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Joint Select Committee
Preventative Health Care Inquiry

Dear Committee members,

Below are some notes on the key contributions community pharmacy currently makes to preventative health in Tasmania. I have also outlined how the infrastructure of community pharmacy could be better utilised (with appropriate legislation) to further this, using over-the-counter codeine as an example.

Community pharmacy can play a key role in the *"integration of a preventative approach to health and wellbeing"* as detailed in the points below.

Infrastructure of community pharmacy

As primary health care providers, community pharmacists are often being the first point of contact between the public and the health care system, with more than 400,000 people visiting Australia's 5200 community pharmacies each day. Individuals who are healthy and unwell visit community pharmacies, providing an opportunity to engage people along the health spectrum and hard-to-reach populations who do not utilise other health services. Community pharmacy is the only health professional service to have expanded its rural services over the last decade.

Pharmacy Workforce

Rural programs and services provided as part of the Community Pharmacy Agreements aim to maintain and improve access to quality community pharmacy services for rural and remote Australia. They also seek to increase the proportion of the total pharmacy workforce starting practice in rural and remote Australia and to retain the pharmacy workforce already there. These programs ensure that Australians pay the same prices for their Pharmaceutical Benefits Scheme (PBS) medicines no matter where they live and that rural and remote community pharmacies can remain viable.

Harm Minimisation:

Presently there are a number of idiosyncrasies relating to the over-the-counter (OTC) or non-prescription provision of codeine and pseudoephedrine containing products from community pharmacies. This is not limited to Tasmania, but for some time perception has been that due to our relatively isolation, inappropriate use of these products was not as big an issue here as it is interstate.

Pseudoephedrine: *(Sudafed)*

(Decongestant; symptomatic relief of cold and flu symptoms; subject to diversion due to clandestine illegal conversion to other agents, such as methamphetamine)

- Currently an exemption from The Privacy Act exists that allows sales of pseudoephedrine-containing products to be recorded on a centralised database, called Project STOP.

- Limitation of this in Tasmania, Victoria and NSW is that recording on Project STOP is not mandatory. Many colleagues record only on this system for a direct product request; "I would like some Sudafed…" but not for a more detailed discussion that involves the pharmacist eventually recommending one of the products.

- While this is their professional prerogative currently, this creates an inconsistent model for provision of supply. Customers do not understand that at one pharmacy they may be requested for (photo) identification when requiring cold and flu medication, whereas at another they do not.

- Indeed, pharmacists that apply a more diligent standard of recording and counselling for pseudoephedrine sometimes are avoided in favour of a pharmacist that will not ask as many, however appropriate questions.

Codeine: *(Panadeine-Extra)*

(Opiate; same family as morphine; used for short-term relief of moderate pain without prescription)

- Presently codeine-containing products are Schedule three; therefore requiring interaction with pharmacist to supply from a pharmacy. There is no requirement to record the supply legally, although some pharmacists do as a matter of course.

- Once again, this creates confusion and uncertainty with patients, as some pharmacies would record as a matter of policy. Many do not.

- I would argue that if codeine is supplied as a Schedule three poison, we have a professional responsibility to make sure it is being used as such. Reference to codeine in current Poisons Schedule (appendix 1) denotes that codeine is to be supplied for only five days treatment at maximum daily dose. Today pharmacists' have no legitimate way of knowing if, when or where a person has previously obtained OTC codeine.

- Example outlined below is from pharmacy dispensing history (figure 1) patient has had codeine-based product (*Rafen Plus*) more than a month ago. They present at the pharmacy on February 15th requesting similar product again. At face value this seems reasonable, however looking at Project STOP denotes more. They have actually had the same product today already!

- Issue we have now is Project STOP only exists for pseudoephedrine-containing products; we do not enjoy the same "legal free kick" for codeine. Therefore even

though a pharmacist may know a person is using codeine too frequently, as such we are not allowed to access this information.

- I am not advocating for use of Project STOP inappropriately. We do not use it for this purpose and as such in the above example I would have most likely supplied what the customer was asking for.

- At the end of the day, pharmacists are not there to prevent people from accessing medications. At present, it is my firm belief that we lack the tools to do this effectively. Mandatory recording of OTC codeine in real-time, on a centralised database that pharmacies could use as decision support for supply, much of the abuse, dependency and misuse of this product could be eliminated.

- Until such legislation exists rendering it mandatory, the status quo will prevail. I feel that this will ultimately lead to further restrictions on this type of medication.

- This would be ill advised for a number of reasons. Patients will suffer, as they will not have timely access to therapeutically effective medication for pain. Medical Practitioners' will suffer greatly increased workload, as these patients will require a prescription for what is available presently after consultation with a pharmacist.

Should you wish to discuss further, I am available in the pharmacy during business hours. The views expressed above are mine alone and do not necessarily represent the Pharmacy Guild of Australia, The AACP or any other professional or industry group I may have involvement with.

Kind Regards

Joseph O'Malley

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Figure 1.

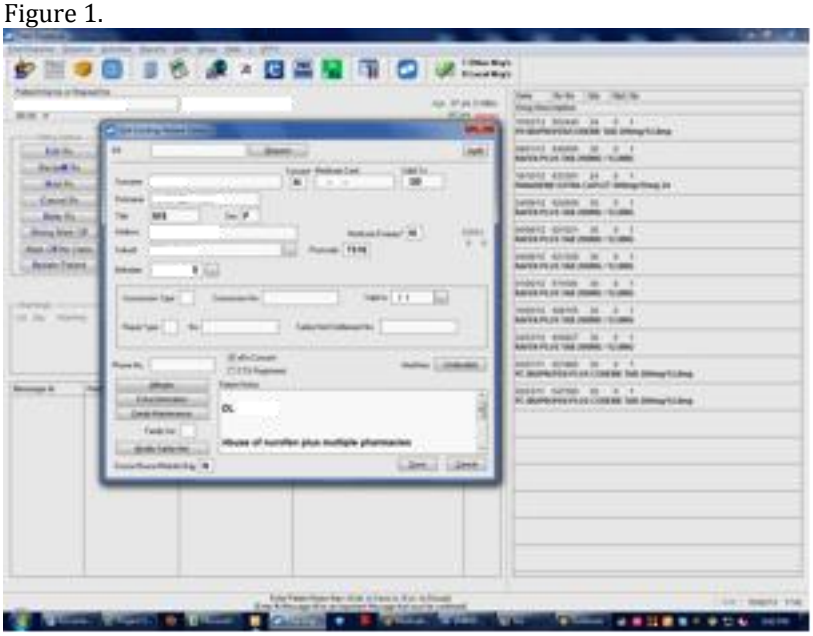

Figure 2.

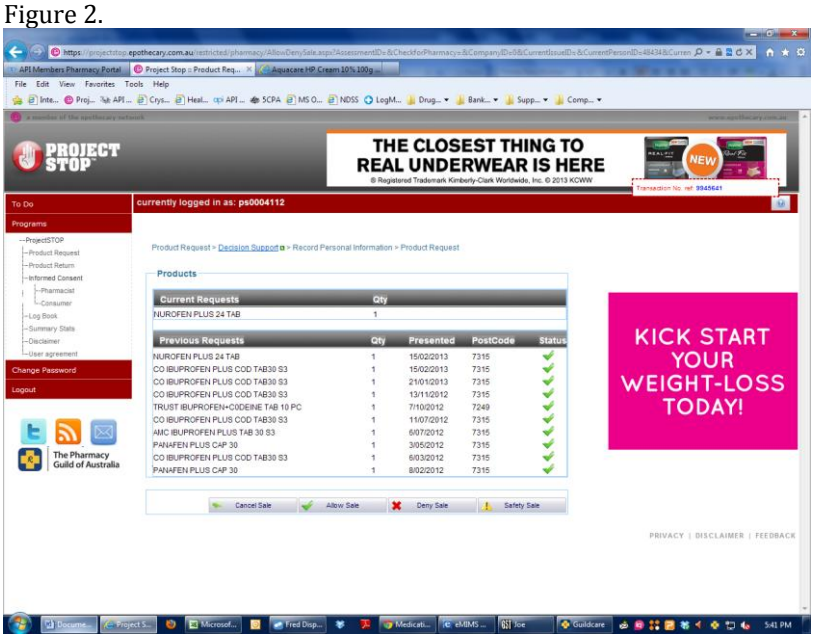

Figure 3

Appendix 1.

SCHEDULE THREE:

CODEINE when:

(a) not combined with any other opiate substance;

(b) compounded with one or more other therapeutically active substances, of which not more than one is an analgesic substance:

(i) in divided preparations containing 12 mg or less of codeine per dosage unit; or

(ii) in undivided preparations containing 0.25 per cent or less of codeine;

(c) labelled with a recommended daily dose not exceeding 100 mg of codeine; and

(d) in packs containing not more than 5 days' of supply at the maximum dose recommended on the label,

except when included in Schedule 2.

SCHEDULE TWO:

CODEINE in preparations for the treatment of coughs and colds when:

(a) not combined with any other opiate substance;

(b) compounded with one or more other therapeutically active substances, of which at least one is phenylephrine and not more than one is an analgesic substance:

(i) in divided preparations containing 10 mg or less of codeine per dosage unit; or

(ii) in undivided preparations containing 0.25 per cent or less of codeine;

(c) labelled with a recommended daily dose not exceeding 60 mg of codeine; and

(d) in packs containing not more than 6 days' supply at the maximum dose recommended on the label.