Yes, there will be a requirement for a change here. But, as I said, we are in discussions currently with the department to work out what is the best way forward.

The CHAIR — If you could provide additional information, that would be most helpful.

Mr TASSONE — Yes, we will do.

The CHAIR — Gentlemen, we are out of time. On behalf of the committee I thank you very much for your appearance and for your presentation. The evidence you have provided has been most helpful. Thank you very much indeed.

Witnesses withdrew.