

CORRECTED TRANSCRIPT

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

LEGISLATION COMMITTEE

Inquiry into the roles and opportunities for community pharmacy

Melbourne — 11 June 2014

Members

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Mr N. Elasmr
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Mrs I. Peulich

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Chair: Ms G. Crozier

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Witnesses

Mr P. Fitzgerald, deputy secretary, health strategy productivity and analytics,

Mr M. McCrone, chief officer, drugs and poisons regulation, and

Mr D. Jefferson, director, health workforce, Department of Health.

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

The CHAIR — I declare open this public hearing of the Legal and Social Issues Legislation Committee. Tonight's hearing is in relation to the committee's inquiry into the role and opportunities for community pharmacy in primary and preventive care in Victoria. I welcome from the Department of Health Mr Dan Jefferson, director, health workforce; Mr Peter Fitzgerald, deputy secretary, health strategy productivity and analytics; and Mr Matthew McCrone, chief officer, drugs and poisons regulation. Thank you, gentlemen, for giving up your time and being with us this evening. We appreciate it.

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, and 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 invite you now to proceed with a brief 5 to 10-minute presentation to the committee, which will be followed by questions from members of the committee. I thank you for providing the overview and slides that we will receive as evidence for this evening's hearing. Thank you for being before us this evening.

Overheads shown.

Mr FITZGERALD — The department welcomes the opportunity to assist the parliamentary committee, and it welcomes the terms of reference and the issue to explore the opportunities for community pharmacy. I will walk through the slides; it is probably 10 minutes worth. Beside me I have the subject matter experts: Dan has the specific expertise in relation to workforce and the scopes of practice of particular practitioner groups; and Matthew has the expertise in relation to drugs and poisons. I will refer you to them for the detailed questions. The topics we are ready to brief you on include the context for the demand for health care in Victoria, some key facts about community pharmacy, an explanation of the trials that are being undertaken nationally and internationally, and the policy and funding considerations in developing new models. Then we will have time for questions and next steps.

In terms of the outlook for health care generally, as you are probably aware, Victoria's population is growing. It took us nearly 30 years to go from 4 million to something less than 6 million people. However, it is going to take us not so long to get to the next million. At the moment the state is growing at the rate of about 100 000 a year; that is a Hobart every second year. In addition to absolute numbers of population, there is an outlook of growth in the aged population, so we are expecting growth among those over 65 to be something like 750 000 to 1.5 million in the next 15 years.

In addition to that, we have an outlook where the elderly will be different to those of the past, because most of us — more than half of the adult population — are either obese or overweight, and this is the first time that has happened in our history. Alongside that is the likelihood of an increasing prevalence of diabetes and cardiovascular disease. In addition to baby boomers retiring from the workforce in the next 20 years, we are likely to face more elderly people with increasing demands.

The objective for the department is that we get the best out of our workforce. This is reflected in our priorities framework. Everything we do in the department is referenced back to seven priorities: that the system is responsive to people's needs; that we improve every Victorian's health status and experience with the system; that we maximise as much as possible the capacity of the system and its responsiveness; sustainability and continuous improvement; accountability and transparency; and increasingly the use of technology as an enabler. The bolded bit is really the workforce capacity.

The department and indeed the health system in Victoria has an active program to test and evaluate new roles and expanded scopes of practice. The department structures its approach so that we try to build on existing arrangements, pilot and evaluate those pilots for wider implementation. Much of the work to date, including expanded roles for pharmacy, has occurred in hospitals, and that is most specifically because we have a greater investment in hospitals, but going forward we expect to also influence out-of-hospital settings as well as an enabler.

I will give some key facts about community pharmacy. There are 6800 registered pharmacists in Victoria. They are individuals who are registered. Of those, 22 per cent are in hospitals and 16 per cent are in research, so a full 62 per cent are in what we call community settings. There are approximately 4150 according to the 2011

census. There are about 1400 registered pharmacy premises in Victoria, and 100 of those are in public hospitals and private hospitals, with the remaining 1300 being community-based registered premises. So they are spread geographically pretty well, but it is worth noting that our pharmacy education is now a four-year pathway plus internship, with the main providers in Victoria being Monash plus La Trobe, with RMIT having commenced courses in 2011. As a result of which, we have an increasing number of both commencing students and graduates. The commencing students have gone from 400 to 700 in the space of five years, with graduates being a slower uptake. As a result of which, pharmacists are younger than other health professionals just in terms of the percentage of them who are in their 20s. You have about 20 per cent of registered pharmacists being in their 20s compared to about 10 per cent for the rest of the health professionals. That might catch up, but it also seems to be a phenomenon of other allied health groupings that there are more young people as a function of them graduating, doing a set of things and then probably other things, but also there might be career limitations, so we need to keep an eye on that.

In terms of the landscape, there are lots of bodies with similar sounding names. The Victorian Pharmacy Authority does the licensing of premises under the authorisation of Victorian legislation. The state government administers the drugs and poisons legislation — it is Victorian legislation — and the Victorian therapeutic goods legislation. The Pharmacy Board of Australia is a national body that operates under Victorian legislation as well as complementary other legislation. It deals with practitioner registration and complaints handling as well as standards and guidelines. The commonwealth government uses its PBS funding to also encourage specific geographic dispersion. So it has an arrangement where it determines location of pharmacies, as well as a regulatory role under the TGA. So that is actually the regulation of the products.

The key stakeholders, as you would know, are at the bottom. The Pharmacy Guild is a terrific organisation based on its membership, which represents independent community pharmacies. There is the Society of Hospital Pharmacists, which deals with that segment of pharmacists dealing in hospitals. There is the Pharmaceutical Society of Australia, which is the peak national, professional pharmacy organisation that represents pharmacists working in all sectors, as well as the Australian Pharmacy Council, which is an independent accreditation agency that has official functions under the national registration scheme, as well as intern programs.

In terms of supporting quality practice, the Pharmacy Board has a code of conduct in relation to individuals who are registered pharmacists, and you have professional practice standards that are issued by the Pharmaceutical Society. That will deal with standards and guidelines for pharmacists in relation to performing clinical interventions, for example. There are also, in addition to standards, guidelines, and the guidelines include things such as home and residential medication management, immunisation services, sick certificates or workplace illness certificates, as well as things like Diabetes MedsChecks. That gives you a feel for the range of broader health-related activities that pharmacists are undertaking consistent with their professional guidelines.

If we needed to provide a list of the range of activities, by way of examples, that are presently being undertaken in Victoria, you have the dispensing of prescriptions, medication management, medication checks and home medication review. There is also an important set of functions in relation to chronic disease screening and monitoring, including diabetes checks, blood pressure checks, asthma management. There is health promotion, such as weight management and smoking. The Quit campaign speaks highly of the role of community pharmacists in that regard. Then there is limited dispensing of opioid addiction treatment and staged supply of medications. Not every pharmacist has that, but a good dispersal of pharmacists have access to that.

The reasons that we think it makes sense to explore an extended role for community pharmacists is there is the increasing demand for health care, and that calls for innovation and new ways of doing things. There is effective primary and preventive health care that is dependent upon locally accessible services. The third point is not to be forgotten, and that is that pharmacists are amongst the most respected and trusted of professionals with whom people deal. They are also locally available, and it is a rare thing to have such a highly esteemed and respected profession that is locally available. They have a high level of health education and knowledge of medicines. Emerging ideas and evidence from other jurisdictions that might be translated to Victoria suggest that there might be an extended role for pharmacists, particularly in consumer-centred care.

In relation to the trials of new roles I will give you the dot points, and then questions can go to my colleagues once we are done. In Queensland they are piloting an influenza role for pharmacists. It does require them to take supplementary training in vaccination episodes and what the response might be if there is an adverse reaction. In

WA there is basic screening for chlamydia and early physician referral. Internationally there is a good deal of evidence around the pharmacist's role in administering vaccinations, as well as prescribing independently or in shared care arrangements for specific types of patients. In New Zealand there is a pilot of pharmacists providing a range of assessment and treatment interventions across a range of matters.

If we had to categorise the types of avenues for exploration, one would be improved shared care in rural and regional settings, including tele-consultations. So if we have Telehealth more readily available and people need to see someone in the city — a specialist — where do they go? A pharmacy might be such a channel. There could be advanced pharmacy roles in medication management — for example, on discharge from hospitals. Other avenues are management and prevention of chronic health problems, as well as areas that might reduce pressure on other health-care services, including unplanned presentations to health services and hospitalisations, which might include basic wound care or after-hours care.

It is worth noting the barriers. Pharmacists are busy, so it might be that we want to put ambitions on them but they might be too busy. Lack of availability of staff and resources — there might be a need for support services that they do not have. Adequate private space — pharmacists are typically pretty good at filling up space. They pay good retail rent and they want to fill it up, but particularly for patient counselling you need privacy. Coordination with other health-care professionals is not always as easy as just picking up the phone. Lack of financial compensation and incentives for health promotion activities — they are capable of talking the stuff but what is the revenue model? The additional skills and knowledge required.

So the funding and policy considerations — safety and quality are primary policy considerations for us as health bureaucrats. There is also the need to remove financial disincentives for new models for pharmacists and consumers. It might also require commonwealth support for new models, specifically through MBS and PBS limitations. Pharmacy-led models need to be compared on quality and cost effectiveness with other potential providers. Immunisations would be an example of that. We have had the WorkCover arrangements where people can get workplace-based immunisation. That gives us a particular cost per reach. The question is what can pharmacy offer by comparison. Questions?

The CHAIR — Thank you very much for that very comprehensive overview and for providing the information you have to give the committee a greater understanding of both the advantages and some of the challenges that the community and pharmacy face. Mr Fitzgerald, you made reference to some of those areas where pharmacists could play an extended role and you have highlighted some of the limitations and barriers also in relation to that. In relation to the evidence that you have put to the committee this evening, specifically around the immunisation programs that are being trialled in Queensland and Western Australia, can you give us an indication of where those trials are at, how they are progressing and an update on what is happening with those trials?

Mr FITZGERALD — If I can refer to Matthew.

Mr McCRONE — Thank you, Chair. What is happening in Queensland is probably what is really under way. While the Northern Territory has amended its legislation, our understanding is that there are not yet pharmacists in the Northern Territory actually administering vaccines. The law is in place but the practice has not yet been established. In terms of what is happening in Queensland, it is actually being conducted as a trial. As such it has a governance arrangement as per a clinical trial. It has ethics committee approval through the University of Queensland. In terms of the legislation, there is an exemption for the trial and that exemption lists the protocols that the pharmacies must follow and the services that the premises must provide. It also outlines, for instance, that two pharmacists must be on duty whenever a pharmacy is administering the vaccines, and it also includes the profile of the person who might be looking to have a vaccination — their age group, the inclusion/exclusion criteria and all those sorts of things.

The trial is being conducted in Far North Queensland between April and December this year. The intention is to deliver 10 000 influenza vaccines to people between the ages of 18 and 65. The information from our Queensland counterparts last month was that they had already delivered about 8700, so they are looking to well and truly exceed the number of doses administered. Up to 25 per cent of those are walk-ins — that is, people who have not made an arrangement, they just happened to be there and decided it was a good idea. A further percentage of those are people who have not been immunised for influenza before. There is an obvious advantage to that in terms of population health principles.

The CHAIR — Thank you. Before I move on to Ms Mikakos, the trial commenced in April, and it is to conclude in December?

Mr McCRONE — That is right.

The CHAIR — Thank you very much, Mr McCrone.

Ms MIKAKOS — I want to raise a slightly different issue to what has been presented so far and that relates to previous parliamentary committee inquiries — in fact one that I was involved in during the term of the previous government that related to abuse of benzodiazepines. At the time we took evidence around real-time information systems that would enable pharmacists to check on prescriptions issued by doctors, basically to prevent the doctor-shopping that may have been occurring.

I am just wondering if you could advise if the department is looking at any work around those types of issues and if there is any progress around specific recommendations that were made in that particular report that related to pharmacies at that time. I am happy for you to take that on notice. I realise that relates to a previous inquiry, but there were a number of very specific recommendations that related to pharmacists at that time. So if you could perhaps — —

Mr McCRONE — I can give you a preliminary answer. The issue of real-time prescription monitoring has been the subject of national discussion — —

The CHAIR — We might just pause there. Thank you. We hope we do not have too many more interruptions. Sorry, Mr Fitzgerald; as you were saying?

Mr FITZGERALD — So the concept of a real-time prescription monitoring scheme is with health ministers nationally. Ministers have considered the matter and given favour to the idea that it needs to be a national system that is developed. A business case has been developed and has been completed. Ministers' consideration of the business plan and what the development of a system might look like is not yet complete. There is the business case that has been developed after a limited pilot took place in Tasmania, but at this stage there is no state that has a fully developed scheme. To take it national requires the development of a system; the cost and whatnot has not been considered by health ministers. So it is a concept that is effectively in the pipeline of consideration.

Ms MIKAKOS — Does that mean that you would not anticipate there would be anything in the pipeline in a tangible sense for a number of years?

Mr FITZGERALD — We require ministers to consider the business case and the development of the scheme. I think the funding has not been set aside for it nationally or by any state. So it is possibly some years away, if it happens.

Ms MIKAKOS — Just further to that, if there is no system put in place to link up GPs with the pharmacists, if we are to move down a proposed model as you are presenting to us tonight of pharmacists taking on a greater role and doing vaccinations et cetera, what would you anticipate could be put in place to ensure that there is communication back to GPs? For example, if I go to my local pharmacist and get a flu shot or whatever, will that information then be communicated back to my GP so my GP has that information on file and I have a complete set of health records somewhere?

Mr FITZGERALD — I think it is a good question — —

Ms MIKAKOS — What would the process be?

Mr FITZGERALD — as to the person who controlled eHealth records. There is a national proposal for all Australians — sorry, there is now a working personally controlled eHealth record, and all Australians have access to that if they opt into it. That same health record can be accessed by a GP or by a health provider that is registered to participate in it. I do not believe pharmacists are presently in those registered health practitioners?

Mr McCRONE — Yes, they are, in terms of dispensed medications.

Mr FITZGERALD — In relation to dispensed, okay.

Ms MIKAKOS — Sorry, so I can clarify — —

The CHAIR — Last question.

Ms MIKAKOS — Yes — that is only if they opt in to be part of this system?

Mr FITZGERALD — That is right.

Ms MIKAKOS — So if we were to go down the path of pharmacists engaging in immunisation, there is currently no system in place unless a pharmacist specifically opted into this eHealth system for that immunisation shot to be that record — —

Mr FITZGERALD — To be registered, okay.

Ms MIKAKOS — To be registered back and that information to be communicated back to someone's doctor, unless the patient themselves volunteers that information on their next visit to their GP?

Mr FITZGERALD — I think it would be the case that not all Australians have opted into the system. There have been proposals that it switch from opt in to opt out. If it was opt out and all Australians were on the record and all pharmacists were part of it, then any immunisation activity would be so registered, so there is a commonwealth register of immunisations. I take your point absolutely that if they were to participate in that, it would make sense to ensure that it was on the register of immunisations. We are not suggesting, and nor is the Queensland pilot targeted at children, but if there was a broader immunisation activity and you had, say, childhood immunisations, you would want that on the register. The infrastructure looks as though it is falling into place where multiple health practitioners can contribute to a person's eHealth record.

Ms MIKAKOS — I have a series of questions around childhood immunisation. I am happy to come back — —

The CHAIR — I would like to go to other members if I could, Ms Mikakos, because we have a number of — —

Ms MIKAKOS — But just on the issue of eHealth — —

The CHAIR — No, I will come back to you.

Ms MIKAKOS — Just on the issue of eHealth because it relates to questions — —

The CHAIR — No, I will come back to you. I understand where you are going with this.

Ms MIKAKOS — Can we just get some evidence around what proportion of Victorians are currently — —

The CHAIR — Ms Mikakos, there are other members, and they will possibly follow up your line of questioning. I think you have made your point, and Mr Fitzgerald has taken it on board. I would like to go to other members, and then if we have time, I will come back to you. I will now go to Ms Hartland. Thank you.

Ms HARTLAND — I have two questions, and both may have to be taken on notice. In regard to current roles, on the issue of the dispensing of methadone, can you tell me how many chemists currently do dispense methadone? You might not have it with you now, but I would be interested in how many there are and where they currently are, because I am aware that for some people getting their methadone dispensed is quite difficult because often they have to travel some distance to get it dispensed.

Mr FITZGERALD — Matthew is going to answer that one. I think it is fair to say that some people do have to go some distance to have them dispensed. The numbers are significant numbers of pharmacists, but Matthew is going to dig out the precise number.

Ms HARTLAND — I am happy for you to just supply that to the chair.

Mr McCRONE — I will tell you what I can, but we might have to take it on notice.

Ms HARTLAND — Yes, that is fine.

Mr McCRONE — Methadone and buprenorphine are the two drugs which are used for the treatment of opioid addiction. The way the treatment is delivered here in Victoria is a little bit different to other states in that it is a community-based model, so you do go to your community pharmacy, you do go to your GP rather than to a specialist dosing point or a specialist addiction treatment medical practitioner. In terms of numbers, there are around 14 000 pharmacotherapy clients in Victoria. The most recent numbers we have for pharmacies across Victoria is 487 — that is as of May this year — which is around about 37 per cent of pharmacies in total.

Ms HARTLAND — The second question is, and again it may need to be taken on notice, because pharmacists currently do a certain number of screening and health checks like for blood pressure and diabetes et cetera, with the co-payment that the federal government intends to do, can you see this then causing more pressure on pharmacists because people will not be able to pay the co-payment and will be going to the chemist? I presume there is also a fee for those checks at chemists, and will that fee also rise?

Mr FITZGERALD — There are PBS pricing changes, but I am not an expert sufficient to speak to that. The Victorian Department of Health is concerned that the GP co-payment will spill over into non-GP-related services — for example, free screening services, community health centres, and of course public hospital emergency departments. So we are alive to the issue of there is likely to be some behavioural change by people who cannot pay the GP co-payment. I think it would be expected that if one was from a family likely to visit a bulk-billing GP clinic for general ailments, there is probably an increased likelihood that they will seek advice from a community pharmacist.

Mr McCRONE — Further to Peter's response, we mentioned in the presentation that PBS/MBS is one source of funding through the commonwealth. The other pretty significant source of funding in terms of pharmacy services is what is called a community pharmacy agreement, which is between the guild and commonwealth each five years. In the current community pharmacy agreement there are incentive payments that are separate to PBS and MBS for what are called professional practice interventions. For things such as diabetes checks and blood-pressure monitoring there are incentive payments through that mechanism; so it would be separate to any changes to MBS/PBS.

Ms HARTLAND — Is it possible to have a list of what those payments are?

Mr FITZGERALD — Yes, in our role in supporting the committee we could provide that information.

Ms HARTLAND — That would be good.

Mr D. R. J. O'BRIEN — Thank you for your presentation. On page 8 under 'Further avenues for exploration' you talk about:

Improved shared care:

rural and regional health care — including tele-consultations;

advanced pharmacy roles in medication management ...

Would medical clinics' co-located practitioners be a logical place to look at the sharing or extension of the traditional role of the community pharmacy into immunisation in particular, so doctors are there if there is a problem?

Mr FITZGERALD — Yes, it would have to be said that existing co-location arrangements are possibly already taking advantage of opportunities of a synergistic nature between GPs and pharmacists, but we would see that there is potentially a broader scope, as you say, potentially for immunisation. Also, if there are capacity constraints in the GP side of things, it may be that pharmacists can deal with some of the lesser issues.

Mr D. R. J. O'BRIEN — Have we got data on any of those clinics that have been doing trials or anything? Would that be a logical place to collect some data as to how many times there was a complication, assuming it is legal et cetera for GPs to do immunisation?

Mr McCRONE — We possibly could get data from others. When we mentioned practice guidelines that are issued by the pharmaceutical society, there are practice guidelines already about delivery of vaccinations within a pharmacy practice. What that requires here in Victoria is for an immunisation nurse to be part of the staff,

basically, but the practice guideline requires the pharmacy still to have certain things available in case there is an anaphylactic reaction or anything. We could seek that information from the pharmacy guild about pharmacies already in Victoria that are providing immunisation services within the store.

Mr D. R. J. O'BRIEN — I seek clarification on what is available. Is it in the actual pharmacy store or can it be co-located? Obviously at a hospital, as opposed to a community pharmacy, one would presume the guidelines are met because it is a hospital; so it is a matter of degree, I suppose, and specification. You mentioned infrastructures falling into place. What did you mean by that in relation to eHealth?

Mr FITZGERALD — The personally controlled eHealth record is a commonwealth initiative that is presently operative. Anticipating the other members' question, there are more than a million registered users across the country. There are more than 10 million households, but there are more than 1 million registered participants with the personally controlled eHealth record. They can call into the record all of their GP visits, so all of their MBS visits; all of their access to PBS, so all of their prescribed medicines; and increasingly they are putting into those records discharge plans from public hospitals.

Not all public hospitals are registered and have the capacity to readily do it, but the vision of being able to enable a GP to see what has happened at a hospital but also to see what has happened at other clinics, and also for the patient to personally control what is in there, is now a reality. It is just that the take-up is moving over time. I am saying that the infrastructure is falling into place. There are repositories in Victoria where this now happens. It is just a question of getting more hospitals and more practitioners hooked up to it, and that is a challenge for the next few years.

Mr ELASMAR — My understanding of a community pharmacist is all those outside the hospitals — that is what you call a community pharmacist. Does the department have any regulations, for example, regarding staff, the hours and how they operate, or are they free?

Mr McCRONE — The Victorian Pharmacy Authority regulates the premises, and they issue guidelines as well. Those guidelines talk about things like the number of professional staff versus number of front-of-store staff and the number of prescriptions a pharmacy might do in the course of a day. Metrics like that reveal what the workload of the pharmacy might be and what staffing levels are appropriate to deal with that workload.

Mr JEFFERSON — It is probably worth adding that the pharmacy authority would have occasion to visit pharmacies from time to time to inspect the premises, for example, to make sure that the area set aside for safe dispensing and storage of medicines is appropriate to the locality, and that drugs and poisons are locked up safely overnight, as you would expect.

The CHAIR — Does that get reported to the department?

Mr McCRONE — The VPA is its own statutory entity. It provides an annual report to the minister, which is tabled.

Ms MILLAR — I am particularly interested in the role of pharmacists in terms of issuing certificates for absences from work, and I would be interested in your views on how extensive this practice is, to what extent employers currently accept a certificate issued by a pharmacist as opposed to one issued by a GP, and also your views on how much of a GP's regular workload is tied up with just the issuing of certificates for work.

Mr FITZGERALD — There is evidence. I think the Grattan Institute had a stab at the percentage of GP time that was being put into those certificates, as well as prescription renewals, but I do not know the percentage. The thought was that it was an unacceptably high percentage. We sniggered a bit when you put that question because we had surprised ourselves that it was clear and on the table that pharmacists did have the authorisation to issue such certificates, and we had in our heads thought that it was only GPs who had it. It is probably because in the Department of Health we work under an EBA that requires a GP to sign such a certificate. We think it is a general policy case that pharmacists are authorised to issue them but that there might be a medicalisation of our own department in relation to those matters. It does look like an opportunity where we could alleviate unnecessary pressure on GP waits by encouraging more to be diverted through community pharmacy.

Mrs MILLAR — You are quite right that it is written into a number of enterprise agreements that the certificate is required to be issued by a GP. That is why I was interested in your input in relation to that.

Mr McCRONE — It is a recent change under the commonwealth's workplace legislation. It has only been in place since 2007 that pharmacists are listed under that legislation.

Mr LEANE — I have about four questions. I want to unpack the difference between community pharmacists versus other ones. If I am at Doncaster shopping town and I go into Amcal, past all the sunglasses and all that, to the end where they have the prescriptions, is that a community pharmacist?

Mr FITZGERALD — Yes.

Mr LEANE — And that is why there are so many. I did not envisage that when we first got this reference, I have to say. So that is a community pharmacist?

Mr FITZGERALD — Yes.

Mr LEANE — At the moment what sort of things happen at non-community pharmacists that are different? What extra things are happening at non-community pharmacists?

The CHAIR — Could I ask Mr McCrone, for the department, to explain to committee members the difference between community pharmacists, hospital dispensary-type pharmacists and the research and medical pharmacy area?

Mr McCRONE — To become a pharmacist you go to uni, you do your internship and you get registered. You can work in whatever area of practice you choose. You can be a community pharmacist and work in a shop or around shops. You can also choose to work in a hospital, which is dispensary-based work or clinical work, and actually work on the wards doing stuff. You can work in industry, so that includes working for pharmaceutical companies — —

Mr LEANE — Glaxo.

Mr McCRONE — GlaxoSmithKline, for example. You can work in research — in academia — or in government, like me. That is the option. The vast majority of graduates, though — and we gave numbers — are actually working in retail, in community pharmacy.

Mr LEANE — To assist us with our reference — and I know you have given some examples — in Amcal at Doncaster, where I go, how many serious options are there to extend what they are currently doing, which is mainly dispensing prescriptions from local doctors?

Mr McCRONE — Different community pharmacies have different business models. Without naming and shaming them, you can go to certain banner groups, and they are just full of discount merchandise — lots of perfumes and other things. What you would describe as their ethical business, which is the professional dispensary part, is not the majority part of their business. But equally there are community pharmacies, particularly the ones that dispense pharmacotherapy, which were referenced earlier, and the majority of their business is actually the delivery of professional services rather than selling stuff.

Mr LEANE — What sort of professional services?

Mr McCRONE — It is stuff like the dispensing of pharmacotherapy for opioid addiction or a staged supply for patients who are not able to deal with their own medicines themselves. They are getting a month's worth at once. Whether they are mental health clients or whatever else, they turn up to the pharmacy every day to get their medicine. There are dose administration aids, which is a similar sort of thing, mostly for the elderly. They are packed into packs per week with breakfast, lunch and dinner so that they do not get confused by all the drugs they are taking. That is a service that a lot of pharmacies in the community are providing.

In terms of the aged population, they provide clinical services for things like residential aged-care facilities and private hospitals. These are the areas of practice that community pharmacists are actually moving into, which is less about selling stuff.

Mr LEANE — Lastly, take away the aged care and private hospital services, can those other services you mentioned possibly be delivered by more community pharmacies? Is there an opportunity for that? Would it be easier for the public to access those services if more community pharmacies were delivering them?

Mr McCRONE — Yes, it would, particularly in terms of pharmacotherapy. I mentioned a number. It is a lot less than 100 per cent of pharmacies. The whole intent of the community-based model of pharmacotherapy delivery here in Victoria is that if you are a pharmacotherapy client, you are no different to anyone else who needs their medicine. You should be able to go to any pharmacy and get that medicine.

Mr ELASMAR — Are you telling me that if a patient has been discharged from the hospital with a prescription, he do not have to get it from the hospital pharmacy? Can he go outside and get it from a community pharmacy?

Mr McCRONE — No, discharge medications are received as you leave the hospital. The service may be provided by a pharmacy that is not within the hospital, but you are certainly getting the discharge meds before you leave.

The CHAIR — You are talking about a methadone treatment program, though, are you not? There are only 100 pharmacists.

Mr McCRONE — I was here, yes.

The CHAIR — Does that clarify your point?

Mr ELASMAR — Yes.

Mr ELSBURY — I am interested in the Northern Territory and Queensland models where they are providing vaccinations. What are we talking about in terms of the additional training that has to be undertaken by a pharmacist? Are we talking about something that is quite extensive or is it just tick-a-box?

Mr McCRONE — It is not tick-a-box. The comparator in the Northern Territory is for immunisation nurses. Immunisation nurses also exist here in Victoria. A certain level of training is required beyond their base competency. Under the Northern Territory model the pharmacist must do exactly the same amount. In terms of the Queensland model, because this is only a trial and it is very locked in in terms of which patients can be administered and which pharmacies can be involved, the training is not as intense. It is training that is provided by the Pharmaceutical Society of Australia, and that is available online to pharmacists. But again I should point out that the Queensland model is about isolated areas in Far North Queensland, so for that training to be available online is probably pretty fundamental in dealing with it.

Mr ELSBURY — Considering we are talking about allowing pharmacists to inject people with substances, would we be going too far to suggest desensitisation medications would also be able to be included in that?

Mr McCRONE — As in allergy testing?

Mr ELSBURY — Allergies, yes. Instead of going to a doctor and having your allergy tests done, you could just go to your pharmacist and have them whack you with a needle.

Mr McCRONE — The training for immunisation delivery includes a very important component about the recognition and treatment of anaphylaxis. Thankfully it is a very rare occurrence that when someone is given a vaccine there is actually such a reaction. When you are allergy testing the occurrence would be a lot more likely. I am not sure what the numbers would be. If I can answer it this way: I am not aware of any international models where allergy testing is performed by pharmacists, given the real risk or much greater likelihood of someone actually having an allergic reaction, because that is the whole point — to see whether —

Mr ELSBURY — You have to have the allergic reaction. Yes, I know; I have been there. It's fun; you become even grumpier than normal.

The CHAIR — Gentlemen, we have gone well over our allocated time, so on behalf of the committee I thank you very much for your presentation and the evidence you have provided to us this evening. It has been most helpful. On behalf of the committee, thank you again.

Ms HARTLAND — I know Jenny has more questions, and I have thought of a few more. Can we email them via you if there are other things that we want answered?

The CHAIR — I will speak to the committee, but if there are any follow-up queries, we might write to the department and get any clarification or, if need be, come back. Thank you again, gentlemen. We do appreciate it.

Committee adjourned.