# 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 — 28 July 2014

Members

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| Ms G. Crozier | Ms M. Lewis |
| Mr N. Elasmar | Mrs A. Millar |
| Mr A. Elsbury | Mr D. R. J. O'Brien |
| Ms C. Hartland | Mr M. Viney |

Substituted members

Mr S. Leane for Mr M. Viney

Participating members

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| Mrs I. Peulich | Mr S. Ramsay |

Chair: Ms G. Crozier
Deputy Chair: Mr M. Viney

Staff

Secretary: Mr K. Delaney
Research Assistant: Ms S. Hyslop

Witnesses

Dr T. Bartone, Victorian president, and

Ms K. Walsh, senior policy officer, Australian Medical Association Victoria.

**Necessary corrections to be notified to secretary of committee**

**The CHAIR** — I declare open the Legal and Social Issues Legislation Committee public hearing. This morning'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 Dr Tony Bartone, Victorian President of the AMA, and Ms Katherine Walsh, Senior Policy Officer. Thank you both for being with us this morning.

All evidence taken today is protected by parliamentary privilege; therefore you are protected 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. Today's evidence is being recorded. You will be provided with proof versions of the transcript within the next week. Transcripts will ultimately be made public and posted on the committee's website.

I thank you for the submission you provided to the committee, and I now invite you to proceed with a brief 5 to 10-minute presentation to the committee, which will then be followed by questions. Again, thank you very much for being with us this morning.

**Dr BARTONE** — Thank you for inviting AMA Victoria to present to the committee today. As I am sure you would be aware, AMA Victoria and our colleagues around Australia feel very strongly about the expansion of the role of pharmacists and other health-care workers into independent practice. Our concerns and objections arise from a deep concern for our patients' safety and the quality of care they receive, not from any need to protect our turf.

Doctors spend many years training to provide comprehensive clinical care to all our patients, mostly from a postgraduate level on. Our education and training requirements continue throughout our professional careers, through thorough and stringent continued professional development. We acknowledge that pharmacists are highly trained and skilled in their specific field; however, the level of education and training they receive is not sufficient to provide independent clinical services without the supervision of a doctor.

I want to make it very clear that we are not against pharmacists taking a greater role in the care of a patient. We do believe there is a role for pharmacists working as part of a multidisciplinary care team led by a GP, and we would like to see increased collaboration between pharmacists and general practitioners. There would be many benefits for our patients from improving collaboration with pharmacists. These benefits would include better patient education on medication, improved use of medicines, a reduction in adverse drug events in our patients and, ultimately, better coordination of patient care.

Our federal colleagues are currently working with the Pharmaceutical Society of Australia on ways to integrate non-dispensing pharmacists into general practices and enable them to participate more readily as a member of a GP-led primary care team. A family doctor is trained to treat the whole person, not just some parts or specific diseases. A family doctor is able to interpret the results in the context of a person's full medical history and treatment regime.

Shifting aspects of care such as preventative health checks outside of the GP clinic or GP-led team risks fragmenting care and could put patient privacy at risk. Pharmacists do not have access to patient files, nor do they keep their own. Most pharmacies are not set up to provide confidential advice in a private and secure setting. Any checks undertaken in a pharmacy setting would only provide at best a general indication of a person's risk. Without taking into account a person's family history, their lifestyle and other clinical and social risk factors, you simply cannot say if someone with a blood pressure of 130 is at risk. GPs use this information to assess the actual risk and to undertake additional necessary tests or referrals. These referral pathways are not available to pharmacists.

A recent study by the University of Adelaide found that health checks conducted outside of a general practice — at work or in pharmacies — were of little benefit but that general practice-based health checks are associated with a reduction in risk factors such as blood pressure, cholesterol and weight. More importantly, it found that the number of people at high risk of cardiovascular disease was reduced through annual GP-based health checks.

The GP often has a strong and trusted relationship with their patient and is able to offer advice and support to follow up and work with the patient to reduce risk factors. Pharmacists have not undertaken the level of clinical training required to provide clinical services such as vaccinations. Immunisations are much more than simply administering vaccinations. It is about assessing whether the patient is well enough to receive the vaccine;

whether the patient has any allergies that might cause any adverse effects; and, most importantly, the ability to respond to any unlikely adverse effects. It is about using the vaccination appointment to provide general health checks.

Finally, let me comment on the perceived cost-effectiveness. This is particularly relevant at the moment with the current proposed co-payment model. Removing such services from GPs removes the opportunity for general health checks, thus removing opportunities for intervention and holistic care. This will ultimately result in patients ending up in more acute settings requiring more intensive and expensive interventions. The AMA believes that pharmacists working with GPs can have a beneficial effect on patient care, but this must remain GP centred and GP led. Thank you.

**The CHAIR** — Thank you very much, Dr Bartone. Ms Walsh, would you like to add any comments for the committee?

**Ms WALSH** — No.

**The CHAIR** — Thank you very much for your presentation. Is AMA Victoria of the belief that there are enough GPs currently?

**Dr BARTONE** — The GP-to-patient ratios across the state are improving all the time. On an across-the-state basis we probably do have enough GPs. The problem is the distribution of those GPs. That GP maldistribution will be addressed by the current training pipeline that is ready to come through. In fact the issue will not be about having enough GPs, it will be about having enough training places for the graduates coming through to be trained into general practice.

**The CHAIR** — In relation to your submission, you state that AMA Victoria supports the possible co-location of non-dispensing pharmacists within GP clinics. In terms of those GP clinics, are you talking about the larger ones in metropolitan or larger regional centres rather than those, for instance, in rural towns? Is that what you are describing in your submission?

**Dr BARTONE** — We are not putting a size limit on the medical centre. It could work in a number of scenarios, and it could be a sort of shared resource between towns in rural Victoria, for example. It would work well where there are relationships between the doctors in the clinic and the local area allied health professionals in delivering a GP-led, patient-centred care approach.

**The CHAIR** — Would that include pharmacists supporting the GPs in assessing minor ailments and things like that?

**Dr BARTONE** — We have found that there is a great desire amongst our GP members, as well as through the research provided, that there is a need to have the pharmacist engaged in various aspects of reviewing medication management and reviewing any interactions post-discharge at attendances of patients from hospital. There is an appetite for and a desire to work integratively. We are basically taking a model that works well on a patient ward round in a hospital and bringing it back out into the community by having what is effectively a consultant, his residents and all the other allied health-care team members on a ward round. We are trying to do the same thing in a general practice setting. We know that patients trust their GP and in that kind of environment the interaction, coordination and usefulness of the information transfer between the various members of that team will be heightened and improved and only lead to better patient outcomes.

**The CHAIR** — But what about in a small rural towns where they do not have large ward rounds and they sometimes just have visiting GPs or seconded GPs to assist in those smaller towns and regions? What do you say about the pharmacist's role in relation to that?

**Dr BARTONE** — We are not against the role of the pharmacist. We can happily have the interaction and transfer of information, but there has to be a leader. There has to be someone coordinating that, and that is what we are saying. If it cannot be co-located — and maybe a rural town is an example of where that might not work — there needs to be interaction amongst the people, even if they are disparate and are not in the same premises. But there needs to be someone leading that — just like an orchestra, where the conductor leads the orchestra. If not, it will only end up fragmenting the care and fragmenting the outcome for that patient.

**The CHAIR** — Thank you, Dr Bartone.

**Ms HARTLAND** — Just following on with that theme, cohealth, which is a community health service, has a clinic now in Barkly Street. There is also a pharmacy, which is a private pharmacy, right next door. Is that the kind of model that you are talking about? Is it about co-location?

**Dr BARTONE** — No. The model we are talking about is specifically a non-dispensing pharmacist. We are working with the Pharmaceutical Society of Australia in that regard. It is basically to bring the aspects of patient care into the setting of the GP environment and the patient consulting room. It could work with a private pharmacy next door, but there is not that opportunity for interaction. When it is under the one roof and coordinated, it works much better.

**Mr ELSBURY** — I am very interested in this idea of building a GP relationship. I am fortunate that I have a GP who is someone I trust and I use all the time. Unfortunately in my electorate, in the western suburbs, not everyone gets that opportunity. There are a lot of clinics out there where the doctors turn over constantly and, to be honest, it can take me a week to get into see my doctor if I am lucky. If I want to get the specific doctor in the practice I go to, it can take two to three weeks before I get an appointment with that doctor. I am struggling with this idea about somehow taking some of the lesser elements of medical dispensing I normally use — if I just want to get a vaccination or something like that, I would just go off to a clinic. My GP does not know that I go to the clinic to get that health care unless I tell him. Would that not work in the same way if I were to go to a pharmacist to get that sort of care?

**Dr BARTONE** — What we are really strong about is an ongoing relationship with the family doctor. In fact last week was Family Doctor Week, and you would have seen a lot of media releases around that.

**Mr ELSBURY** — And that is a wonderful idea. It does not work in reality.

**Dr BARTONE** — You have addressed where it might fail in some regional centres, and I used to — —

**Mr ELSBURY** — No, I am talking metropolitan Melbourne.

**Dr BARTONE** — Okay; sorry about that. But I did work out in Werribee. I have worked in Epping, I have worked in Lalor, I have worked in Niddrie and I have worked in Cranbourne as a general practitioner. I know that there are pressure points in those communities. Unfortunately often non-GP owners set up clinics in areas and turn over doctors in the way that you described. That is something that we do not feel is in the patients' best interests. We believe that basically having a general practice run with coordinated allied care members and using our skills more efficiently and more effectively, and not being hamstrung with red tape and with duplication issues that occurred chronically in our practice we could be freed up and be more efficient and be more effective in outcomes. I do share your concern that it is not ideal if you have to wait two weeks to see your GP of preference. It is about all GPs improving their game in that respect.

I know that in my practice I have never turned away a sick child on the day, and I make availabilities for people after work or for whatever the issues may be. Perhaps I am guilty of not being able to say no, but the average GP that I know will try to accommodate issues of need. So basically if it is a post-discharge event, they will utilise their practice nurses, and that is probably the moral that you do need to look at fairly strongly. Good practices have more than one nurse, and we work with them in a very flexible and very responsive way to the needs of our patients to accommodate what is a pressing need or an urgent need. If it is an non-urgent need and it takes a couple of days, unfortunately that is a question of resources.

You mentioned travel vaccinations, going off to another clinic to have that and what the differences would be between that and doing it at a pharmacy. The vaccination issue is about the training of the person delivering the vaccination, the assessment and the environment where the vaccination is being done. General practices are accredited under AGPAL or GPA standards — members of the Australian Commission on Safety and Quality in Health Care. So there is the accreditation, the infection control, the backup support should something go wrong. You only need to have one baby go floppy on you from an immunisation once in your lifetime to know that you do not want to see that ever happen again.

**Mr ELSBURY** — You are talking about children receiving vaccinations and going floppy, but surely we have got child health care nurses who go out into community centres all over the western suburbs, and in fact

right across the state, who deliver those vaccinations as well. I am just trying to understand why it is okay for the nurses to deliver these vaccines with the training they have got, compared to a pharmacist who had received the same training.

**Dr BARTONE** — But they are under the supervision of a GP; either directly or indirectly, they would work with GPs in delivering that service.

**Mr ELSBURY** — And that could not happen with a pharmacist?

**Dr BARTONE** — But why do you need to do that when you have already got a very good model, a model that has already achieved in excess of 90 per cent and as much as 95 per cent immunisation rates in Australia, making Australia one of the world's leaders in immunisation rates? Why do we need to reinvent the system?

**The CHAIR** — Mr Elsbury, have you concluded your questions?

**Mr ELSBURY** — I am also interested in what hours your clinic actually works. I am not saying my doctor is turning people away willy-nilly. He is just flat out. He is an exceptionally good doctor and well respected right across the community —

**Dr BARTONE** — As most of our — —

**Mr ELSBURY** — and that is why he is flat out. To try to give him some relief from having to do the minor things which only take 10 minutes — but if you have got 10 appointments at 10 minutes each throughout the day, that is impacting on other patient care.

**Dr BARTONE** — But does he have a nurse? Does he have other trusted GP members in his team that could do that?

**Mr ELSBURY** — He does.

**Dr BARTONE** — We work as a team. We cannot work 24/7. We have got to basically tag in and tag out as we are required, and we work as part of a team. That is part of having the health record on the computer that can be shared between every doctor, every nurse and every other allied health professional in the practice — everyone knows — and that record is then complete and up to date. We do not have — —

**Mr ELSBURY** — But then if I go off to a clinic and get a jab, my doctor does not know unless I tell him.

**Dr BARTONE** — But why couldn't you do that jab at that clinic under the auspices of a nurse working for that doctor?

**The CHAIR** — I might move on, but I make the point that we get our vaccinations here at Parliament, and I am not sure that every MP would alert their doctor to the fact that they have had their vaccination. It is conducted each year, and I think it is a very good program. Ms Hartland has another follow-up question before I go to Mr Elasmar.

**Ms HARTLAND** — On vaccinations, yes, we all do get our flu vaccinations here. On the issue around vaccinations, especially childhood immunisations, because there are more things that can go wrong — the floppy baby et cetera — are there vaccinations that you would feel more comfortable with a pharmacist doing rather than a doctor, or if there was a nurse in the pharmacist practice who was doing the vaccinations, is that a step that could be taken, or is there still that concern about lack of supervision?

**Dr BARTONE** — I feel that it is totally inappropriate to vaccinate a baby in a pharmacy — let us just make that point front and centre, right at the beginning. With adults and occupational-based vaccinations, when it is run by a nurse working under the auspices of a doctor and, depending what is happening, reporting back, that obviously does work well. The question is about the completion of the medical information and the coordination and the housing of that medical information. Flu vaccinations is the example that is often given, and yes, it does happen in workplaces through trained professionals, but there is always a point of recall, a point of reference, a point to go back to that oversees the program, not just at the pharmacy level.

The program is run independently of a commercial enterprise, and it is run to deliver the services that are engaged for — you are engaging someone to come in, do the vaccination and go. There is no opportunity for, 'By the way, at the same stage', to try to do any other health checks that are appropriate at the time or to recommend some other complementary medication.

**Mr LEANE** — Doctor, you said — don't let me put words in your mouth, but to paraphrase, the association is pretty keen to find prudent ways to coordinate between doctors and pharmacies. Are there any suggestions about what that would be and how it could be improved, or is there anything being worked on at the moment?

**Dr BARTONE** — There was a media release last week specifically on that. Discussions are progressing. The model would work, essentially, maybe in a couple of ways. There are home medicine reviews, and studies have shown that home medicine reviews are effective when they are GP led or initiated in a general practice. The pharmacist would go out to the home and compare what the patient is taking with records at the surgery and make sure there are no duplications. Often patients come out of hospital pharmacies with one generic form of a medication and may have a different generic form of that same medication at home in a different trade name, so there are opportunities for confusion and mismanagement. It works well in that regard.

It works well in terms of alluding to possible ways of reducing — sometimes patients with very complex comorbidities might end up on a number of medications, and the pharmacist and the GP working together can maybe reduce that list of possible interactions and look at things through a different pair of lenses. But it is an interplay. It is about consultants sitting down together and making decisions, and it would work because either the pharmacist would attend a surgery on a part-time basis, sharing between various other practices, or as a full-time resource, depending on the size of the practice, and be housed and be working with patients as they come in.

**Mr LEANE** — Just to follow up, that media release — do we have a copy of that?

**Dr BARTONE** — We can provide you with one.

**The CHAIR** — Thank you very much.

**Mr O'BRIEN** — Thank you for your evidence and your submissions. If I understand the heart of your submission, at the first sentence you say that the AMA rejects any expansion of the role of pharmacists into the independent provision of health care and prescribing. I have put emphasis on the word 'independent'. Am I right in saying that you do not necessarily object to a co-located facility — because you sort of say that?

**Dr BARTONE** — Yes.

**Mr O'BRIEN** — In a sense, that is bringing the pharmacy into the medical practice rather than extending general practice provisions to an independent pharmacy, and that is where your concerns are.

**Dr BARTONE** — Precisely.

**Mr O'BRIEN** — This is just a question; do not take it is an assumption that I am saying that this is where we would go. Would you recommend that any consideration of extension of the role of the pharmacy would need to proceed, even if it were doing a trial in only those co-located-type facilities?

**Dr BARTONE** — That would make logical sense because basically you are able to then assess and independently evaluate how that is progressing and the benefits that are ensuing accordingly. We have a rough idea of what the benefits would be and how they would have occurred, but obviously a study or a review of the process in those facilities would be appropriate and would hopefully show that what we are suggesting is actually the case.

**Mr O'BRIEN** — And just one way of again exploring it hypothetically, not just the benefits but the concerns — this probably applies to the medical profession. Please do not take it as a criticism, but a concern is overprescription, and maybe in an integrated practice this would be an exacerbated concern because you have a whole business enterprise with perhaps an incentive to actually be selling more prescribed drugs, whereas at the moment you have a physical delineation in some instances — not in all. How would we limit concerns about overprescription or poor treatment, accepting that some of those concerns exist already?

**Dr BARTONE** — The keyword there is that we are looking to work with 'non-dispensing' pharmacists so there is no commercial imperative to dispense occurring in the general practice.

**Mr O'BRIEN** — So you would not accept it extending to dispensing pharmacists in a co-located facility yet?

**Dr BARTONE** — We feel that, for the reasons you are just espousing, it creates that opportunity or that inference that there may be other pressures to bear in terms of what might occur. We feel that if it is a non-dispensing pharmacist, it clearly then is all about the patient's care and the patient's outcomes, and they can be the only motivating factors.

**Mr O'BRIEN** — Just one last question for clarification: I was at an integrated facility at Smythesdale on Friday, and that has a pharmacy there — —

**The CHAIR** — Smythesdale is?

**Mr O'BRIEN** — It is called the Well at Smythesdale.

**The CHAIR** — Outside Ballarat?

**Mr O'BRIEN** — In western Victoria. Thank you. Sorry, Ms Crozier; I presumed everyone knew where Smythesdale was. I did not know that there was a difference in relation to the structure there. Would you not support pharmacies coming into a business model that also includes the general practice? Do they have to be separate businesses, or can they be integrated into a medical clinic?

**Dr BARTONE** — I am not specifically aware of the Well at Smythesdale, but even if it is an independent pharmacist next door to the practice or in the next area of a facility, that would work better than that distance down the road or in the next shopping centre.

**Mr O'BRIEN** — You are seeing a financial barrier.

**Dr BARTONE** — Yes. As you would imagine, there is an independence between the pharmacist in that facility and the general practice. They work as separate business entities, but there are some benefits and minor scales of cooperation and coordination that would occur by having them in the same facility. What we are saying is that having the pharmacist removed from their commercial enterprise but working as part of a team would really upscale and promote the benefits of the interrelationship between the two.

**Mr O'BRIEN** — My final question is: would you accept a non-dispensing pharmacist within the medical team or the business model —

**Dr BARTONE** — Absolutely.

**Mr O'BRIEN** — and a dispensing pharmacist located in the same building? That is what is presently occurring.

**Dr BARTONE** — Yes. That is out of our control, and that is usually an independent business decision by whoever is leasing out the premises or whoever ultimately owns the entire medical complex.

**Mr O'BRIEN** — From a medical point of view the AMA does not have objections to the model that is presently operating?

**Dr BARTONE** — No, we do not.

**Mr O'BRIEN** — Thank you. And you would not accept a pharmacist outside of that being able to extend into traditional general practice areas for the reasons you have said?

**Dr BARTONE** — We just feel that it offers too many opportunities for questions to be raised rather than the benefits that would be espoused.

**Ms HARTLAND** — This might be out of the scope of what we are talking about today, but of late I have been reading a number of articles about supermarkets that are going to set up pharmacies and health checks. Could you talk a little bit about that? I have been quite concerned about a lack of supervision in this setting. I have had a number of stories conveyed to me about people who rocked up to receive these health checks, but nobody could be found and they found the pharmacist actually stacking shelves for the supermarket.

**The CHAIR** — I think it is a little bit outside the scope of the inquiry, but if you have a brief comment, Dr Bartone, that would be sufficient. Thank you.

**Dr BARTONE** — For a number of reasons we feel that that would be absolutely the end of the game for quality care — the lack of privacy and the lack of security around the medical records**,** and the health checks being conducted in an environment which sells tobacco and alcohol at the same time sends mixed messages. It is something we would be totally opposed to.

**The CHAIR** — Before I move on to Mrs Millar, could I just ask, in your submission you say there is a lack of evidence supporting the value of performing preventive health checks outside of general practice. What do you say to those community-based programs that are running that do blood pressure checks and at times pick up various health implications for an individual and then ask them to go to see their GP? There are many stories in relation to that. It might be the local Rotary that is conducting a blood pressure check. Do you not support those initiatives?

**Dr BARTONE** — The research shows that if you look at the outcomes of such interventions — as well meaning and as well purposed as they are — the outcomes in the reductions of risk factors and the outcomes in terms of the reduction in morbidity and mortality are just not there. There are a lot of things that can happen between that finger prick that might occur in a community setting and then finally going to see your GP and doing something about it. There are a lot of opportunities along the way where things may fall off the perch. What it has clearly shown is that when preventive checks and health assessments are done in a general practice setting they by far lead to outcomes that are desirable in the reduction of risk factors and the reduction of morbidity and mortality.

**The CHAIR** — Thank you. I could go on further, but I will ask Mrs Millar for her question.

**Mrs MILLAR** — My question follows on from Ms Crozier's and relates to the fact that particularly in rural and regional sittings access to GPs can be extremely limited. One of our submissions is from a community pharmacy in Wedderburn, where there is a GP who runs a practice four days a week. Pharmacies play an enhanced role in those communities. We have talked about vaccinations in some detail this morning, but I am likewise interested in pharmacies playing more of a screening role for things like diabetes, which is already occurring. I am interested in your view as to why preliminary testing or screening at a pharmacy for diabetes, hypertension and similar complaints is not an effective mechanism for members of the public to have some initial tests at the pharmacy level.

**Dr BARTONE** — It is not that I am saying it is ineffective. I am saying, number one, that compared to the other alternatives it is not as effective, and number two, Medicare Locals, soon to be the Primary Health Networks, will enhance the ability of GPs in rural towns to work more effectively and cover more of the areas where there is market failure. That is what we are talking about.

We are addressing areas of market failure through an ever-increasing pipeline of new graduates. The training positions in general practice have gone up from 600 positions a year, I think, in 2006 to 1300 or 1400 this year, and 2000 are envisaged by 2016. Basically there is enormous talent and enormous potential with new GPs coming through and a lot more targeted, specific rural incentives for doctors in general — not just GPs but all specialists. It is about coordinating that resource no matter how remote or how rural the facility. That is where the better performing Medicare Locals have started to do some really good work. That is where Primary Health Networks will eventually take over the running and increase the effectiveness of resourcing GPs with the people who are doing it.

It does not matter who actually pricks the finger. It is about making sure that that information ends up with a GP and that there is coordination between the two. It is not a turf war. It is about making sure that the outcome occurs, and the outcome is obviously a reduction in morbidity and mortality. Stroke, diabetes, heart disease and

cancer are the big four. Every patient who comes into my clinic, if they have not had it done for at least a year or 18 months, gets their blood pressure, waist circumference and weight measured, and gets some basic screening in terms of blood tests and other gender-based appropriate investigations. That is what makes good family practice and good preventative primary health care, and the leaders of that should be the people who can create a model, a plan and a path through modification of lifestyle and prevention of primary and secondary events.

**Mrs MILLAR** — That is certainly a best practice case model, absolutely I agree with you, but you also have to acknowledge that not every Victorian is being treated in this way and is having those routine tests done. If you look at the increase in the incidence of type 2 diabetes, it is very much escalating not only in Victoria but across Australia and the Western world, and what we are doing has not been effective to date to address and ensure that all Victorians are aware of this risk.

Is there not the potential for community pharmacy to play a larger role? I am particularly interested in regional and rural Victorians having greater access to these types of tests, not to replace the role of their GP but to play a more significant role in increasing awareness, early screening and a closer relationship between the services. I agree it is not a turf war — it is a matter of working more closely together — and in many communities this happens already, but I do not think we can say it happens in every community.

**Dr BARTONE** — The market failure issues that occur in some towns need to be addressed. They can be addressed by having that screening occurring in a coordinated fashion through GP-led teams. It does not mean that the GP will actually do the finger prick or that the GP will be at the site where it is occurring, but it is about how we get the information from that finger prick occurrence into that patient's record, wherever they may be. So that is the first point I want to make.

Secondly, you mentioned diabetes, and that is a classic example. Diabetes is on the increase significantly, but it is not through want of information. Some people know that their weight, their diet or their lack of exercise are fundamentally putting them at risk, and even in a GP consulting room it is a hell of a task to try to get the lifestyle modification to reduce that risk. So just a finger prick will not reduce the rate of diabetes significantly. It is about a multifaceted program that looks at lifestyle modification, treatment, exercise and follow-up by somebody coordinating all of that, but using people like a dietician or a nurse for regular monitoring, or like a pharmacist in terms of the medication they may or may not need to be on, to get those things done. We are on the verge of a diabetic epidemic like we have never seen before.

**The CHAIR** — Thank you very much, Dr Bartone. I do not believe there are any further questions. On behalf of the committee I thank you very much indeed for your appearance this morning and for your submission. Your evidence has been most helpful. Thank you and good morning.

**Witnesses withdrew.**