The Parliament of the Commonwealth of Australia

House of Representatives
Standing Committee on Community Affairs

PRESCRIBED HEALTH

A Report on the Prescription and Supply of Drugs

PART 2 - Prescribing and Medication Management

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FOREWORD

This is the second report on the Committee's inquiry into the prescription and supply of drugs and examines the role of doctors as a central part of the medicines distribution chain.

It is tabled at a time when increasing scrutiny is being given to the place of medicines in health and the dangers as well as the benefits of using potent substances to improve individual well-being. Emphasis has also been placed on the important role of the patient as the consumer of these products, stressing the need to exercise responsibility for maintaining and monitoring individual responses to treatment regimes.

The report follows the Committee's first report which discussed the role of the pharmaceutical industry and the regulatory framework underpinning drug distribution. The first report was tabled in March this year.

In the Government's response to the first report, support was given to all but one of the Committee's 43 recommendations. The Committee welcomes the Government's timely response and is pleased to note the level of support for its work to date. It illustrates the importance of maintaining a coordinated and cooperative approach from all major players to achieving the best possible health outcomes for all Australians.

The second report also builds on the partnership approach to managing medicines, as did the first, and stresses the importance of securing support from all players involved in the whole system. This includes the manufacturers, the regulators, the prescribers, the dispensers and the consumers. All of these have equal and interdependent roles to play in order to maximise the benefits to be gained from the enormous advances achieved in medicinal therapy to date.

Harry Jenkins, MP
Chairman

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36th Parliament

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TERMS OF REFERENCE

The House of Representatives Standing Committee on Community Affairs is to inquire into and report to the Parliament on:

i) current legislative and regulatory controls and professional practices which influence the prescribing, retailing, supply and consumption of pharmaceuticals;

ii) the responsibilities and standards which should apply to the distribution, promotion and marketing of pharmaceuticals; and

iii) the range and quality of information and education on appropriate drug use as opposed to commercial promotion and marketing.

ABBREVIATIONS

ADR	Adverse Drug Reaction
ADRAC	Adverse Drug Reactions Advisory Committee
AMA	Australian Medical Association
ANF	Australian Nursing Federation
APAC	Australian Pharmaceutical Advisory Council
ASCEPT	Australasian Society of Clinical and Experimental Pharmacologists & Toxicologists
CARPA	Central Australian Rural Practitioners Association
CHF	Consumers' Health Forum
DATIS	Drug & Therapeutics Information Service
DHHCS	Department of Health, Housing & Community Services
DUSC	Drug Utilisation Subcommittee
FMP	Family Medicine Program
GP	General Practitioner
GPCC	General Practice Consultative Committee
HIC	Health Insurance Commission
NDIS	National Drug Information Service
PBS	Pharmaceutical Benefits Scheme
PEAC	Pharmaceutical Education Advisory Committee
PHARM	Pharmaceutical Health and the Rational Use of Medicines Working Party
PIPA	Product Information on Pharmaceuticals in Australia
PRD	Professional Review Division (of the HIC)
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RANZCP	Royal Australian & New Zealand College of Psychiatrists
RDNS	Royal District Nursing Service
RFDS	Royal Flying Doctor Service
SACOTA	South Australian Council on the Ageing

SHPA	Society of Hospital Pharmacists of Australia
TGA	Therapeutic Goods Administration
TIS	Translating & Interpreting Service

RECOMMENDATIONS

CHAPTER 2 - Undergraduate and Postgraduate Training of Prescribers

1. The Committee recommends that the core curriculum in clinical pharmacology be taught in all medical schools in a broad context which includes community, as well as institutional settings of prescribing. (para 2.18)

2. The Committee believes it important that all undergraduate medical students be assessed on their interactive skills and recommends that all students should be required to pass communication units as part of their curriculum. Furthermore, the Committee believes that such behavioural studies should play an integrated role in undergraduate courses, reintroduced and reinforced through clinical role models. (para 2.24)

3. The Committee recommends that the General Practice Consultative Committee undertake a national review of medical school use of preceptors in order to ascertain how the contribution of preceptors to medical education should be recognised. (para 2.35)

4. The Committee recommends that the Royal Australian College of General Practitioners be funded to conduct research to evaluate the long term influence of intern acquired prescribing on doctors in private practice. (para 2.55)

CHAPTER 3 - Vocational Training and Continuing Medical Education

5. The Committee considers it imperative that all continuing medical education courses include a quality use of medicines component and recommends accordingly. (para 3.16)

6. The Committee supports developments to improve continuing education opportunities for health professionals in rural and isolated areas and recommends that funding for the Rural Health Support Education and Training program be maintained. (para 3.20)

7. The Committee recommends that the needs of rural practitioners receive greater emphasis under the Family Medicine Program and Quality Assurance Program. (para 3.22)

8. The Committee recommends that a comprehensive assessment of grants allocated under the variety of schemes in the general practice area be monitored to ensure progress towards clear goals. Furthermore, scrutiny of these grants should include money made available under rural incentive schemes and general practice division funding to minimise duplication and provide maximum target effectiveness. (para 3.29)

9. The Committee recommends that financial and administrative responsibility for the "Australian Prescriber" journal be moved from the Therapeutic Goods Administration to an area in the Department of Health, Housing & Community Services more directly concerned with pharmaceutical education. The Committee stresses, however, that the journal should be allowed to maintain its editorial independence. (para 3.36)

10. The Committee recommends that the "Australian Prescriber" journal be allocated additional funds so as to allow it to be distributed at least once every two months. (para 3.38)

11. The Committee also recommends that "Australian Prescriber" produce an index for its back issues so that it can be more easily used as a drug reference guide. (para 3.39)

CHAPTER 4 - The Drug Database

12. The Committee views with concern the reluctance by organisations who have useful information which could improve existing pharmacoepidemiological information bases and recommends that this information should be provided to legitimate research and government bodies on the basis that the information not reveal details of individual doctors or patients or pharmaceutical companies. (para 4.14)

13. The Committee recommends that the Australian Adverse Drug Reactions Bulletin be issued every two months to increase its impact and to maintain the emphasis on reporting adverse drug reactions. (para 4.21)

14. The Committee supports the views expressed in the issues paper on pharmaceutical drug use in Australia and recommends that the Government should seek the agreement of State and Territory health authorities for ways of supplementing the pharmaceutical database by inclusion of State data

sources such as drug use data from public hospitals. This would mean that public hospitals must strengthen their adverse drug reporting processes and provide aggregated information on drug use. (para 4.24)

15. The Committee further recommends that professional and consumer associations should be involved in developing new methods to increase the rate of reporting of adverse drug reactions, in line with suggestions made by the Consumers' Health Forum. (para 4.25)

CHAPTER 5 - Other Sources of Independent Information

16 The Committee supports the work of the Department of Health, Housing & Community Services in sponsoring academic detailing pilot studies and recommends that further nationally based academic detailing projects be sponsored on the basis of evaluations of the present schemes to examine longer term benefits. (para 5.15)

17. On the basis that there is an expressed need for a coordination function for current hospital based drug information services operating in most States, the Committee recommends the reestablishment of a small coordinating unit within the Department of Health, Housing & Community Services whose task it would be to maintain a consolidated database linking States to a national drug information service which would have benefit for medical practitioners and pharmacists. (para 5.25)

18. In order to counter the reservations expressed to the Committee about the use of such a service, it is further recommended that the existence of a national drug information service and its database collection should be widely advertised and promoted to the medical profession and to pharmacists. (para 5.28)

19. The Committee supports the continuation of work to develop national therapeutic guidelines and recommends that such guidelines complement an Australian National Formulary in the form of a compendium volume, updated on a regular basis. (para 5.39)

CHAPTER 6 - Government Strategies

20. The Committee recommends, in line with the Minister's announcement, that the PHARM Working Party continue its work as an implementation committee receiving appropriate support from the Department of Health, Housing & Community Services. One of the aims of this implementation committee should be to examine in greater detail the scope and functions of the proposed national centre for the quality use of medicines. (para 6.11)

21. It is further recommended that a small unit of dedicated Departmental staff be established within the Pharmaceutical Benefits Branch to develop guidelines and an operational charter for such a national centre. (para 6.11)

22. In the longer term, a national centre for quality use of medicines should be established in an academic setting to give it the credibility and objectiveness necessary to develop policy which will be acceptable to the range of interest groups who will be affected by its work. Such a centre should primarily be funded by government, as the potential savings in better use of drugs through the PBS should offset any running costs associated with the establishment and maintenance of the national centre. (para 6.12)

23. The structure of the general practice consultative process would appear to be a little cumbersome. The Committee does not consider it necessary to have two levels of monitoring for the working parties and recommends that the General Practice Consultative Committee should be the body to which the working parties report directly. (para 6.19)

24. Moreover, some of the working parties do not appear to be very active and the Committee recommends that a rationalisation of the functions and effectiveness of all working parties be undertaken as part of the consultative process. (6.21)

25. The Committee recommends that the memberships of the General Practice Consultative Committee and the Diagnostics and Pharmaceutical Working Party be expanded to include the Health Insurance Commission. (para 6.24)

26. With the aim of using Departmental resources more efficiently and establishing stronger links between the General Practice Branch and the Pharmaceutical Benefits Branch, the Committee recommends that a comprehensive database should be developed to coordinate all educational activities impacting on prescribing. (para 6.25)

CHAPTER 7 - Consumer Initiatives

27. The Committee recommends that the Health Insurance Commission give consideration to making medication review an individual consultation item under Medicare. (para 7.50)

28. The Committee recommends that the facilities of the Translating and Interpreting Service and courses on successfully using interpreters be promoted to health professionals through the appropriate professional journals. The Committee recommends that this promotion be funded by the Department of Health, Housing & Community Services. This is an example of an area where the pharmaceutical industry could also extend its range of educational activities. (para 7.56)

CHAPTER 8 - The Team Approach

29. The Committee recommends that the communication links between outpatient clinics and general practitioners be a focus of further research and that funds be provided under the Federal Government's 1992-93 Budget allocation for further incentives to improve continuity of care by general practitioners. Such research should determine the extent of this problem. (para 8.25)

30. The Committee recommends that individual nurses with specific training be licensed to dispense a limited range of prescribed drugs at specific locations. For example, in an urban context, nurses could dispense oral contraceptives through family planning clinics. In remote areas, nurses could dispense antibiotics when a doctor is not available or contactable. The Committee appreciates that implementation of this recommendation requires amendments to State and Territory legislation. (para 8.36)

Chapter 1

INTRODUCTION

1.1 On 20 June 1990, the Minister for Aged, Family and Health Services, the Hon Peter Staples MP, asked the Committee to inquire into and report to the Parliament on:

i) current legislative and regulatory controls and professional practices which influence the prescribing, retailing, supply and consumption of pharmaceuticals;

ii) the responsibilities and standards which should apply to the distribution, promotion and marketing of pharmaceuticals; and

iii) the range and quality of information and education on appropriate drug use as opposed to commercial promotion and marketing.

CONDUCT OF THE INQUIRY

1.2 Because of the broad scope of the inquiry, the Committee decided to table three separate reports, each addressing selected aspects of the terms of reference. The first report, titled "Regulation and the Pharmaceutical Industry" was tabled in Parliament on 24 March 1992 and focused on the current legislative and regulatory controls and the responsibilities and standards which should apply to the promotion and marketing of pharmaceuticals.

1.3 This, the second report, which should be read in conjunction with the first, focuses on the professional practices which influence the prescribing of

pharmaceuticals and the range and quality of information and education on appropriate drug use as opposed to commercial promotion and marketing.

1.4 The final report will examine the current legislative and regulatory controls and professional practices which influence the distribution, retailing and supply of pharmaceuticals.

1.5 To assist its investigations for the second report and to build on information already gathered during earlier stages of the inquiry, the Committee held further public hearings in Adelaide, Alice Springs, Canberra, Melbourne and Sydney. A list of witnesses who appeared before the Committee can be found at Appendix I.

1.6 Informal discussions were also held at a number of centres. In Adelaide the Committee was briefed on the Drug and Therapeutics Information Service (DATIS) run from the Daw Park Repatriation General Hospital and in Sydney the Committee held discussions with the NSW Therapeutic Assessment Group and other staff from St Vincent's Public Hospital.

1.7 In addition, the Committee visited the University of Newcastle and consulted staff in several departments involved in the teaching of medical and nursing students. Discussions were also held with the Royal Australian College of General Practitioners (RACGP) concerning continuing medical education. Furthermore, the Committee Secretariat was represented at the following national conferences: the Academic Detailing National Workshop, held in Sydney in April 1992; the Australian National Formulary Workshop, held in Melbourne in June 1992; and the Consumer Medication Information and Education Seminar, held in Sydney in July 1992.

1.8 The final section of the Committee's first report gave an indication of future directions for the remainder of the inquiry and outlined areas which would be dealt with in the subsequent parts of the Committee's investigations.

PRELIMINARY OBSERVATIONS

1.9 Since the completion of the Committee's first report, major developments have occurred in areas to be addressed as part of the second stage of the Committee's inquiry.

1.10 The Trade Practices Commission's draft report on self-regulation of therapeutic goods advertising and promotion was extensively covered in the first report, already tabled. In its final report on the self-regulation of promotion and advertising of therapeutic goods, the Commission has also made some observations on rational prescribing practice and the promotional activities of the pharmaceutical industry, which may distort appropriate prescribing practices.

1.11 A major document on the quality use of medicines has been prepared by the Department of Health, Housing & Community Services in conjunction with the Pharmaceutical Health and the Rational Use of Medicines (PHARM) Working Party. The PHARM draft policy examines educational initiatives and other strategies for encouraging better use of medicines.

1.12 In addition, two reports released as issues papers for the National Health Strategy, conducted by Jenny Macklin, have covered areas relating to the future of general practice as well as a comprehensive analysis of issues in pharmaceutical drug use in Australia. This work forms some of the backdrop to this inquiry into the prescription and supply of drugs and has a direct bearing on health outcomes, particularly in relation to prescribing and medication management. Reference has been made to these reports where appropriate.

1.13 As outlined in the Committee's first report, any approach to foster quality drug use at a national level relies on cooperation and coordination between government, the industry, health professionals and consumers. Suboptimal use of medicines includes underutilization as well as overutilization and in the context of prescribing involves underprescribing, misprescribing and overprescribing.

1.14 Inappropriate use of non prescription products in combination with or instead of prescribed drugs also complicates good medication management. Reference is made to the appropriateness of non drug therapy in situations where drugs may not the most appropriate way of providing optimal patient care.

1.15 However, the Committee also recognises that drugs do constitute a very important component of the therapeutic armoury and that, when used judiciously, pharmaceutical products are of immense value in promoting and maintaining good health. This is also important in the context of known side effects, where the benefits of drug therapy have to be weighed against the potentially known deleterious effects that a drug or combination of drugs may have on individual well-being.

1.16 Against the background that studies in Australia have indicated that the cost of hospital admissions on the basis of adverse drug reactions may result in costs in dollar terms of between $55-69 million in one year[1], the consequences of suboptimal drug use in Australia are serious. An estimated 30 000 to 40 000 hospital admissions and 700 -1 400 deaths relate to drug use each year[2].

1.17 The question of improving drug use is very complex because it involves several stages in the distribution chain and consequential potential for communication breakdown at each part of the link. Each year, about 160 million prescriptions are dispensed in Australia, with each prescription passing through at least three sets of hands before use. Moreover, many individuals receive care from a number of doctors and institutions.

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1 National Health Strategy Issues Paper No 4, Issues in Pharmaceutical Drug Use in Australia, June 1992, p 36.

2 Harvey R, unpublished paper, 1992.

1.18 In 1989-90 over 16 000 people aged over 70 years received medical services from six or more general practitioners while about 17 000 people aged between 60 and 70 years were also attended to by six or more general practitioners. In addition to this, more than 10% of pensioners have Pharmaceutical Benefits Scheme (PBS) prescriptions filled at three or more pharmacies. Eighteen percent of pensioners who received PBS drugs in the community received one or more prescriptions per week (52 per year), while 40% of residents in hostels received one or more per week[3].

1.19 This report aims to examine the second part of the distribution chain, namely the prescriber and in so doing will look at factors contributing to the assessment a doctor makes in arriving at a prescribing decision, look at objective sources of information on drug usage and finally examine ways of encouraging more appropriate use of available drugs as part of an overall strategy for promoting and maintaining good health.

1.20 As the role of the prescriber is pivotal in the decision making process whereby a patient receives appropriate treatment for a particular condition, this report commences with a detailed discussion of the training of medical practitioners both at the undergraduate level and continuing into postgraduate and further education.

1.21 In its examination of prescriber training, the Committee highlights the importance of good communication skills. Communication is vital in all professional areas where technical information is to be imparted. It is particularly important where it involves giving and receiving information which can make a significant difference to the well-being of individuals and give better health messages to the broader community.

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3 *Ibid.*

1.22 The Committee is aware of extensive consultations between Government and the medical profession in relation to changes in general practice. Proposed reforms involve the removal of many barriers to general practitioner involvement in health promotion and creating greater incentives for doctors to become more involved in providing better care to patients. This includes such general practice reforms as vocational registration and quality assurance.

1.23 Other information which clinicians could use to make judgements and which could provide a better basis for making assessments about appropriate drug therapy includes academic detailing and use of therapeutic guidelines. These are discussed in greater detail later in this report.

1.24 The role of the pharmaceutical industry, which to a large extent has been canvassed in the Committee's first report, is further discussed in relation to the role and influence of industry in medical education.

1.25 Without a good database of drug utilisation, it is impossible to provide adequate feedback and information either in the form of peer review or more generally, to be able to evaluate present levels of consumption of pharmaceutical products in the community. The Committee has made some recommendations about ways of providing a more comprehensive drug database by better use of existing mechanisms and better cooperation between bodies who have a responsibility in this regard. The report also examines various Government strategies which are designed to improve and inform medication use and to obtain better community health outcomes. These include the elements of the Pharmaceutical Education Strategy.

1.26 With the focus on patients as consumers, the report addresses various consumer initiatives to improve patient access to information and to encourage patients to become more actively involved in the management of their own medication and to take individual control of their own well-being.

1.27 Finally, the report deals with the health care team approach involving hospital, institutional and community settings looking particularly at the role of nurses in the community setting and discharge arrangements for patients. The role of pharmacy and community and hospital pharmacists will be examined in the Committee's third report.

Chapter 2

UNDERGRADUATE AND POSTGRADUATE TRAINING OF PRESCRIBERS[1]

INTRODUCTION

2.1 In 1991-92, Australians were prescribed 94 million scripts at a cost to the Pharmaceutical Benefits Scheme of approximately $1.14 billion. (Health Insurance Commission: Transcript of evidence, p 1671) Not included in this figure are prescriptions not presently captured by the Health Insurance Commission as part of its data collection (a greater discussion of this issue can be found in Chapter 4). This level of fiscal outlay on one component of the health care system leads to the expectation that doctors will prescribe appropriately, taking account of relevant factors contributing to quality medicinal usage.

2.2 Appropriate prescribing is premised on the recognition that the management of all conditions requires consideration of non drug as well as pharmaceutical options. In order to ensure quality use of medicines, a doctor should on the basis of the diagnosis, determine whether drug or non drug treatment is best.

2.3 If drug treatment is chosen, a doctor needs to be able to prescribe the most effective drug after taking into account the patient's clinical condition; be able to assess the risks and benefits of a particular regimen and any potential contra indications if the patient is on multiple medications; determine the correct dosage and length of treatment; consider whether less costly alternatives would be equally effective and monitor any adverse drug reactions. Finally the prescriber needs to

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[1] The issue of limited prescribing rights for nurses is addressed in Chapter 8.

be able to communicate with patients in a way that enables the patients to use drugs correctly and safely[2].

2.4 However, in practice, not all doctors prescribe appropriately according to recent data indicating the extent of suboptimal prescribing in Australia. Studies of drug use in hospitals, nursing homes and the community show that even after correct diagnoses, doctors prescribe clinically incorrect drug treatments for approximately 2% - 5% of scripts written, which is equivalent to 3.2 to 8.0 million PBS prescriptions in 1991-92[3]. Such errors include prescribing contra indicated drugs, overprescribing, underprescribing and prescribing in ways that are inconsistent with recommended clinical practice. The data available is not definitive and difficult to extrapolate from, but indicates that one consequence of this suboptimal prescribing was some 30 000-40 000 pharmaceutical related hospital admissions in one year[4].

2.5 Suboptimal drug use is influenced by a range of factors. Improved usage will involve close cooperation between manufacturers, prescribers, dispensers, government regulators and consumers of pharmaceuticals.

2.6 One of the first steps in encouraging quality drug use and reducing prescribing errors is to ensure that doctors are given a firm grounding in the principles of optimal prescribing as part of general medical education. These principles need to be introduced at the undergraduate level and then reinforced and developed during post graduate internships and vocational and other continuing medical education to ensure that newly trained doctors can prescribe appropriately and effectively.

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2 PHARM: A Policy on the Quality Use of Medicines (Draft) May 1992, Appendix III.

3 For a review of literature evaluating suboptimal prescribing in Australia see A Policy on the Quality Use of Medicines (Draft), op cit, Appendix I and Issues in Pharmaceutical Drug Use in Australia, op cit.

4 Issues in Pharmaceutical Drug Use in Australia, op cit, p 35.

UNDERGRADUATE TRAINING

Course content: clinical pharmacology

2.7 The Committee is concerned that too many doctors are completing their undergraduate medical education without a firm grounding in the principles of optimal drug use. The Committee has been told:

> "One of the problems in our country has been that there has been an under emphasis on therapeutics education for prescribers as opposed to education concerning diagnosis. This has been an historical imbalance... and we believe that it is misplaced and unbalanced because a major activity of doctors is to prescribe. In fact, if you look carefully at what doctors do, you will see that a big proportion of what they do is to prescribe and to manage, yet the balance in undergraduate education is the other way around". (St Vincent's Hospital: Transcript of evidence, pp 1478-79)

and furthermore, that:

> "Students get quite a lot of lectures, which are a cost effective way of off-loading information to students but there is not a lot of help for students in learning the practical problems of making decisions about patients... but that is a symptom of a much larger problem in dealing with a course that is over hospital dominated, and prepares students badly, to some extent, for having to go out into the community to practice". (Department of Social and Preventive Medicine, University of Queensland Medical School: Transcript of evidence, p 886)

2.8 The study of drugs and their effects on patients (clinical pharmacology) and appropriate disease treatments (therapeutics) are vital components in the practice of good medicine. A member of the Royal Australasian College of Physicians' (RACP) Therapeutics Committee believes that the best one can do for medical students to encourage optimal prescribing is:

> "to provide them with a good framework of understanding of the principles of pharmacology and the principles of clinical pharmacology... I think that is what we should be aiming to do at an undergraduate level". (RACP: Transcript of evidence, p 1191).

2.9 This view is supported by the Chair of the Pharmaceutical Health and the Rational use of Medicines (PHARM) Working Party who told the Committee that "a very good core curriculum in clinical pharmacology" is needed in medical schools. (PHARM: Transcript of evidence, p 1639)

2.10 The Committee has been told, however, by a number of witnesses that most medical students are not taught enough clinical pharmacology or therapeutics. The Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists (ASCEPT) stated:

> "It is generally accepted that at present there is overuse and irrational use of prescription drugs in Australia. We consider that the situation is unlikely to change until we have a medical profession which has been fully educated in the basic principles of Clinical Pharmacology and Therapeutics". (ASCEPT: Submission, p 176)

2.11 Staff from one hospital believe:

> "It comes back to the question of how much therapeutics is taught to doctors... I really do not think enough is taught". (Daw Park Repatriation General Hospital: Transcript of evidence, p 1339)

2.12 It appears that not only is there insufficient clinical pharmacology taught to students, but that it varies between medical schools. In 1988, the Consumers' Health Forum (CHF) surveyed medical schools across Australia and concluded that there "was marked variation in the information provided by various Schools, the hours they allocated to therapeutics and the topics listed"[5].

2.13 While there have been minor improvements since 1988, there are still marked variations in the teaching hours and emphasis placed on the subject by medical schools. For example, some schools teach clinical pharmacology in first and second years, others introduce the subject in third year; some schools use tutorials, others combinations of tutorials and lectures and some units are not formally

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[5] CHF, Towards a National Medicinal Drug Policy for Australia: Implications for Medical Schools, Health Forum, No 10, July/August 1989, p 1.

assessed, although most are[6]. The Australian Medical Association (AMA) raised this as a matter of concern, commenting that:

> "on the education process, there is room for improvement. Clearly we know that. There is not sufficient uniformity in the undergraduate therapeutic area. That could be improved. (AMA: Transcript of evidence, p 1709)

2.14 The problem is compounded by the limited number of clinical pharmacologists available to teach students in their preclinical and clinical courses. The Director of Clinical Pharmacology at St Vincent's hospital in Sydney warned that:

> "without a clinical pharmacologist in major teaching hospitals and at major universities given the remit to oversee the quality of therapeutics education, we will remain in a parlous state with regard to therapeutics standards in the community". (St Vincent's Hospital: Transcript of evidence, p 1479)

2.15 In December 1991, ASCEPT codified a core curriculum in clinical pharmacology to be presented to each of the medical schools as the minimum level of knowledge and skills on clinical pharmacology that should be taught to students. ASCEPT has subsequently been awarded a Commonwealth Pharmaceutical Benefits Scheme Education Program tender to assist in the take up and implementation of the core curriculum.

2.16 The Committee is well aware that students need exposure to a number of disciplines in their undergraduate training and that any increase in clinical pharmacology teaching time will mean a corresponding decrease in the teaching time for other disciplines. Nevertheless, the Committee believes that clinical pharmacology needs greater prominence in undergraduate curricula in the interests of optimising the quality use of medicines.

2.17 Accordingly, the Committee supports ASCEPT's endeavours to

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[6] ASCEPT: A Core Curriculum in Clinical Pharmacology (Draft), December 1991, Annexe 3.

introduce a common core curriculum into each of the medical schools. The Committee is also encouraged by the example of the University of Newcastle's introduction of clinical pharmacology units from first year level.

2.18 **The Committee recommends that the core curriculum in clinical pharmacology be taught in all medical schools in a broad context which includes community, as well as institutional settings of prescribing.**

Course content: communication skills

2.19 Quality drug use requires a close interaction between health professionals and patients. The basis of that interaction is good communication skills. Doctors need to gather accurate information from patients in a non judgemental and accepting way. Furthermore, if drug treatment is selected, doctors then have the responsibility for giving patients enough information in a comprehensible form so that the patients can take the medication safely and as directed. However, there is evidence from consumer groups and independent studies that many doctors lack adequate communication skills to impart this information to their patients. The CHF explained:

> "There is a widespread concern about general practitioners lacking communication skills, and that affects the information that they are able to impart to their patients... People also complain of not being listened to, of being patronised, and that relates particularly to the elderly. They feel that when explanations are given they are not given in terms that ordinary people can understand. Above all, they do not feel free to ask questions". (CHF: Transcript of evidence, pp 1712-13)

and that "It is no good treating somebody if the person does not understand what the treatment is about". (CHF: Transcript of evidence, p 1714)

2.20 The Committee addressed the link between consumer information and patient compliance in Chapter 5 of its first report, citing evidence that patients who

were better informed about their treatment were more likely to comply with their drug regimen. Research has also indicated a link between non compliance and "adverse patient outcomes"[7]. The Springvale Community Aid & Advice Bureau gave the Committee some examples of this:

> "a client of the Bureau was prescribed a strong liniment for her arthritis. She understood it to be a medicine, ate it, and subsequently died". (Springvale Community Aid & Advice Bureau: Transcript of evidence, p 1261)

2.21 The Bureau also detailed reports of women who did not understand the instructions they were given for oral contraceptives and subsequently became pregnant and of other patients who took suppositories orally. (Springvale Community Aid & Advice Bureau: Transcript of evidence, p 1261) These communication problems are, of course, compounded when doctors and patients are from different ethnic backgrounds and speak different languages. This is developed in more detail in Chapter 7.

2.22 After evaluating a group of doctors and patients from the Newcastle region in NSW, a research group concluded that "thorough training in communication and compliance-aiding strategies needs to be introduced in the undergraduate medical curriculum... "[8]. The CHF also believes that the "emphasis on giving GPs and doctors generally greater communication skills is imperative". (CHF: Transcript of evidence, p 1714)

2.23 The Committee is pleased to note that these issues are now being addressed by a number of medical schools using patient role playing and video feed back sessions to develop students' interactive techniques. One witness reported on

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7 Issues in Pharmaceutical Drug Use in Australia, op cit, p 49.

8 Cockburn J et al, The process and content of general-practice consultations that involve prescription of antibiotic agents, Medical Journal of Australia, 147, 1987, p 324.

the practice at Monash Medical Centre[9]:

> "we commenced a course in communication skills which really got the thumbs down and although we went ahead with it, there was very little support. Now that has all changed. Communication skills are taught in every year of the course... So I think it now has a very high priority". (Prof Carson: Transcript of evidence, p 1283)

2.24 **Given the complaints by consumer groups and demonstrated links between patient compliance and doctor/patient communication, the Committee believes it important that all undergraduate medical students be assessed on their interactive skills. The Committee recommends that all students should be required to pass communication units as part of their curriculum. Furthermore, the Committee believes that such behavioural studies should play an integrated role in undergraduate courses, reintroduced and reinforced through clinical role models.**

Departments of General and Community Practice

2.25 Given that over 50% of medical students ultimately become general practitioners, it is important that students at least be exposed to prescribing "in action" and made aware of the pressures faced by practitioners. The Committee believes that departments of general and community practice have an important role to play in exposing students to the processes of prescribing. These departments can also emphasise preventive care and the importance of community health care programs, topics not otherwise discussed in many undergraduate curricula. The importance of such departments was highlighted by the AMA:

> "the broader implications of how doctor prescribing affects health outcomes and what the effect of their prescribing behaviour is on the cost to the community and the various things that impinge on a medical graduate or doctor to prescribe or not prescribe or use any

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9 Monash has also received a PBS Education Program grant to expand its consulting skills program and offer it to other medical schools.

kind of treatment modality, those things are largely put together in the departments of community medicine and general practice which the AMA has advocated that the Government establish in every medical school". (AMA: Transcript of evidence, pp 1685-86)

2.26 The University of Queensland's Department of Social and Preventive Medicine believes that not enough is done in this area:

"Insufficient time in Medical Courses in this country is devoted to teaching about practical matters relating to drug prescribing, eg, cost effectiveness, legislation, drug safety & drug interactions". (Department of Social and Preventive Medicine, University of Queensland: Submission, p 536)

2.27 The National Health Strategy concurs, stating that "there should be greater time devoted to general practice teaching for undergraduates"[10].

2.28 Such departments can also have an important role to play in informing students, as future prescribers, about the influence the pharmaceutical industry may have on their prescribing patterns. As St Vincent's Hospital explained:

"We believe that medical practitioners gain a large proportion of their information about drugs from pharmaceutical drug company detailers. This activity has been largely overlooked by educators and it needs to be looked at carefully and the whole activity explored for the benefit of students who will become prescribers". (St Vincent's Hospital: Transcript of evidence, p 1503)

2.29 With appropriate teaching, students should gain an understanding of the role of pharmaceutical company detailers and recognise the value and limitations of their information. Exposure to actual or role playing detailers, in the controlled environment of medical schools or teaching hospitals, should assist students in future to critically evaluate information from detailers.

2.30 While it is not the role of medical schools to train general practitioners

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[10] National Health Strategy, Issues Paper No 3, The Future of General Practice, March 1992, p 72.

per se, the Committee believes that departments of general and community practice have an important role to play in introducing students to good quality prescribing and patient management.

General practice preceptors

2.31 Departments of general practice are usually responsible for ensuring that undergraduates are seconded to general practitioner tutors or "preceptors" for work experience. Most students throughout the country receive an attachment or attachments to general practitioners through which they can participate, to varying degrees, in the consultation process. The secondments offer students a more realistic view of general practice and allow them to observe at first hand the work of a general practitioner in the community setting.

2.32 Preceptors have to be picked with some care as students will accrue most benefit from secondments where they are actively involved in the consultation process rather than being passive observers. Students can observe and participate to a limited extent in patient diagnoses, consideration of treatment options, decisions on appropriate drug use where drug treatment is the preferred option, evaluation of potential adverse reactions and contra indications and doctor/patient communication. These are factors which need to be taken into consideration to ensure the quality use of medicines. Furthermore, students can observe this in the context of the general practitioner's surgery, which is where most prescribing in Australia is done.

2.33 In a review of academic general practice, Professor Kamien noted that general practitioners give up time, and hence money, to become preceptors and receive very little academic recognition or remuneration for their contribution[11].

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[11] Kamien M, Academic General Practice in Australian Medical Schools, 1990, Australian Association for Academic General Practice, Sydney, p 9.

2.34 The Committee has been impressed with the contribution of preceptors to undergraduate teaching and believes that this community service should receive greater acknowledgment.

2.35 **Accordingly, the Committee recommends that the General Practice Consultative Committee undertake a national review of medical school use of preceptors in order to ascertain how the contribution of preceptors to medical education should be recognised.**

2.36 Preceptors could be granted forms of academic recognition or title or be financed through innovative uses of Federal funded Practice Grants and the Rural Health Support Education and Training Program.

Awareness of treatment costs

2.37 The Committee believes that students from their undergraduate years should be made aware that quality drug use involves consideration of cost effectiveness. The Royal Australian College of General Practitioners (RACGP) believes that this will not occur automatically:

> "In general, if you are looking at awareness of costs and things like that, perhaps there is a need to go right back to undergraduate training. This question of health economics, the costs of various tests and medication et cetera, is not really covered to any great extent. I think perhaps that is an early target area to really look at...". (RACGP: Transcript of evidence, p 1588)

2.38 A point highlighted by a number of witnesses was that few doctors are aware of the real cost of the drugs they prescribe. St Vincent's hospital found that "many of the prescribers have no concept of the relative value of different drugs". (St Vincent's Hospital: Transcript of evidence, p 1504) The Committee believes that, given the financial restraints on hospital drug budgets and on the PBS, doctors

should not use expensive drugs where less expensive and equally effective alternatives are available.

2.39 Furthermore, the Committee believes that cost effectiveness can be taken into account without compromising clinical standards, as evidenced by the cost containment strategies used by hospital drug committees. St Vincent's Hospital commented:

> "we do not see that high quality need necessarily be high cost. Our focus has always been on good therapeutic practices". (St Vincent's Hospital: Transcript of evidence, p 1504)

2.40 Professor Day also believes it is:

> "important for the training of doctors for the future that they would consider that cost would be built into their assessment of the selection of drugs in particular". (St Vincent's Hospital: Transcript of evidence, p 1504)

2.41 The question of cost awareness can also be assisted by the inclusion of price information in the proposed Australian National Formulary, which was discussed in the Committee's first report.

Non drug treatments

2.42 The terms of reference for this inquiry focus on the prescription and supply of drugs. However, the Committee believes that quality drug use incorporates consideration of non drug treatment. A number of witnesses felt it important that medical courses should not emphasise medicinal treatments at the expense of non drug alternatives. The Doctors' Reform Society (NSW) believes:

> "It may be important to expose medical students to alternative ways of treating patients who present to General Practitioners with problems

such as pain syndromes, mild anxiety-depressive syndromes and common upper respiratory tract infections. If special emphasis was placed throughout under graduate medical training on alternative (non drug related) methods of dealing with these common problems, it would be hoped that the medical students would be infused with a countervailing cautious philosophy by the time they reached their phase of hospital training". (Doctors' Reform Society (NSW): Transcript of evidence, p 1197)

2.43 St Vincent's Hospital gave evidence that part of undergraduate training is to "emphasise in courses on therapeutics that a large part of the activity is not using drugs or stopping them. We believe that there has not been enough focus on that activity...". (St Vincent's Hospital: Transcript of evidence, p 1504)

2.44 A hospital pharmacist told the Committee that it seemed:

"unfortunate to concentrate on the teaching of pharmacology over and above the treatment of non drug therapies and so on. It may indeed put too much of an emphasis on a medicalisation of a lot of problems...". (Daw Park Repatriation General Hospital: Transcript of evidence, p 1328)

2.45 The Committee concurs and is aware that departments of general and community practice examine non drug patient management. It is also hoped that clinical pharmacology courses draw students' attention to the important role of non drug patient management.

POST GRADUATE EDUCATION

Internships

2.46 Upon graduation, medical students are required to work as "interns" in hospitals for one or two years, depending on the particular State registration requirements, before they can be registered as independent medical practitioners. Professor Moulds of the Royal Australasian College of Physicians (RACP), explained

that new doctors are required to work as interns since:

> "The undergraduate is trained as a bit of a jack-of-all-trades in some ways. It is broad-based education which really does not fit the first graduate for doing anything except under supervision". (RACP: Transcript of evidence, p 1190)

2.47 The year or years of internship offer newly graduated doctors a range of supervised clinical experience to complement their undergraduate teaching. As the RACGP explained, the limitation of the undergraduate degree is that:

> "the training you get in undergraduate medicine is very theoretical and is not practically based. It is not sitting down with a prescription pad in front of you and dealing with a problem" (RACGP: Transcript of evidence, p 1579)

Teaching hospitals: teaching optimum prescribing habits

2.48 Hospital based supervisors see the intern period as an opportunity to instil within newly graduated doctors good prescribing habits before they practice independently:

> "As training institutions we should set a standard which our students and so on can aspire to and look back to when they go into practice". (St Vincent's Hospital: Transcript of evidence, p 1503)

2.49 The AMA sees teaching hospitals as "primarily institutions in which doctors learn to manage illness appropriately", where interns can learn from "people who largely are focused on the science of medical management". (AMA: Transcript of evidence, p 1686) The RACGP agrees, seeing the intern years as "a very powerful learning area...". (RACGP: Transcript of evidence, p 1579)

2.50 Hospital drug committees are an important source of information on optimal and acceptable drug treatments for hospital based health professionals. These committees, comprising pharmacists, clinical pharmacologists and experienced

medical staff, define drug policies for their own hospital and disseminate information on appropriate doses, new drugs, adverse drug reactions and associated information through drug bulletins. St Vincent's Hospital believes:

> "The key feature about drug committees in teaching hospitals is that they can be the engine room for change with regard to quality of drug use. All potential prescribers... go through these institutions in their training period and it is a marvellous opportunity to influence the standard of prescribing of potential prescribers". (St Vincent's Hospital: Transcript of evidence, p 1480)

2.51 A number of witnesses have told the Committee that interns should leave hospitals with firmly established, appropriate prescribing habits. The AMA believes that when interns leave the "perhaps more cloistered environment of a teaching hospital" they will have left with a "very good grounding in the most scientific way to manage a particular illness with particular drugs" and that it would not be "at all a bad thing if doctors carry their prescribing patterns with them into the community". (AMA: Transcript of evidence, p 1686)

2.52 However, while hospitals may offer interns a firm grounding in the quality use of medicines, there is some evidence that if bad prescribing practices are learnt during intern years, they can be difficult to alter later. Anecdotal evidence presented to the Committee by the RACGP suggested that doctors' inappropriate prescribing habits may originate in hospital casualty departments where interns spend much time working. (RACGP: Transcript of evidence, p 1578)

2.53 Other research indicates that interns in casualty departments fail to ask patients questions about common, preventive health risks and do not see the need to ask such questions. The researchers involved believe that this indicated the interns had not absorbed practices of good quality patient care and warned that "internship is the last formal opportunity to correct this deficiency"[12].

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[12] Gordon J et al, Interns' identification of patients' health risks in a casualty department, Medical Journal of Australia, 148, 1988, p 615.

2.54 Another consideration which may impact on prescribing behaviour is that most prescribing in the hospital setting is for acute conditions from a hospital drug list. This is not necessarily an appropriate environment for learning about prescribing for the general community.

2.55 **The Committee recommends that the Royal Australian College of General Practitioners be funded to conduct research to evaluate the long term influence of intern acquired prescribing on doctors in private practice.**

The prescriber as a member of a professional team

2.56 Interns become closely involved in the team approach to health care operating within hospitals and work with and consult pharmacists, nurses and other health professionals. The Society of Hospital Pharmacists of Australia (SHPA) sees a direct link between good prescribing habits and the team approach common in hospitals, believing:

> "one of the reasons that drug prescribing and usage has improved in hospitals over the last 10 to 15 years is closer cooperation between health care professions, namely, doctors, pharmacists and nurses". (SHPA: Transcript of evidence, p 1286)

2.57 The Committee believes that it is important that interns leave hospitals to practice in the community with a clear understanding of the contribution of other health professionals to patient health and treatment. The interaction between doctors, pharmacists and nurses, and comprehensive patient management is explored in Chapter 8.

Chapter 3

VOCATIONAL TRAINING AND CONTINUING MEDICAL EDUCATION

GENERAL PRACTITIONERS

The need for vocational training

3.1 In the past, on successful completion of their internship, doctors have been registered to practice medicine independently and thus have been able to enter unsupervised general practice without further training. There is now increasing recognition that general practice is a specialty in its own right and that doctors, as in other specialties such as anaesthetics or surgery, need specific vocational training. The RACGP believes the need for vocational training arises because medical schools:

> "do not attempt to train general practitioners. They train an undifferentiated doctor who then requires training to become a general practitioner". (RACGP: Transcript of evidence, p 1120)

and that on graduation, doctors:

> "go to a hospital for one or two years and all of a sudden they are in general practice and they have to re-sort how they think, what they do... That re-sorting of what drugs to use, what facilities to use, which are very different in private practice from what they are in the hospital, does take time". (RACGP: Transcript of evidence, p 1578)

3.2 The AMA supports this view and feels "that six years plus an intern year is an inadequate amount of training for someone to be a good family doctor in 1992". (AMA: *Transcript of evidence, pp 1697-98)*

3.3 Interns in hospitals write few prescriptions, don't have to worry about patient compliance (which is ensured by nurses) and will only have experience of those adverse drug reactions that occur immediately. Furthermore, few hospital specialists will have enough experience to prepare interns for the prescribing pressures put on general practitioners by pharmaceutical companies and patients.

3.4 In 1991, the General Practice Consultative Committee (GPCC), consisting of representatives from the AMA, the RACGP and the Department of Health, Housing & Community Services, was established to coordinate a range of reforms to general practice. The GPCC accepts that:

> "entry into unsupervised general practice without adequate training... is no longer acceptable. The requirement for vocational training prior to entry into unsupervised general practice is fundamental to improving the quality of general practice"[1].

Vocational registration

3.5 By 1993 all newly graduating doctors wishing to practise independently as general practitioners will have to be "vocationally registered". Once vocationally registered, doctors will be able to claim higher than standard Medicare patient rebates under new Content Based Consultation Items. Using these content based billing items, doctors will be able to provide more comprehensive consultations than under the existing time limited Medicare rebates, which discourage extended, time consuming examinations. Vocational registration is already available for currently practising doctors and as at July 1992, 11 400 general practitioners have registered.

3.6 Vocationally registered doctors can now receive additional remuneration for spending more time, if necessary, with patients to take or update comprehensive histories, conduct extended examinations and devise a treatment management plan with the patient and other health professionals. The Committee

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[1] Open letter from GPCC to all general practitioners, August 1992, attachment p 4.

believes that in such an environment, doctors will be less likely to prescribe medicines inappropriately as a quick and easy alternative to counselling or the development of extensive treatment programs and more effectively manage patients on multiple medications. The Committee fully supports the concept of vocational registration, believing that it will encourage better patient management and, indirectly, better use of medicines.

The Family Medicine Program

3.7 To gain vocational registration, general practitioners will have to be Fellows of the RACGP or be completing or have completed other postgraduate qualifications or continuing education training approved by the RACGP. To qualify for fellowship of the RACGP, doctors will have to, inter alia, complete the RACGP's three year Family Medicine Program (FMP) consisting of at least:

- first year specified training in hospitals (internship);
- second year intensive general practice training with lessening degrees of supervision by an RACGP vocationally registered and accredited general practitioner supervisor; then
- 6 months general practice experience supervised by a mentor, with independent practice encouraged; and finally a 6 month elective in a variety of relevant subjects.

3.8 There are a number of interim arrangements in place for general practitioners already practising who wish to become vocationally registered. In practice, newly registered doctors are expected to undertake the FMP as the most appropriate form of vocational training.

3.9 The RACGP believes that doctors who have completed the FMP vocational training are:

"by far more critical and by far more acute in questioning and formulating their own ideas and asking for the research evidence to base decisions on than some GPs who have been in practice for a while... ". (RACGP: Transcript of evidence, p 1577)

3.10 The AMA supports compulsory vocational training for new general practitioners and told the Committee:

"we in fact are going to bite the bullet on this and see that there is a formal requirement for training. It is those four years of postgraduate training which are the best time to focus on issues like drug interactions and what is appropriate advertising and what is not appropriate. (AMA: Transcript of evidence, p 1697)

3.11 The Committee fully supports the requirement for doctors wishing to practise as independent general practitioners to complete vocational training. The Committee believes that with such training, new doctors will have the knowledge and experience to offer quality patient care. In particular, the Committee sees the time spent completing the FMP as an ideal way for new doctors to develop optimal prescribing habits in the appropriate context and under the guidance of experienced supervisors.

The Quality Assurance Program

3.12 To remain on the Vocational Register, doctors are required to undertake continuing medical education, through the RACGP's Quality Assurance Program.

3.13 Since 1986, the RACGP has, as a condition of membership, required that its clinically active members undertake at least one continuing education option offered through its Quality Assurance Program every three years. The Program has now been expanded so that non RACGP members who are vocationally registered can also participate.

3.14 The Program is very flexible and offers doctors a wide range of self assessed and formally assessed continuing education options. These cover a wide range of topics including preventive medicine, practice assessments and advanced training options in topics such as geriatrics and women's health. It is possible to undertake approved postgraduate courses through tertiary institutions such as graduate diplomas in family medicine, and have them credited. Furthermore, doctors can follow up their own areas of interest, and with RACGP approval, have these credited as options.

3.15 The Committee believes that all prescribers should be required to undertake some form of ongoing medical education, particularly given the almost continuous introduction of new drugs and the rapid advances in patient treatment. The Committee believes that the nature of such acceptable continuing education should be developed by the professional bodies of each specialty and sees the quality and flexibility of the RACGP's Quality Assurance Program as an appropriate model.

3.16 **The Committee considers it imperative that all continuing medical education courses include a quality use of medicines component and recommends accordingly.**

Rural and isolated prescribers

3.17 Doctors usually complete at least one year's extra vocational training in skills such as anaesthetics and obstetrics before practising in rural and isolated areas. While rural doctors receive additional vocational training, access to continuing education courses is far more limited. Doctors in rural and remote areas face particular problems due to their isolation and the difficulties of finding locums to allow regular doctors to attend continuing education programs, which are often based in large cities.

3.18 The Committee notes the role of the various State based rural resource

networks such as the Rural Doctors' Resource Network (NSW), the Rural Doctors' Association (NSW) and the Western Australian Centre for Remote and Rural Medicine. These organisations contribute to the continuing education needs of rural health professionals by running conferences, teleconferences and rural locum services.

3.19 In 1990-1991, the Department of Health, Housing & Community Services introduced the Rural Health Support Education and Training program which funds a number of projects aiming to enhance training and professional support for rural health workers and for those wishing to work in rural areas. Some of the projects funded are to write and coordinate the development of therapeutic guidelines or "standard treatment protocol manuals" which list, inter alia, optimum drug treatments for various illnesses. Chapter 5 examines the importance of therapeutic guidelines in greater detail.

3.20 **The Committee supports developments to improve continuing education opportunities for health professionals in rural and isolated areas and recommends that funding for the Rural Health Support Education and Training program be maintained.**

3.21 The RACGP has established a Faculty of Rural Medicine to examine the requirements for training for rural general practice and other options of direct relevance to rural practitioners.

3.22 **The Committee recommends that the needs of rural practitioners receive greater emphasis under the Family Medicine Program and Quality Assurance Program.**

3.23 The Committee is also pleased to note that in March 1992, Monash University introduced its Graduate Diploma in Family Medicine by distance education.

3.24 Another recent measure designed to attract new general practitioners to rural practice and to encourage greater support for the activities for already practising rural general practitioners is the rural incentive package announced in the 1992-93 Budget. The Federal Government has allocated $8 million for this purpose this financial year. The Committee supports this initiative.

General practice grants

3.25 In the 1991-92 Federal Budget, the Government allocated funds for "Practice Grants"[2]. Practice grants were intended to offset general practice reliance on fee for service payments. By complementing their fee for service remuneration with *such grants, doctors would be able, for example,to develop health promotion* programs with other health professionals or hold clinics on patient management of chronic conditions.

3.26 Practice grants are administered by DHHCS and projects were approved for a wide range of activities. The program was allocated nearly $12 million in 1991-92 and approximately 300 grants were approved, some of which were rolled over into the 1992-93 financial year.

3.27 In the 1992-93 Budget, further financial incentives are provided in the nature of Practice Enhancement Grants. Under this scheme $8 million is provided to assist accredited practices to improve patient care. In addition, further appropriations have been made available for the trialing of other initiatives not yet addressed such as information technology, patient enrolment and practice budgets. All of these developments are further encouraged through the funding of divisions of general practice. This is discussed later in the report.

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2 Minister for Health, Housing & Community Services, Health Care in Australia: Directions for Reform in the 1991-92 Budget, Budget Related Paper No 9, 1991, AGPS, pp 15-16.

3.28 A few of the projects funded directly or indirectly promote the quality use of drugs and, as such, the Committee believes should be encouraged. The Committee sees these grants as a cost effective and innovative method of improving health care as they are driven by perceptions of need at a local level.

3.29 **The Committee recommends that a comprehensive assessment of grants allocated under the variety of schemes in the general practice area be monitored to ensure progress towards clear goals. Furthermore, scrutiny of these grants should include money made available under rural incentive schemes and general practice division funding to minimise duplication and provide maximum target effectiveness.**

Australian Prescriber

3.30 One of the most effective ways of reaching general practitioners and providing them with up to date written information on therapeutics is through the "Australian Prescriber" journal. "Australian Prescriber" is an independent publication fully funded by DHHCS which provides prescribers with current, authoritative information on the appropriate use of drugs. The journal is distributed free of charge to all doctors, dentists, pharmacists and medical schools throughout Australia.

3.31 Prescribers receive a daily barrage of written information in their surgeries, most of which is pharmaceutical advertising and most of which, according to a number of witnesses, is not read. Surveys indicate, however, that "Australian Prescriber" is well received by prescribers, seen as an important source of, independent information on drugs and their appropriate use, and that back copies are kept by prescribers as a drug reference. (DHHCS: Transcript of evidence, p 1615 & Australian Prescriber: Submission, pp 1936-39)

3.32 The Committee sees "Australian Prescriber" as an important and cost effective vehicle for providing prescribers with independent information and

education about the quality use of drugs.

3.33 The journal is currently funded and supported by the Therapeutic Goods Administration (TGA). The editorial Board of the "Australian Prescriber" is concerned about the impact on the journal of recent financial reforms to the TGA:

> "The Therapeutic Goods Administration is now 50 per cent cost recovery. So the pharmaceutical industry is, if you like, funding 50 per cent of the program through fees and charges. The board is concerned about that because they feel that the pharmaceutical industry will not want to be paying for an educational journal as part of that program. That is the perception. The new national manager of the Therapeutic Goods Administration shares that view to a certain degree and feels that 'Australian Prescriber' may now be a lower priority for the TGA than it once was. Hence the board's concern". (DHHCS: Transcript of evidence, p 1616).

3.34 "Australian Prescriber", as an educational tool, should be administered in conjunction with the Department's educational programs. The Committee believes that "Australian Prescriber" can be more effective if coordinated with other initiatives to encourage the quality use of drugs. As the Executive Editor of the journal stated:

> "We feel that, although Australian Prescriber is the principal printed vehicle driving towards rational prescribing, it is not the only way that we are going to encourage rational prescribing. We feel very much that it should be linked in with some of the other initiatives". *(DHHCS: Transcript of evidence, p 1617)*

3.35 DHHCS officers agree, seeing "Australian Prescriber" as:

> "a very useful vehicle... it plays a role as part of, or augmenting, the efforts in pharmaceutical education generally by the Department". (DHHCS: Transcript of evidence, p 1618)

3.36 **Accordingly, the Committee recommends that financial and administrative responsibility for the "Australian Prescriber" journal be moved from the Therapeutic Goods Administration to an area in the Department of Health, Housing & Community Services more directly concerned with pharmaceutical education. The Committee stresses however, that the journal should be allowed to**

maintain its editorial independence.

3.37 The journal is currently distributed on a quarterly basis, which the Committee does not believe is frequent enough to reinforce messages about appropriate prescribing or provide comprehensive, independent drug information.

3.38 **Thus, the Committee recommends that the "Australian Prescriber" journal be allocated additional funds so as to allow it to be distributed at least once every two months.**

3.39 **The Committee also recommends that "Australian Prescriber" produce an index for its back issues so that it can be more easily used as a drug reference guide.**

3.40 The Committee is aware that other commercial publications such as "Current Therapeutics" are also available to prescribers. The Committee supports the publication of any journals that encourage the quality and appropriate use of medicines, as long as there is not undue emphasis on brand name promotion of individual products.

The role of the pharmaceutical industry

3.41 In its first report, the Committee examined drug promotion by pharmaceutical manufacturers and the role that such companies can play in providing product information for consumers.

3.42 The Committee believes that the pharmaceutical industry can also play an important role in promoting the quality use of drugs through sponsoring continuing education programs.

3.43 A number of witnesses have been concerned that company sponsored

educational programs may be biased or used for subtle product promotion. However, this need not be so if the topic contents are the responsibility of an independent organising committee, presentations are made by recognised experts in the field, and there is no promotion of brand name drugs. As a further step to removing any perceptions of bias, sponsoring companies should be encouraged to seek vetting and accreditation for their programs from the appropriate professional bodies.

3.44 Several companies already fund education activities that fit these criteria. For example, the General Practitioner Universities Program of Merck Sharp & Dohme (Australia) Pty Ltd covers general issues such as cardiovascular and geriatric medicine with course topics developed by panels of specialists. Enrolment in the program can be credited towards Quality Assurance Program requirements for both RACGP membership and vocational registration.

3.45 The AMA has acknowledged the significant role the pharmaceutical industry plays in continuing education:

> "We know clearly that much of [continuing] medical education in the Australian community does come through pharmaceutical company influences. We think that is, in many instances, a good thing and it is a very valuable component of [continuing] education". (AMA: Transcript of evidence, p 1084)

3.46 Manufacturers also stand to benefit from their involvement in such educational activities. Prescribers with a thorough understanding of diseases and current treatment options will be more likely to appreciate any therapeutic advantages of a sponsor's new product. Furthermore, sponsoring educational programs generates good will for the company involved. As one prescriber admitted, consideration as to whether:

> "a company that has a good reputation, that has good quality control in its product and which is innovative in terms of trying to further medical research and development of things, would not play an inconsiderable part in my decision making to support that brand name... ". (AMA: Transcript of evidence, p 1114)

3.47 It is important to stress, however, that any pharmaceutical company sponsored continuing education program should be evaluated by the RACGP or other specialist colleges to ensure scrutiny of its educational content. This is particularly important where such a program is an option for maintaining vocational registration.

3.48 The Committee believes that it will be a waste of existing knowledge and resources if the pharmaceutical industry is not encouraged to provide further scholarly and balanced medical education. While encouraging industry participation, the Committee recognises that the cost of sponsorship acts as a disincentive for companies to finance drug education as distinct from drug promotion.

SPECIALISTS

3.49 The focus of this report is on strategies to encourage the optimal use of medicines by all prescribers. The comments on vocational training and continuing medical education have addressed the needs of general practitioners but can be equally applied to other specialists who prescribe drugs. Specialists and consultants are subject to the same, or greater, commercial pressures to prescribe particular drugs. They are also faced with an expanding range of new and increasingly potent drugs, have to consider alternative therapies and need to ensure compliance through effective communication with their patients.

3.50 Specialists, however, are not exposed to the wide range of health problems presenting to general practitioners, nor are they likely to need a working knowledge of such a large number of drugs. As specialists work with a much narrower spectrum of drugs, their opportunities for keeping up to date with new products and treatment strategies are greater.

3.51 Therefore, the Committee limits its comments on the continuing education requirements of specialists to encouraging any initiatives by the respective

professional colleges to promote quality drug use by their members.

3.52 Specialists however, have an important role to play in providing continuing drug information to general practitioners. The AMA believes that general practitioners "do tend to learn a lot about the newer drugs through that specialist interaction" and that when a general practitioner refers a patient to a consultant physician, the physician:

> "routinely sends back to the GP a detailed written report extending for some pages. That is regularly cited by general practitioners as a major source of their continuing medical education. So [physicians] summarise the case and outline the reasons why they are providing certain sorts of treatment". (AMA: Transcript of evidence, p 1093)

3.53 The Royal Australasian College of Physicians (RACP) agrees:

> "the physicians usually write very comprehensive letters back to the general practitioners outlining their diagnostic thoughts, but perhaps even more importantly their management thoughts, and outlining the reasoning behind recommending certain lines of management et cetera. It is certainly perceived as an important educational activity...". (RACP: Transcript of evidence, p 1190)

3.54 Thus, the networks between general practitioners, specialists and other "opinion leaders" should be recognised as an informal, but important, conduit for information on quality drug use and patient treatment.

3.55 The development of health teams is discussed in relation to the creation of divisions of general practice in Chapters 6 and 8.

Chapter 4

THE DRUG DATABASE

EXISTING SOURCES OF DATA

4.1 As referred to in the Committee's first report, in the course of the inquiry the Committee was made aware of the shortage of data which exists in the area of drug use in the community. Such information, if used effectively, would allow better targeting of groups at risk of therapeutic poisoning, enable planning to overcome potential abuse or dependency on certain drugs and provide better feedback to prescribers and patients and augment existing quality assurance processes already in place.

4.2 At present, the major independent sources of population based drug use information are the Health Insurance Commission, the Drug Utilisation Sub-committee of the Pharmaceutical Benefits Advisory Committee, and the Adverse Drug Reactions Committee, a subcommittee of the Australian Drug Evaluation Committee within the Therapeutic Goods Administration of the Department of Health, Housing & Community Services.

Health Insurance Commission

4.3 In relation to the Pharmaceutical Benefits Scheme, the Professional Review Division (PRD) of the Health Insurance Commission (HIC), which was set up in 1991, has responsibility for the development and ongoing review of a comprehensive national program to monitor prescribing patterns of medical practitioners within the Scheme. The aim of the program is to encourage the

provision of high standards of health care through a responsible attitude to prescribing. According to a submission from the Health Insurance Commission:

> "In the complex environment of drug prescribing, the HIC/PRD is thus a player in the high quality use of medicinals. Its approach, which will centre on the provision of feedback information from the HIC databases to the medical profession in relation to individual and overall drug usage patterns, combined with appropriately targeted educative strategies, will be important to optimise drug prescribing. To achieve equity of access and quality of drug usage, strategies not purely related to cost containment must be implemented to encourage the provision of high standards of health care". (HIC: Transcript of evidence, p 1671)

4.4 In response to Committee questioning about the effectiveness of the peer review processes developed by the HIC, the Department of Health, Housing & Community Services stated:

> "We are working quite constructively with the Health Insurance Commission in that area in developing descriptions of inappropriate prescribing habits and patterns of behaviour, but developing it in conjunction with the colleges and actual groups who are responsible for the people who are out there doing the prescribing. So the review process is coming from within those professional organisations, and it is in their own interests to change the behaviour of their participants, because they are the people whom they want to affect. They are probably some of the ones who will be more likely to be sustained". (DHHCS: Transcript of evidence, p 1611)

4.5 The HIC has another major goal in its collection of prescribing statistics. It has a legislative responsibility for monitoring prescribing patterns to prevent and detect overutilisation and/or abuse of the PBS. The tensions which exist between the regulatory and the educative role of the Commission create role conflicts and limit the potentially useful role of the Commission in being a major player in the area of prescribing education. This will be developed in greater detail in Chapter 6.

4.6 The HIC receives prescription information only where the cost of a drug exceeds $15.70, for concessional patients or safety net recipients, and the

supply of drugs to repatriation patients. This constitutes approximately two thirds of scripts dispensed and therefore, many important drugs fall below the patient contribution figure and are not identified.

4.7 The Drug Utilisation Subcommittee has developed a more comprehensive database by use of a sample of computerised pharmacies. This information, while useful for pharmacoepidemiological and public health issues, will not assist with medical practitioner prescribing profiles. Another area of concern is that whereas accurate prescriber information is available for original prescriptions, prescriber identification is not provided on all repeats.

4.8 Finally, the HIC has stated that the requirements by the Privacy Commission to separate Medicare and PBS claims information, means that it is not possible to compare data across the two programs and no combined patient record system can be established. Therefore, no database linkages exist whereby diagnosis and indication for drug use can be identified. (HIC: Transcript of evidence, pp 1674,1675)

Drug Utilisation Subcommittee

4.9 The Drug Utilisation Subcommittee (DUSC) is a subcommittee of the Pharmaceutical Benefits Advisory Committee set up mainly to provide information on trends and patterns of prescription use in the Australian community. The initial information base for the DUSC data was gathered from the HIC where prescription information would be provided with an internal HIC number which would not identify either doctor or patient.

4.10 DUSC has now added to its database information concerning private scripts and scripts beneath the patient copayment level. However, DUSC would like to improve on the information gathered by including information on indications for use of drugs, age and sex.

4.11 One way of augmenting already available information would be to get greater cooperation from commercial market research companies which provide survey information based on general practitioners direct to manufacturers. Cooperation to achieve this level of information coordination has so far been unsuccessful.

4.12 The Committee, in an endeavour to resolve the difficulties with the provision of information from commercial market research companies, invited representatives of IMS Australia Pty Ltd to appear before the Committee. According to the Managing Director:

> "IMS Australia is part of an international organisation that provides marketing statistics for the health care industry. We operate in a number of countries around the world. Our services comprise a number of services. One is that we have a national index of ethical drug sales. We produce sales territory reports and we have an Australian medical index. We also run a call reporting system for pharmaceutical manufacturers which is a system that monitors the calling performance of drug representatives". (IMS: Transcript of evidence, pp 1592-93).

4.13 When IMS Australia was questioned about access to its drug database on the basis of providing information which is not presently available from other sources, the company representatives said that this information "belongs to the manufacturer" (IMS: Transcript of evidence, p 1595) and that "we have a high level of integrity and confidentiality" (IMS: Transcript of evidence, p 1599) and therefore was not prepared to release details about the database to anyone outside the industry on the basis of breach of contractual obligations.

4.14 **The Committee views with concern the reluctance by organisations who have useful information which could improve existing pharmacoepidemiological information bases and recommends that this information should be provided to legitimate research and government bodies on the basis that the information not reveal details of individual doctors or patients or pharmaceutical companies.**

Adverse Drug Reactions Advisory Committee

4.15 The Federal Government established the Adverse Drug Reactions Advisory Committee (ADRAC) in 1972. This initiative attempted to supplement the limitations on drug information obtained through clinical evaluation prior to drug marketing with actual experiences of drug use in the community. However, "in 1990 ADRAC received only 4 920 reports of adverse drug reactions. This would correspond to an improbably low rate of adverse drug reactions of one ADR for every 37 000 scripts issued in Australia"[1].

> "of the 30 000 - 40 000 drug related hospital admissions each year, somewhere between 21 000 - 27 000 would have been due to adverse drug reactions. No estimates are available for the level of adverse drug reactions in the community. However, it is reasonably well accepted that there is inadequate reporting of adverse drug reactions, both in the community and in health care institutions."[2]

4.16 The low reporting rate may be partly due to a lack of awareness by health professionals of the existence of the adverse drug reaction reporting scheme. The Acting Chief Pharmacist at Alice Springs Hospital, when asked whether there was general awareness of the scheme replied:

> "No, and I base that on someone ringing me up only about two weeks ago and saying, 'If there is an adverse drug reaction should we report it?'. That was from a nurse. I was aghast because I thought of course you should.
>
> But it was not her fault because there were no forms there. No-one had told anybody that they should be doing this. That actually came about in the last couple of weeks. I got forms from ADEC in Canberra and I will be sending out an educative memo telling people of the importance of that." (Department of Health & Community Services (NT): Transcript of evidence, p 1455)

4.17 As the reporting of adverse drug reactions provides valuable

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1 Issues in Pharmaceutical Drug Use in Australia, op cit p 15.

2 Ibid.

information about drug use in the general population as well as data on potential harm related to misuse of drugs and drug toxicity, this is another area of interest to the Committee. The Consumers' Health Forum, in a discussion paper on systems for the improved reporting of adverse drug reactions, made several recommendations for involving professional and consumer groups in developing new methods to increase the rate of reporting adverse drug reactions.

4.18 The Consumers' Health Forum recommended that a pilot study be conducted to test different methodologies for the adoption of systems providing for consumer reporting of adverse drug reactions in such a way that they feed into and foster the existing program of health professional reporting. Also recommended were new guidelines to allow commencement of industry sponsored postmarketing surveillance and new guidelines to improve spontaneous voluntary adverse drug reaction reports by doctors[3].

4.19 The Forum also made further recommendations to increase the resources to ADRAC to improve and expand the search of the medical literature and to pilot and evaluate cohort and case control studies[4].

4.20 ADRAC also produces the Australian Adverse Drug Reactions Bulletin which is issued every 3 months. The Committee has been told that the incidence of reporting adverse drug reactions improves greatly in the period immediately following the issue of such a bulletin and there may be merit in increasing the frequency with which they are produced. This would necessitate the provision of increased resources to ADRAC and the Committee supports this.

4.21 **The Committee recommends that the Australian Adverse Drug Reactions Bulletin be issued every two months to increase its impact and to**

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3 Consumers' Health Forum: Discussion paper on systems for the improved reporting of adverse drug reactions, January 1990.

4 Ibid.

maintain the emphasis on reporting adverse drug reactions.

IMPROVING THE DATABASE

4.22 The potential for the development of a comprehensive pharmacoepidemiological database would assist in supporting research studies on the effects of drugs. It would also provide an enhanced capacity for the detection and recording of adverse drug reactions and enable the evaluation of broad issues in drugs such as the effectiveness of different educational methods[5].

4.23 It is apparent to the Committee that the preconditions for the establishment of an effective drug information database already exist. A comprehensive pharmacoepidemiological database could be established by the Department of Health, Housing & Community Services and the Health Insurance Commission using the existing data on medical services and pharmaceutical use and data on nursing home and hostel residents.

4.24 **The Committee thus supports the views expressed in the issues paper on pharmaceutical drug use in Australia and recommends that the Government should seek the agreement of State and Territory health authorities for ways of supplementing the pharmaceutical database by inclusion of State data sources such as drug use data from public hospitals. This would mean that public hospitals must strengthen their adverse drug reporting processes and provide aggregated information on drug use.**

4.25 **The Committee further recommends that professional and consumer associations should be involved in developing new methods to increase the rate of reporting of adverse drug reactions, in line with suggestions made by the Consumers' Health Forum.**

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[5] Issues in Pharmaceutical Drug Use in Australia, op cit, p 16.

Chapter 5

OTHER SOURCES OF INDEPENDENT INFORMATION

5.1 The previous Chapter described the collection of pharmacoepidemiological statistics and information to better inform policies designed to maximise quality drug use. It is also essential, however, that prescribers, as part of quality assurance and continuing education about optimal use of drugs, have access to other independent sources of information to guide decision making about appropriate drugs for given indications.

5.2 Sources of such drug information include academic detailing, drug information services and therapeutic guidelines.

ACADEMIC DETAILING

5.3 As detailed in the Committee's first report, the pharmaceutical industry uses a range of promotional activities to increase and maintain market share. One of these is the direct promotion of brand name products to prescribers by company detailers. This is a tried and tested way to provide individual prescribers with information about new products as they become available on the market. Company detailers provide information about the product and follow up initial visits with periodic visits to reinforce the original message given. This acts to promote sustained prescribing of that product.

5.4 Throughout the course of the inquiry, the notion of academic detailing has been suggested as a way of countering the influence of company detailers or

"drug representatives", as they are called, as well as using this strategy to provide objective, up to date information about new drugs. Concern has been expressed that because of the influence of company detailers and the use of incentives already described in the first report, prescribers may be successfully persuaded to order particular brands and classes of drugs even when they may be unnecessary and costly.

5.5 Hence, academic detailing is an educational technique modelled on the success of pharmaceutical manufacturers use of drug detailing to influence doctors' prescribing behaviour. The technique depends on the power of face to face contact between practitioner and detailer and some evidence that this technique may be more effective in influencing prescribing behaviour than mailed educational material or traditional lectures or seminars[1].

5.6 The academic detailing method is based on the assumption that with a non-coercive approach that seeks to provide doctors with enough impartial advice about drugs, they may wish to modify their prescribing habits themselves. Adopting many of the marketing techniques used successfully by company detailers, independent health professionals (academic detailers) visit doctors on an individual basis to discuss optimal prescribing habits. The detailer may also provide supporting literature, therapeutic guidelines and telephone drug information services for doctors.

5.7 Because of concern about the connotations of the term "academic detailing", other terms such as "educational outreach" or "educational advocacy" are also used. While the notion of such detailing is a relatively recent one, Australia is at the forefront of current research world wide. Such research is largely confined to pilot studies whereby health professionals and Government agencies evaluate the success and cost-effectiveness of this method of modifying doctors prescribing habits. There are currently a dozen pilot projects being undertaken in Australia

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[1] Avorn J, Soumerai S, Improving Drug-Therapy Decisions through Educational Outreach, New England Journal of Medicine, 1983; 308:1457-63.

demonstrating the variety of approaches to academic detailing. Some of these studies are directed at general practitioners, some at general practitioners and specialists, with some of the detailing carried out by doctors and in other cases by hospital based pharmacists.

5.8 The Committee conducted inspections and received briefings on two such academic detailing projects currently being conducted. One of these is being run by the Drug and Therapeutics Information Service (DATIS) in Adelaide and based at Daw Park Repatriation General Hospital, and the other is conducted by the NSW Therapeutic Assessment Group at St Vincent's Hospital in Sydney.

5.9 Both projects have been provided with funding from the Federal Government's Pharmaceutical Benefits Scheme Education Program and will be evaluated to determine whether they could usefully form the basis for a national strategy. Both of these projects have to date focused on the use of non-steroidal anti-inflammatory drugs and have employed hospital-based pharmacists to visit doctors in their surgeries. In addition to providing general information about appropriate use of non-steroidals and alternative therapies, the DATIS project also offers a telephone-based drug and therapeutics information service as well as a therapeutic drug monitoring consultancy service.

5.10 Current projects underway indicate that academic detailing is a successful method of modifying prescribing habits, as long as visits to doctors are maintained. If the academic prescribing message is not reiterated, doctors tend to revert to prescribing the heavily promoted, and often more expensive products. It has also been found that academic detailers have generally been well received by most doctors who see them as a useful source of independent advice to counteract heavy promotion by company detailers who have other interests to pursue.

5.11 In April 1992, the Pharmaceutical Health and the Rational Use of Medicines (PHARM) Working Party convened a national workshop on academic detailing in conjunction with the NSW Therapeutic Assessment Group at St

Vincent's Hospital. This workshop brought together information about all current academic detailing projects being undertaken and was attended by representatives of all major interest groups, namely prescribers, pharmacists, consumers, industry representatives and government.

5.12 This workshop supported conclusions emphasising that for cost reasons, it may be necessary to concentrate future resources more effectively. For example, selectively detailing opinion leaders in the medical community rather than all doctors or focusing on more judicious prescribing of high cost, new or overprescribed drugs may be more cost effective given the expensive nature of academic detailing both in time and resources.

5.13 Another issue to be resolved is whether academic detailing is best carried out by doctors or pharmacists or combinations of both. On the basis of available evidence, it would appear that flexibility is required in putting together an academic detailing team.

5.14 Academic detailing is one means by which prescribers can receive feedback on their prescribing patterns and monitor their reliance on pharmaceuticals as a first line of therapy. It is an important strategy for providing independent information and advice if properly focussed on high risk drugs where potential for negative health outcomes due to drug interactions or overuse is a major concern. However, it should be augmented by other sources of information such as drug information services and therapeutic guidelines.

5.15 . **The Committee supports the work of the Department of Health, Housing & Community Services in sponsoring academic detailing pilot studies and recommends that further nationally based academic detailing projects be sponsored on the basis of evaluations of the present schemes to examine longer term benefits.**

NATIONAL DRUG INFORMATION SERVICE

5.16 In 1975, a joint State and Federal health authorities working party was convened to inquire into a suitable form for a nationwide system of drugs, poisons and narcotics information; the form of the technologies which could be used in such a system; and the potential users, on a State basis, of such assistance. As a result of the work of this group a comprehensive analysis was done of the usefulness of commercial information retrieval services and published material relating to drug and poison information services in other countries. Views were also sought from all State health authorities, prescribers, pharmacists and nurses and the draft of the working party's report was reviewed by pharmacy consultants to each State health authority.

5.17 As a result of its final deliberations, it was recommended that the Australian Health Ministers' Conference agree to the early establishment of a computerised drug information service. The 1977 Health Ministers' Conference accepted this recommendation. This led to the establishment of the National Drug Information Service (NDIS).

5.18 The aim of the establishment of the NDIS was to set up a Federal coordinating body with major State centres.

> "That was the first stage of the process. Further down the track it was proposed that regional centres in major country towns would be established and that at the end point of the development of this service there would be the means by whether every individual pharmacist or medico practising in even remote areas would have a network back through which he could work to obtain unbiased and independent information." (Society of Hospital Pharmacists of Australia: Transcript of evidence, p 349)

5.19 According to the report on the review of drug evaluation procedures by the Public Service Board:

"The National Drug Information Service was established to provide authoritative monographs on all prescription drugs available in Australia. Its monographs are available on-line, in hard copy and on microfiche. Its users are mainly specialist clinicians, either directly or through the State-run drug information centres ..... . There are currently 328 completed NDIS drug profiles. About 21 new full profiles were added last year, and 15 in 1985[2].

5.20 The Public Service Board report recommended that the "NDIS should be discontinued and the staff involved transferred to other duties on the basis that ... the need to maintain an independent source of information about drugs for the use of specialist clinicians was a luxury"[3].

5.21 The Committee, in seeking views from witnesses at public hearings about the usefulness of a national drug information service, was told in most instances that the service had performed a useful function. According to the Society of Hospital Pharmacists of Australia (SHPA):

"One of the things that body used to do was to have a network of professional scientists, pharmacists and others working for it compiling profiles about drugs. These were not only based on the official documentation that was obtained by ADEC but they also meant that the professional preparing them referenced maybe 40-80 scientific journal articles about a given drug. It is somewhat ironical that we had a system that, had it developed to its full potential - may well have provided what many practitioners in the field and consumer groups are calling for at the moment." (SHPA: Transcript of evidence, pp 349-50)

5.22 The Society of Hospital Pharmacists further went on to say that:

"What we now have is that the major State centres are still operating but they have no federal coordinating." (SHPA: Transcript of evidence, p 350)

5.23 According to the Queensland Drug Information Centre:

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2 Public Service Board, Review of Drug Evaluation Procedures report. June 1987, AGPS, pp 101-102.

3 Ibid.

"The withdrawal of a range of Commonwealth support has certainly increased difficulties... The record system that used to be maintained by the Commonwealth of the calls received being withdrawn has effectively put it in the situation of not having access to responses it gave prior to 1990. With any sort of drug information service, one of the prime resources that are used are the answers given previously. So having to re-research those answers is increasing the workload significantly... The centre now has to hold a wider range of resources which it previously had some access to through Commonwealth data. Some aspects that regularly occurred within the National Drug Information Service profiles which were discontinued, do not automatically show up in all the ADEC approved package information. So some aspects like protein binding, which can be very useful for extrapolating some responses, are not routinely available. It is certainly experiencing difficulties, which is increasing its workload. (Queensland Health: Transcript of evidence, pp 875-76)

5.24 Professor Day, in evidence to the Committee when discussing the drug information services said:

"There is certainly a great need to get together at least. Currently there is very little interaction between the State drug information services, largely because they have all been wound down and I suppose they have become defensive. We certainly do not feel that way and we believe strongly that there is a real need to get together, collaborate, share and probably for some sort national organisation, which may be simply an association. But that would be a good start. Out of that you would start to see pretty quickly whether there was value in a central coordinating body or what have you. One can imagine, in a quality of drug use plank of the national Australian drug policy, that one of the *things the central body looking after this could do would be to simply* look after State drug information services in some sensible way." (St Vincent's Hospital: Transcript of evidence pp 1507-08)

5.25 **On the basis that there is an expressed need for a coordination function for current hospital based drug information services operating in most States, the Committee recommends the reestablishment of a small coordinating unit within the Department of Health, Housing and Community Services whose task it would be to maintain a consolidated database linking States to a national drug information service which would have benefit for medical practitioners and pharmacists.**

5.26 A National Drug Information Service would reinforce the message that

there is a need for more unbiased drug information and provide a level of commitment by Government to this end.

5.27 One of the key responsibilities of this service would be to keep up to date with new drug entities to assist prescribers and pharmacists in negotiating through the vast array of pharmaceutical products coming onto the market. According to Goodman & Gilman:

> "The flood of new drugs in recent years has provided many dramatic improvements in therapy, but it has also created a number of problems of equal magnitude. Not the least of these is the 'therapeutic jungle', the term used to refer to the combination of the overwhelming number of drugs, the confusion over nomenclature, and the associated uncertainty of the status of many of these drugs."[4]

5.28 **In order to counter the reservations expressed to the Committee about the use of such a service, it is further recommended that the existence of such a service and its database collection should be widely advertised and promoted to the medical profession and to pharmacists.**

5.29 Its usefulness would be enhanced by new developments in computerised data processing technology which would enable more advanced access to data based on specific need. It would also form an important component of a broadly based education strategy and complement other initiatives in the area of quality drug use.

THERAPEUTIC GUIDELINES

5.30 In the Committee's first report, there was brief discussion of therapeutic guidelines and more detailed coverage of the development of an Australian National Formulary.

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4 Melmon K et al, Principles of Therapeutics, Goodman and Gilman et al (eds) Goodman and Gilman's The Pharmacological Basis of Therapeutics, 1980, 6th edition, MacMillan, p 51.

5.31 Therapeutic guidelines, which list recommended treatment regimens on the basis of defined conditions or disease categories, already exist in various forms throughout the country. These include therapeutic guidelines laid down by State drug usage advisory committees, guidelines covering specific areas of therapeutics such as those published by the Victorian Drug Usage Advisory Committee, and specific treatment protocols in various remote and rural locations such as Central Australia and the North of the Northern Territory.

5.32 One of the benefits of therapeutic guidelines is that they provide a peer consensus approach to drug prescribing and contribute to the continuing education of medical practitioners.

5.33 As discussed in the Committee's first report, therapeutic guidelines may be an adjunct to a national formulary. Because of the distinctive function of guidelines in recommending appropriate means of therapy, they can assist in establishing standards to measure quality drug use and form part of the quality assurance cycle.

5.34 In the establishment of peer consensus guidelines, it is important to develop a document which has acceptability at a national level.

5.35 In evidence to the Committee, Dr Harvey said:

> "Antibiotic guidelines is the nearest that Australia has got to a national consensus and it has taken us 12 years and six editions to pick up one State after another. This has been important - to get local representation - because things imposed from Canberra without local representation are often rejected on principle ... The other guidelines, which are all in that first edition, are still Victorian guidelines. They were produced by the Victorian Drug Usage Advisory Committee and, commendable as this activity is, the Victorian Drug Usage Advisory Committee is a committee of the Ministry of Health, primarily concerned with drug use in Victorian hospitals. It is commendable and it started, I think, a revolution and a direction as to how we can go. But to me I do not want to wait another 12 years before these get up and become national." (Dr Ken Harvey: Transcript of evidence, pp 433-34)

5.36 At the same public hearing, Dr Mashford went on to say:

> "The antibiotic guidelines represent the reverse of setting up a central authority which gets everybody together and writes a set of guidelines. That sort of thing can go on forever. What the antibiotic guidelines have done, as Ken said, was to start in Victoria and then gradually to bring in the other States. They have blazed the trail and the analgesic guidelines are now having a second edition written. In fact, there are interstate representatives on the writing committees from South Australia and from New South Wales and that will almost certainly increase the penetration of those particular guidelines. That would be the intention, I think, for subsequent editions of all of the guidelines. I think that this is a way of expanding a successful enterprise rather than attempting to set up something de novo. (Dr Mashford: Transcript of evidence, p 435)

5.37 Another issue relating to such guidelines is the currency of the information contained in them:

> "As a prescriber, I find that guidelines certainly are a good way of getting a general consensus of issues at this particular snapshot in time. But new drugs come along and things change and if you go another year or two down the track and the latest and greatest drug does not have a place in those guidelines, then they lose credibility. Therefore, it is a matter of having some sort of continuing process of refinement and optimisation of guidelines if they are to remain credible with the prescribers. (Dr Jennings: Transcript of evidence, p 1312)

5.38 The Victorian Drug Usage Advisory Committee has made a policy decision to review all guidelines booklets every two years to ensure that currency is maintained. However, if national guidelines are to complement an Australian National Formulary as a compendium volume, it will be necessary to ensure that revisions of both texts occur more often.

5.39 **The Committee supports the continuation of work to develop national therapeutic guidelines and recommends that such guidelines complement an Australian National Formulary in the form of a compendium volume, updated on a regular basis.**

5.40 The production of national therapeutic guidelines will not obviate the need for local treatment protocols and instruction manuals for remote and rural settings. The Committee, in taking evidence in the Northern Territory, was made aware of special conditions for treatment and lack of availability of therapeutic and medical resources which made it necessary to devise separate guidelines for treating conditions of particular significance to certain areas. In the Northern Territory, the Central Australian Rural Practitioners Association (CARPA) determined that a comprehensive and uniform standard treatment manual was required for the region. CARPA undertook to develop the "Red Book" to cover childhood, general and men's problems, incorporating and enlarging on the protocols produced by the various agencies in the region.

5.41 In a letter to the Committee from the staff specialist in infectious diseases at Royal Darwin Hospital, the question of availability of drugs for use in Aboriginal communities in Central Australia and the general issue of pharmaceuticals supply in tropical Australia was raised. The point was made that over the last three years there has been increasing recognition across Central and Northern Australia of the importance of standard treatment protocols as a means of enabling health workers, nurses and doctors to provide appropriate therapy in their own communities. A further point was made that:

> "It is evident that the specific needs of remote communities are not always being met, predominantly because drug supply is dependent on a centralised regulatory system working with the pharmaceutical industry geared to an affluent society"[5].

5.42 An acknowledgment of these special conditions is illustrated by the CARPA Red Book which was described in the following way:

> "The aim of the protocol was to provide guidance for people working in the bush clinics, mostly nurses and health workers, as to the sorts of things that they would need to look for in managing a particular condition and to provide straightforward steps in how to manage that condition - which drugs to use and how to use them - again with the

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5 Letter to Committee from Dr Bart Currie, dated 13 April 1992.

> emphasis on, as far as treatment goes, making compliance easier as far as possible, for example, steering clear of four times a day medication, and as much as possible, trying to use once or twice daily medications, and using injectible medications where possible for certain conditions. That is a broad overview of the process and what the manual is all about." (CARPA: Transcript of evidence, p 1414)

5.43 Therefore, it is important to acknowledge that although national therapeutic guidelines should aim to improve quality drug use these will, as required, be supplemented with other protocols and manuals specifically designed to satisfy particular needs in specialised communities.

Chapter 6

GOVERNMENT STRATEGIES

6.1 The Federal Government, through its National Health Strategy, is addressing ways in which Federal Government funding of health services can improve the health of all Australians in an equitable and efficient manner. In the pharmaceutical area, the Department of Health, Housing & Community Services is addressing the fourth plank of the National Drug Policy, namely "Quality Use of Medicines" in several ways.

6.2 The major sections of the Department involved are the Pharmaceutical Benefits Branch and the General Practice Branch. These areas of the Department, together with the Professional Review Division of the Health Insurance Commission, constitute the major bureaucratic structures whereby Government policy is brought to bear on issues within the prescribing environment.

6.3 The Federal Government's Pharmaceutical Education Strategy, which was discussed and detailed in the first part of the Committee's inquiry, has three arms. These are:

- The Pharmaceutical Education Advisory Committee (PEAC) - an interdepartmental committee which coordinates the department's activities in pharmaceutical education;
- The Australian Pharmaceutical Advisory Council (APAC) - comprising representatives of all community and professional groups working in the pharmaceutical environment; and

. The Pharmaceutical Health and the Rational Use of Medicines (PHARM) Working Party - set up in June 1991 as a multi-disciplinary body to provide the department with expert advice on the promotion of the quality use of medicines.

ROLE OF PHARM

6.4 PHARM brings together the disciplines of clinical pharmacology, general practice, the consumer movement, pharmacy, health education, pharmacoepidemiology and nursing, as well as industry and government. Its charter, as set out in its original terms of reference, was to:

> "provide a report to PEAC outlining the most appropriate structure by which to organise ongoing pharmaceutical education (through the development of) ... a coherent and integrated educational strategy, related to real issues and needs in the area of pharmaceutical education."

6.5 PHARM was initially established to complete its work within 12 months. In that period the working party has conducted a series of meetings, assessed over 50 projects for funding and developed a comprehensive set of procedures, application forms and information resources to streamline the operation of the PBS Education Program.

6.6 Examples of the range of projects funded through PHARM include the National Academic Detailing Workshop and the Consumer Information Workshop, referred to earlier in this report, a review of literature on medicinal drug use in Australia, seeding grants in nursing, clinical pharmacology and pharmacy to develop quality of use issues, as well as several others.

6.7 A major part of PHARM's work was the development of a policy document on the quality use of medicines. This document in draft form was

released in May 1992 for public comment. After responses have been received from APAC, State and Territory Health Ministers and relevant community professional government and industry organisations, the policy will be refined and redrafted for release later in the year.

6.8 One of the major thrusts of the draft policy is to promote the establishment of a national centre for the quality use of medicines. This centre is envisaged as a vehicle which:

- coordinates and evaluates activity being undertaken by the various players;
- facilitates further activity;
- conducts and/or facilitates research as appropriate;
- acts as a clearing house for information about activity in the area of quality use;
- provides resources - both financial and people - for appropriate activities, initiating them when necessary;
- provides incentives to encourage greater activity in the area; and
- facilitates discussion and cooperation with the other three arms of the National Medicinal Drug Policy[1].

6.9 Although some detail about the structure of such a national centre is provided in the draft PHARM policy document much of the practical analysis of the workings of the centre, its management structure and links to government have yet to be developed.

6.10 The Committee supports the achievements of the PHARM Working Party and notes the commitment by the Minister for Aged, Family and Health Services, to continue to investigate methods by which the quality use of medicines

[1]Policy on the Quality Use of Medicines (draft), op cit, p 20.

can be implemented. It is also the Committee's view that part of the success of PHARM was due to its multi-disciplinary nature and the degree of commitment by each member to work constructively and creatively to look at practical impediments and solutions to encouraging better health outcomes in the pharmaceutical area.

6.11 **Therefore, the Committee recommends, in line with the Minister's announcement, that the PHARM Working Party continue its work as an implementation committee receiving appropriate support from the Department of Health, Housing & Community Services. One of the aims of this implementation committee should be to examine in greater detail the scope and functions of the proposed national centre for the quality use of medicines. It is further recommended that a small unit of dedicated Departmental staff be established within the Pharmaceutical Benefits Branch to develop guidelines and an operational charter for such a national centre.**

6.12 **In the longer term, a national centre for quality use of medicines should be established in an academic setting to give it the credibility and objectiveness necessary to develop policy which will be acceptable to the range of interest groups who will be affected by its work. Such a centre should primarily be funded by government, as the potential savings in better use of drugs through the PBS should offset any running costs associated with the establishment and maintenance of the national centre.**

6.13 It is important to stress that the national centre's main objectives would be coordination and facilitation:

> "The national centre would not be a controlling centralised body. The model is very much that it is there to link groups together. Because there has been no articulated policy about quality of use and because the issues about how to use drugs and what is involved are very complex, many groups have had to develop something to be able to deal with the problems over the years. So lots of different programs have been developed from different points of view and there has not been very much coordination between them." (PHARM: Transcript of evidence, p 1642)

6.14 In the PHARM draft policy, the functional areas of a national centre are stated to be as follows:

- the provision of objective information;
- the facilitation of training;
- national educative campaigns; and
- provision of services to both consumers and health care providers.

6.15 The Committee supports this structure and notes that the effective operation of such a centre will require the support of industry, government, consumers and the media.

ROLE OF GENERAL PRACTICE BRANCH

6.16 The General Practice Branch of the Department of Health, Housing & Community Services was established to implement measures set out in Budget paper No 9, 1991-92, relating specifically to Medicare reforms[2] and is responsible for developing policies and programs which promote access to high quality general practice services at a reasonable cost.

6.17 As well as administering the Demonstration Practice Grants Program referred to earlier in Chapter 3, the General Practice Branch is responsible for servicing the general practice consultative process. This consists of a General Practice Consultative Committee which is a tripartite group with representatives from DHHCS, AMA and RACGP which is responsible for setting parameters and making proposals to cabinet and councils of the AMA and RACGP about general practice reforms. The second level of the consultative process is the General Practice Working Group with, the same membership as the General Practice Consultative Committee, whose function it is to develop an integrated package of

2 Health Care in Australia, op cit.

proposals for consideration by the Consultative Committee.

6.18 In addition, working parties are set up by the General Practice Working Group to research specific issues and to develop proposals for incorporation into the overall package. These working groups are presently in the areas of:

- evaluation;
- workforce issues;
- ordering by GPs of diagnostics and pharmaceuticals;
- continuity of care;
- trends in Medicare data;
- vision of general practice; and
- information technology.

6.19 **The structure of the general practice consultative process would appear to be a little cumbersome. The Committee does not consider it necessary to have two levels of monitoring for the working parties and recommends that the General Practice Consultative Committee should be the body to which the working parties report directly.**

6.20 . In private discussions with DHHCS, the Committee has been told that some of the working groups earlier referred to are no longer active or have not met for a considerable time.

6.21 **For this reason the Committee recommends that a rationalisation of the functions and effectiveness of all working parties be undertaken as part of the consultative process.**

6.22 Another concern is that the level of representation by relevant and critical players is inadequate in some cases. It is the Committee's view that the HIC should be represented on the General Practice Consultative Committee. The Professional Review Division has a direct role to play in monitoring prescribing

patterns and providing better feedback mechanisms to help prescribers foster better quality use of medicines.

6.23 Similarly, the HIC is not represented on the ordering Diagnostics and Pharmaceuticals Working Party. As this working party is examining ways general practitioners make choices in ordering tests and drug options with an aim to make the use of tests and ordering of drugs more efficient, the HIC has a direct role to play and should be included as part of this group.

6.24 **The Committee therefore recommends that the memberships of the General Practice Consultative Committee and the Diagnostics and Pharmaceutical Working Party be expanded to include the Health Insurance Commission.**

6.25 **With the aim of using Departmental resources more efficiently and establishing stronger links between the General Practice Branch and the Pharmaceutical Benefits Branch, the Committee recommends that a comprehensive database should be developed to coordinate all educational activities impacting on prescribing.**

6.26 Another significant part of the work of the General Practice Branch involves looking at how general practitioners can be better linked into the rest of the health system. A key initiative in this regard is what the profession is calling *divisions of general practice, or local structures which will encourage general* practitioners not only to group together so they can work more cooperatively in an area, but also to link with the rest of the health system:

> "At the moment they tend to be isolated, working in general practice; they are not involved very much in things like area health planning or district-wide or community-wide health promotion and prevention programs. They tend very much to be operating separately from a lot of those sorts of activities." (DHHCS: Transcript of evidence, p 1623)

6.27 The Department, in evidence to the Committee, thinks that divisions of general practice:

"would help not only to improve those links but also to provide a stronger base for things like peer review and quality assurance in general practices. At the moment, because GPs are so isolated, it is difficult to do any peer review or quality assurance, but through the divisional structure, which would involve groups of general practitioners who could collectively engage in peer review and quality assurance activities, those major steps towards dealing with peer review and quality assurance would be possible. As well, better integration and getting GPs more involved in some of those broader health promotion and prevention programs which they are currently separated from, may ultimately impact on the use of drugs and other treatment methods." (DHHCS: Transcript of evidence, p 1624)

6.28 The Committee strongly supports a more integrated approach to the delivery of health care services and deals with this in more detail in Chapter 8.

Chapter 7

CONSUMER INITIATIVES

THE IMPORTANCE OF CONSUMERS IN THE QUALITY USE OF MEDICINES

7.1 Quality drug use involves a team approach to health care in which health professionals (prescribers) and consumers (patients), play informed and interdependent roles. Consumers bear the ultimate impact of drug therapy and should therefore be recognised as participants in health care decisions. The nature of this interdependent relationship was described by the South Australian Council on the Ageing (SACOTA):

> "I think we have to encourage and nurture this idea that prescriptions are tripartite consultations and that the pharmacist has as much say as the doctor, and the doctor has as much say as the patient et cetera. The three work together, not one above the others". (SACOTA: Transcript of evidence, p 504)

7.2 Furthermore, patient compliance is a vital factor in quality drug use. This requires consumers to be actively involved in their own treatment, rather than just as passive participants[1].

Consumer rights

7.3 It is the responsibility of prescribers to provide consumers with appropriate information to maximise patients' ability to take drug treatments

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[1] A discussion of sources of consumer information can be found in Chapter 5 of the Committee's first report.

correctly and safely. All consumer groups giving evidence before the Committee described the growing consumer demand for drug information and the push for a more active role for consumers in illness management.

7.4 The Endometriosis Association of Victoria highlighted the drug information they thought consumers, in this case women, should be given by doctors during consultations:

> "What we believe is that it is a woman's right to know all the side effects; and it is up to her to decide whether she wants to go on that drug... She needs to have an overall picture of the different types of drugs, what all the side effects are, what the drugs are all going to do. Then, in consultation with the doctor, she should decide what drug she wants to go on". (Endometriosis Association of Victoria: Transcript of evidence, p 396)

7.5 SACOTA reinforced this view:

> "it is essential that people actually have the full details of the options: that they may take this medicine; that they would probably need to take it for either the rest of their life or a short time... the most important thing of all, is that at the end they must know, if they opt not to take a drug, what the consequences will be... So, if you are going to give patients a choice, which... is very important, you must make sure they have all the options straight". (SACOTA: Transcript of evidence, p 497)

Consumer responsibilities

7.6 There are limits to the extent to which information health professionals provide to patients is taken in and understood. The individual consumer needs to make the final decision to ensure compliance or make an informed choice about treatment options. Once consumers have the information, they also have a responsibility to ensure any medicines prescribed are taken correctly.

7.7 To ensure compliance and quality drug use, consumers have

responsibility for filling scripts, taking correct doses at the correct time for the full course of treatment, storing medicines in safe places and not hoarding out of date pharmaceuticals. They need to provide doctors with case histories and information about possible adverse side effects. The Consumers' Health Forum (CHF) accepts that quality drug use is not just the responsibility of health professionals, but that "we need to move towards getting consumers to be more responsible as well". (CHF: Transcript of evidence, p 1715)

7.8 The medical profession agrees, with a representative of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) arguing:

> "prescribing is not a one way process... it is an interactive process... I think that patients have responsibilities themselves. I do not think that patients can just sort of sit back as passive consumers and I am very much in favour of informed patients and an informed interaction with practitioners in terms of medication usage". (Royal Australian & NZ College of Psychiatrists: Transcript of evidence, pp 365-66)

7.9 The AMA:

> "promote the concept of patients asking doctors for information - they should not have to ask, of course - about the drugs they are receiving...". (AMA: Transcript of evidence, p 1707)

7.10 In summary, the CHF sees that:

> "consumers need education about asking the right questions, taking responsibility for their health care, and providing the doctor with the information that the doctor might need to know...". (CHF: Transcript of evidence, p 1715)

CONSUMER EDUCATION PROGRAMS

The need for cooperation

7.11 Chapter 5 of the Committee's first report examined the role of the

pharmaceutical industry in providing consumers with drug information and Chapter 2 of this report has already detailed the need for doctors to have good communication skills to convey information to consumers during consultations.

7.12 However, as a number of professional bodies have identified, there needs to be a far broader, multi-tiered approach to consumer education. On one level, educational strategies need to generate consumer interest about the role of drugs in health, the possibility of non drug alternatives and the importance of a healthy lifestyle. At another level, consumers need specific information about the drugs they are taking, when they are taking them. Finally, consumers should also receive enough information to be conscious of the impact of drugs on their own bodies, and be alerted to potential adverse drug reactions.

7.13 In order to be successful, education programs must be developed with cooperation between consumers, health professionals, government agencies and the pharmaceutical industry. As the Director of Product Information on Pharmaceuticals in Australia (PIPA) pointed out, it is "like there is not an answer unless all parties become involved in it". (PIPA: Transcript of evidence, p 293) The CHF believes in the value of "consensus conferences":

> "The idea of consensus conferences, of bringing people together to look at different things, works well. It gives rise to things that everyone can agree on and we can implement and get on with. That would satisfy our concerns for consumer involvement". (CHF: Transcript of evidence, p 1721)

7.14 Health Department Victoria also sees the benefits of cooperation:

> "There need to be government activities, industry activities, health provider activities, and the consumer element... there is no point in just trying to educate the consumers without undertaking some action in all the other areas as well". (Health Department Victoria: Transcript of evidence, p 1318)

7.15 The need for consultation has also been recognised by the Federal Government which sponsored a seminar and colloquium on consumer medicines

information and education in July 1992 through the Pharmaceutical Benefits Scheme Education Program, with assistance from PHARM.

7.16 One important theme that was developed at this seminar is the need for consumers to establish their own priorities and education requirements, rather than having these imposed by health professionals. Witnesses before the Committee also made this point, noting that education programs developed with little consumer input often are not successful. The problem with a "top down" approach is that:

> "if you try from a great height to tell people what is good for them... you are going to tell them all these serious and significant facts - they are not interested and it does not work". (Health Department Victoria: Transcript of evidence, p 1313)

7.17 Education programs developed without consumer input do not tend to provide the information that consumers want. This was mentioned to the Committee by the Endometriosis Association of Victoria which commented that, for women with endometriosis, "what the medicos think that women need to know is generally not at the same level that women want to know". (Endometriosis Association of Victoria: Transcript of evidence, p 393) A representative from the CHF echoed this by making:

> "the very strong plea that policy changes of this nature be made not only in consultation with the medical profession, as frequently happens, but also in a situation where consumers are represented at all points and where there are sufficient resources devoted to consulting with the community. In the end I think that leads to much better policy, and can in fact save the Government money". (CHF: Transcript of evidence, p 1720)

7.18 The goal of consumer education is to change behaviour so that consumers use drugs appropriately and safely. To achieve this goal, health professionals and consumers need to share the same assumptions about "rational" or "appropriate" drug use. For example, some consumers may see it as "rational" drug use to share a course of antibiotics with their children as a prophylactic measure.

7.19 Similarly, consumers may expect drug treatment, even when unwarranted. This is because taking medicines "proves" that they are sick and is a sign that they are getting "value" out of a visit to a doctor. These types of consumer imperatives, which may seem "inappropriate" drug use to health professionals, need to be taken into account in education programs if there are to be lasting changes in consumer behaviour.

7.20 The Committee strongly believes that programs need to be developed to address demonstrated education needs as identified by consumers. Consumers are not homogeneous and different groups in different locations will have different priorities and needs. Once the education needs have been identified, health professionals, governments and pharmaceutical manufacturers can then be consulted to address the information shortfalls and the best way of getting the message across.

Funding consumer programs

7.21 The Committee believes that the current government funding system, whereby consumer groups apply for State and Federal grants for specific projects, best ensures that education programs are community driven. The Committee notes the significant role the Federal Government's Pharmaceutical Benefits Scheme Education Program can play in funding consumer initiatives. This program is administered by the Pharmaceutical Benefits Branch of DHHCS.

7.22 The Committee believes that the Branch, by administering the Education Program, is well placed to ensure duplication is avoided, put consumer groups in touch with each other, provide project management advice and a national pool of experience. The Branch can also provide advice on other funding sources, such as the pharmaceutical industry and medical or pharmacy professional organisations. This sort of coordinating function was described earlier in Chapter 6 and was referred to by the Chair of the PHARM Working Party:

> "Funding is one way of facilitation. Helping people apply for grants from different sources is another facilitation function that a national centre can provide... keeping an eye on the variety of programs and where it would make good sense to coordinate and bring groups together to do it more as a one-off for Australia and the other areas where it is great to encourage proliferation because everybody is different...". (PHARM: Transcript of evidence, p 1651)

7.23 With this form of funding approach, educational programs can remain flexible enough to meet the needs of different consumer groups and yet remain as part of a coherent national initiative to improve quality medicine use.

7.24 A critical component of any education program is determining the most effective means of disseminating the information, whether through the mass media, the ethnic media, consumer or pharmaceutical distribution networks or fliers in doctors' surgeries. Attention needs to be given to ensuring consistency of message, particularly if the mass media is to be used.

POLYPHARMACY

Adverse drug reactions and contra indicated prescribing

7.25 One issue of particular concern to consumers and health professionals alike, is the number of consumers suffering from adverse drug reactions (ADRs) or the consequences of taking contra indicated drugs as a result of being on multiple medications ("polypharmacy").

7.26 The incidence of adverse drug reactions is not, per se, evidence of inappropriate prescribing. However, research indicates that the chances of patients suffering adverse drug reactions is proportional to the number of pharmaceuticals they are taking concurrently. (Larmour et al: Transcript of evidence, pp 1073-78) The people at greatest risk are older people who are more likely to be suffering a range of chronic conditions requiring multiple medications. One group of hospital

researchers concluded:

> "the patient at particular risk of experiencing an ADR is the elderly patient with multiple medical problems... who is taking a large number of different medications". (Larmour et al: Transcript of evidence, p 1077)

7.27 Older people are also more likely to suffer adverse drug reactions because the ageing process affects metabolism and makes it more difficult for prescribers to determine appropriate doses.

7.28 The risks of polypharmacy increase when consumers receive prescriptions from several doctors and outpatient clinics. The problem is made worse when patients also take non prescription drugs and alternative therapies. The result is that no one health professional is coordinating, or even aware of, a consumer's total drug intake. This problem was highlighted by the AMA:

> "One of the difficulties is having actual demographic data as to where people go to get their prescription filled out as well as where they get their initial medical advice. So there is the shopping around component and it is a major issue. The risk of adverse reactions to a medication goes up enormously when a patient adds drug A to drug B taken from doctors C and D. These are major problems". (AMA: Transcript of evidence, p 1094)

with the result that:

> "The more you fragment patient care... the more you get problems with pharmaceutical prescribing and knowing what the patient is on". (AMA: Transcript of evidence, pp 1095-96)

7.29 With fragmented patient care, patients can inadvertently be prescribed drugs that should not be taken together. As the Royal District Nursing Service (RDNS) described:

> "you can have a situation where people are going to a hospital outpatients clinic for a particular condition and anything else that they may happen to have wrong with them is being treated by somebody separately... So people are often broken up into bits and one bit is treated separately from another... It is not considered what this bit is

likely to do to something else or what this medication is likely to cause". (RDNS: Transcript of evidence, p 329)

7.30 Researchers from a Melbourne Hospital also warned about the need for careful prescribing:

> "The importance of avoiding unnecessary medications, keeping dosage regimens simple and being aware of potential drug interactions, particularly in the elderly, cannot be over-emphasised. It is also important to maintain accurate records of the drugs a patient receives from other sources. This is often a difficult task...". (Larmour et al: Transcript of evidence, p 1077)

7.31 In recognition of these problems, the Australian Council on the Ageing held a National Conference on Polypharmacy and Older People in 1990 which was funded through the Pharmaceutical Benefits Scheme Education Program. The Conference noted that much of the information on polypharmacy was either anecdotal or not definitive enough to base policy on and detailed a number of recommendations to improve research, optimise drug use and provide greater focus on ageing issues in health education courses.

7.32 One solution to the risks of polypharmacy is to focus on alternatives to drug treatment, where possible. Problems such as insomnia, constipation or mild hypertension, which are often treated with medications, may be more appropriately treated by a change in diet and exercise without any risks of iatrogenic illness. This approach may be particularly relevant in nursing homes, given the high rates of polypharmacy identified there[2].

7.33 The important role pharmacists can play in reducing contra indicated prescribing will be discussed in the Committee's third report.

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2 Issues in Pharmaceutical Drug Use in Australia, op cit, pp 25-26 & 71-77.

Consumer initiatives

7.34 Consumers, as well as health professionals, have a role to play in reducing the risks of polypharmacy, a point that was made to the Committee by a witness from the RDNS:

> "It is easy to blame the doctor but I think sometimes the patients do not share what they are doing in various aspects... the doctor may be quite ignorant of the fact that this person has been ordered a string of medications by someone else". (RDNS: Transcript of evidence, pp 329-30)

7.35 The RACGP also encourages consumers to assist their doctors prescribe safely:

> "the patient can help the general practitioners by recording side effects... They do not understand, perhaps, side effects but they understand the difference in how they feel, 'Doctor, I do not feel well', and that helps us in their management". (RACGP: Transcript of evidence, p 1132)

7.36 There are a range of consumer initiatives designed to reduce the risks of polypharmacy such as information pamphlets for consumers, including those by the Australian Consumers' Association and the Australian Council on the Ageing. Another example is the establishment by the Combined Pensioners' Association of NSW of a scheme where older people can get free help and information from their peers about how to use medicines. These trained advisers are called "Medicine Information Persons" and can provide advice on such topics as using medicines safely, memory aids for taking medicines and understanding the Pharmaceutical Benefits Scheme. The Committee encourages such innovative, programs as examples of consumer initiated projects to encourage safe drug use.

Medication record management

7.37 When attempting to reduce the risks of polypharmacy, one is faced with

the problem of how to maintain comprehensive and accurate patient drug records when patients receive medication from different sources. This problem has been addressed by a number of groups.

7.38 The Committee has received suggestions that there be a financial penalty for patients who use more than one doctor. For example, consumers could register with one general practitioner, as in the United Kingdom, and face additional premiums if they visit another doctor.

7.39 The Committee believes that a patient should be encouraged to see one general practitioner who can monitor visits to other health professionals and maintain a comprehensive medication record, thus reducing the risks of being prescribed contra indicated drugs. As the AMA pointed out:

> "I think there is a perception amongst general practitioners that care has been fragmented and that is not in the best interests of the patients. We have to educate patients that there is a role in continuing care that the family practitioner can provide". (AMA: Transcript of evidence, p 1110)

7.40 Recognising that consumers do visit different prescribers has led to suggestions that all consumers be issued with electronic "smart cards". These cards would encode a list of a patient's medication intake which could be read through computers held by doctors and pharmacists.

7.41 The issues of patient confidentiality and computer compatibility need to be resolved before the adoption of smart cards can be considered a practicable option.

7.42 As a less sophisticated and far cheaper alternative, manual patient medication cards have been developed by various consumer and professional groups. The cards usually list key questions for patients to ask doctors and pharmacists, such as the name of the medicine, what it is for, what to do if a dose is missed and what side effects to expect. There is also space on the cards or in the booklets for

the prescriber to record details of each prescription the patient is currently taking.

7.43 These cards do not replace medical histories kept by general practitioners, but offer a portable list that patients can keep and show to other doctors and health professionals. The advantages of the cards were described by the RDNS:

> "A suggestion we have made... is for people to have a drug book of some description... So wherever they went, be it to the outpatient section or the GP or whoever, someone could look and tell them they are already on this drug, that drug and the other drug and that it would not be a good idea to give them something that will not work well with those things". (RDNS: Transcript of evidence, p 326)

7.44 The cards have the advantage of being simple, relatively cheap to produce and easily understood by consumers. The Committee is aware of the wide range of patient medication cards already in use, as one community worker critically observed:

> "Like everybody else, we were funded to produce medication management cards-there are about 40 different medication management cards that exist... We will probably also go through the Smartcard phase, like everybody else". (Health Department Victoria: Transcript of evidence, 1305)

7.45 The Committee does not see it as a disadvantage that there are so many different medication cards in use, given that the cards will have been developed for the needs of particular consumer groups.

7.46 The cards are not foolproof. People lose them, forget to take them when visiting doctors and may use several cards simultaneously or not use them at all. However, the Committee believes that the cards can usefully assist different health professionals reduce the risks of polypharmacy and prompt consumers to become more involved in their own medication management.

The benefits of polypharmacy

7.47 The Committee acknowledges that pharmaceuticals play a positive role in allowing many people with chronic conditions to maintain active lifestyles. As the RACGP pointed out:

> "people equate multiple medication use with the creation of a risk of an adverse reaction, but for the majority of people that reaction does not occur. So I think we have to be a little bit careful because here are a great many elderly people who remain active because of the medication, not in spite of it". (RACGP: Transcript of evidence, p 1131)

7.48 There is no question that consumers may need multiple medications to treat multiple problems, what is needed though is the regular reappraisal of the risks and benefits of multiple medication to ensure optimal health outcomes.

7.49 The RACGP has developed procedures for medication review as part of the consultation process for general practitioners. The Committee understands, however, that it is not commonly recognised by general practitioners that medication review, by itself, would be a legitimate consultation item to be reimbursed under Medicare. This requires further examination as it is a potentially beneficial use of consultation time to improve a patient's health, as well as reducing the cost of hospital admissions on the basis of adverse drug reactions.

7.50 **Therefore, the Committee recommends that the Health Insurance Commission give consideration to making medication review an individual consultation item under Medicare.**

PARTICULAR CONSUMER GROUPS

Consumers from a non English speaking background

7.51 The problem for prescribers trying to ensure that their patients leave

consultations with enough information to take their medication correctly and safely is compounded when the consumers come from non English speaking backgrounds. As the Springvale Community Aid & Advice Bureau pointed out:

> "English speaking people often leave their consultations with doctors with little understanding of their condition and even less understanding of the prescriptions they have been given. Non English speaking people are even more disadvantaged. They are even more likely to leave a doctor's consultation without any knowledge of their condition, its prognosis or the likely effects of the medication they receive". (Springvale Community Aid & Advice Bureau: Transcript of evidence, p 1261)

7.52 A spokesperson for the SACOTA pointed out that these difficulties can be exacerbated if consumers come from a culture where medical authorities are not questioned:

> "their culture, I suspect, means that they do not question doctors. My mother was looking on the doctor as something above everything and whatever he said she was taking as gospel. It is only lately that people are becoming aware that so much harm is done from overmedication". (SACOTA: Transcript of evidence, pp 499-500)

7.53 On the other hand, consumers from other cultures may have exaggerated ideas about the benefits of drugs:

> "In some communities there is an unrealistic expectation of the effects of the drugs and a tendency to 'shop around' from one doctor to another in the hope for 'an instant cure'". (Springvale Community Aid & Advice Bureau: Transcript of evidence, p 1262)

7.54 The telephone Translating and Interpreting Service (TIS) is a national telephone interpreting service, available 24 hours a day, seven days a week for the cost of a local telephone call. This is a valuable resource that should be used to assist communication between health professionals and consumers. There are courses available on making the best use of interpreter services and avoiding cultural misunderstandings. Examples of such courses are run in Victoria by the Victorian Interpreting and Translating Service of the Office of Ethnic Affairs.

7.55 The existence of these interpreter services can be promoted to health professionals through professional journals. As well, and consumers from non English speaking backgrounds can be encouraged, through the ethnic media, to ask for a telephone interpreter when visiting health professionals.

7.56 **Accordingly, the Committee recommends that the facilities of the Translating and Interpreting Service and courses on successfully using interpreters be promoted to health professionals through the appropriate professional journals. The Committee recommends that this promotion be funded by the Department of Health, Housing & Community Services. This is an example of an area where the pharmaceutical industry could also extend its range of educational activities.**

7.57 The Springvale Community Aid & Advice Bureau issues its clients with cards stating, in English, which language they speak, that they would like to use TIS and then listing the TIS telephone number. These cards offer a cheap and effective way of prompting health professionals and consumers to use TIS and the Committee encourages their wider use.

School children

7.58 Long term strategies to improve the quality use of medicines should begin early, preferably when consumers are still at school.

7.59 The Chair of PHARM noted the need to provide education on quality drug use for school children is:

> "one of the key long term strategies that we need to target. With schools, obviously the first approach, attitude and expectation that you can develop with children is in regard to what is health, where medicines fit in and what are their broad risks and benefits...
>
> There are a lot of very simple skills and knowledge and motivation that you

> There are a lot of very simple skills and knowledge and motivation that you can get across at the school level". (PHARM: Transcript of evidence, pp 1638-39)

7.60 Any drug information provided to school children is usually introduced as a component of the health curriculum, and the Committee is encouraged to note that, in Queensland schools at least:

> "the importance of appropriate use of both prescription drugs and more freely available pharmaceuticals is addressed in the health education curriculum from Year 1 onwards... Education about safe drug use should focus on decision making... with a changing focus as the responsibility for medication moves from parents and others to the individual concerned". (Minister for Education, Youth & Sport (Queensland): Submission, p 131)

7.61 While drug education is incorporated in health curricula, a specific school based kit for 11-12 year old children called the "Tay-Kair" kit has been developed by the Pharmaceutical Society of Australia with financial assistance from the Federal Government and the Australian Pharmaceutical Manufacturers Association. The kit introduces children to such topics as what is a drug, how drugs affect the body; the roles, rights and responsibilities of the patient, doctor and pharmacist and the beneficial and harmful uses of drugs. The Committee supports this innovation and awaits with interest an evaluation of its effectiveness.

7.62 Experience in Queensland has noted that drug education programs for children should also include a component directed to parents, as it is often parents giving drugs to children, as much as the children themselves, that need to be the target of the school based education programs. (Minister for Education, Youth & Sport (Queensland): Submission, p 132)

7.63 The Committee believes that educational programs to encourage long term behavioural changes towards more appropriate drug use needs to begin when consumers are still school aged. The Committee encourages any initiatives to promote this.

The Homeless

7.64 The Committee received evidence from Youth Programmes Incorporated in Tasmania on the difficulties that homeless youth have in obtaining information on the appropriate use of prescription drugs.

> "Everything gets down to educating people at younger age to know what to expect from GPs ... With young people I do not think they have that mass of information. I just think they are not articulate enough to ask a doctor and be assertive enough to ask the questions". (Youth Programs Inc: Transcript of evidence, p 702)

7.65 This problem is compounded because the homeless are transient and unlikely to have a regular general practitioner or any continuity of health care.

7.66 Furthermore, while efforts are being made to educate homeless youth on the dangers of heroin, tobacco and alcohol abuse and AIDS, Youth Programs Incorporated believes little is being done to educate these consumers on the abuse of legal drugs:

> "With advertising, most kids are aware of AIDS, heroin, tobacco abuse, but there is nothing there about pills. It is totally ignored. It is a shame". (Youth Programs Inc: Transcript of evidence, pp 706-07)

7.67 This highlights the difficulty of designing targeted messages to all sections of the community at risk. The best approach to ensuring that disadvantaged groups are not overlooked in education campaigns or service provision is to ensure better collaboration between all parts of the health system. One way of achieving this is to strengthen the team approach to health care delivery. This is developed in the next Chapter of the report.

Chapter 8

THE TEAM APPROACH

8.1 As stressed in previous chapters, a coordinated approach by health professionals is required to ensure the quality use of medicines. This means that, where necessary, doctors, pharmacists, nurses and allied health professionals work together with consumers and their carers to improve health outcomes.

8.2 A team approach can lead to improved prescribing (doctors consulting pharmacists), greater consideration of non drug alternatives (doctors consulting allied health professionals), improved drug administration and consumer compliance (nurses, pharmacists, carers) and the early detection of adverse drug outcomes (all health professionals). As witnesses from St Vincent's Hospital described:

> "We believe it is very important to understand that the process of prescribing involves not just the consumer and the prescriber but many others, including the society at large, other health professionals, et cetera. And we believe that it is very important for prescribers in particular to understand that there are others who are involved in this process and who can contribute greatly". (St Vincent's Hospital: Transcript of evidence, p 1481)

8.3 The Society of Hospital Pharmacists of Australia (SHPA) believes that there should be:

> "a network established whereby doctors and pharmacists, nurse practitioners, community groups - everybody involved in the health care system - could be sharing the ideas with the one aim: the better outcome for the patient at the end of the chain". (SHPA: Transcript of evidence, p 1287)

8.4 While doctors, pharmacists, nurses and other support staff generally have close contact within hospitals, there is far greater professional demarcation and

isolation amongst community based health professionals[1]. The practical difficulties were explained by the SHPA:

> "Of course, in the hospital setting we have this nice, friendly environment... where we all interact constantly each day for the same purpose. It may take a bit more effort in the community, but I do not think it is insurmountable". (SHPA: Transcript of evidence, p 1287)

8.5 Within the community setting, many general practitioners see themselves as the first point of contact for consumers seeking primary health care and then as coordinators for any other health care services that are necessary. As the AMA described:

> "We have a very complex system of health care which has many points of entry... most general practitioners see their role as attempting to keep some continuity in that whole process. A lot of the time can be spent chasing up what happens to people in various other parts of the system and trying to have some coordinating role for the patient". (AMA: Transcript of evidence, p 1122)

8.6 However, a number of witnesses were concerned that community doctors are often not in a position to provide a comprehensive referral service for consumers. The Consumers' Health Forum commented:

> "One of the complaints we frequently hear is that general practitioners do not know what else there is. They do not know about self-help groups... they do not know about family counselling centres, and they do not know about other services that might be offered in a local community health centre, for example, that might be more appropriate than prescribing a drug. So there is a problem with general practitioners being isolated". (CHF: Transcript of evidence, pp 1719-20)

8.7 Even doctors agree, and according to one survey of general practitioners, over 60% of the 1 800 respondents believed that there was insufficient

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1 Prescribing practices in private and nursing hospitals and the role of health professionals is discussed in Issues in Pharmaceutical Drug Use in Australia, op cit.

teamwork between general practitioners and community health professionals[2].

8.8 The RACGP acknowledges this problem too, but notes the structural disincentives for general practitioners to become any more involved in the coordinating role:

> "The difficulty comes as a very practical barrier in general practice of the time commitment needed for that teamwork, the time out of consulting hours or taking parts of the consulting day... the fact is that any of that consultation is really done on a voluntary basis with no remuneration and in fact there is often a loss of remuneration because the practice has to keep going". (RACGP: Transcript of evidence, p 1589)

and that:

> "in terms of any sort of systematic method of either formulating policies for managing your patients with other health professionals or having case conferences to discuss the management of various patients, I just think it is too awkward". (RACGP: Transcript of evidence, pp 1589-90)

Divisions of general practice

8.9 One structural reform to integrate community health care is through the Federal Government's support for general practitioners who formally group together in regional "divisions" of general practice, some of which have been in existence for 18 months or more. General practitioners who join a division continue to practise privately but may also be remunerated on a full time or sessional basis for working on behalf of their division.[3]

8.10 Divisional work is designed to encourage general practitioners to

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2 Douglas R M & Saltman D C, W(h)ither Australian General Practice, Discussion Paper No 1, National Centre for Epidemiology and Population Health, 1991, Australian National University, p 14.

3 Ibid, pp 32-37.

broaden their role beyond the level of individual patient care. Doctors could, for example, undertake divisional responsibilities to visit hospital outpatient clinics, help design hospital discharge policies, become more involved in community based initiatives such as health promotion and palliative care and represent general practitioners in local area health planning.

8.11 Divisions can also form the focus of professional life for general practitioners and be a forum for members to discuss common problems, set local quality assurance goals, provide opportunities for members to engage in research and continuing education and assist the training of undergraduate and postgraduate doctors. By establishing divisional rosters, members would be able to provide better after hours and locum services for their patients.

8.12 The Federal Government is funding divisions of general practice through practice grants and specific Federal government budget allocations[4].

8.13 Through membership of general practice divisions, doctors will have the opportunity to develop links with local hospitals and other community based health professionals. General practitioners will thus be able to coordinate an integrated health service for consumers and, inter alia, improve the quality use of medicines.

8.14 There have been other initiatives to improve coordination between general practitioners and other health professionals, including the General Practice Community Health Liaison Project in South Australia, the Community Health and Medical Practitioners Scheme in NSW and the Central Sydney Area GP Association.

8.15 The Committee encourages the diversity of approaches towards integrating health care within the community and between the community and hospitals. The Committee believes that the expansion of general practice divisions

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4 Minister for Health, Housing and Community Services, Health Care for All Australians: 1992-93 Reforms, 1992-93 Budget Related Paper No 8, 1992, AGPS, p 35.

and innovative use of general practice grants will provide a climate in which greater communication between all members of health teams can develop. Care must be taken to effectively coordinate and evaluate these grants, as recommended in Chapter 3.

Liaison between hospital and community prescribers

8.16 An area where close coordination between health professionals is particularly important is where consumers are being treated by both hospital and community prescribers. Liaison is critical where a patient is prescribed medications on discharge from hospital and returns to his or her general practitioner or where a patient is having drugs prescribed simultaneously through a hospital outpatient clinic and by a general practitioner.

8.17 Standard practice in most hospitals is for formal discharge summaries to be prepared for each patient leaving hospital. The summaries list all drugs the patient has been prescribed on discharge, with recommendations on further treatment. These are forwarded to the patient's general practitioner.

8.18 However, due to budgetary restraints, discharge prescriptions are kept to a minimum at most hospitals, requiring consumers to visit their general practitioner shortly after discharge for any repeat scripts and reissuing of any pre admission medication. As a result, "many patients often were turning up in the community setting prior to typed summaries from specialist A getting to GP Y". (SHPA: Transcript of evidence, p 1293)

8.19 Given these problems, most hospitals now provide patients with interim discharge summaries for them to hand to their general practitioner on discharge. As the SHPA explained:

"We do know from our experience that GPs have used [interim

discharge summaries] to discuss therapy with their patients. Of course, it is supported by letters from their hospital to the general practitioner, but in the interim, and even sometimes after that, those sheets are used as the basis for ordering medication in future". (SHPA: Transcript of evidence, p 1293)

8.20 The need to improve hospital communication has meant that hospitals are planning discharge arrangements for patients as soon as they arrive, as the AMA explained:

"Now hospitals need to focus on discharge planning so from the time the patient is admitted... we will already be thinking about when they are to be discharged. The resident staff have an obligation then to be thinking about how they will communicate the details of the admission to the family doctor who will have to continue the care, as well as to the nursing staff who will be carrying out ancillary health services in the community". (AMA: Transcript of evidence, pp 1688-89)

8.21 The Committee accepts that there is now generally sufficient communication between hospital and community doctors on discharge medication for patients. However, the Committee is concerned that this level of communication is not maintained when patients continue to be seen on an ongoing basis through hospitals' outpatient clinics. As the Royal District Nursing Service (RDNS) explained:

"From our experience the patients most at risk of poly pharmacy are those patients discharged from public hospitals whose post acute care is managed by their local general practitioner and their long term care monitored through the outpatient system". (RDNS: Submission, p 728)

8.22 The problem is compounded because:

"Letters and communications between outpatients and GPs vary in their frequency and quality, so it is difficult sometimes for the GP to know why this person is having this other medication, but there is a reluctance on the GP's part to change it because it is obviously for some particular reason". (RDNS: Transcript of evidence, p 329)

8.23 This issue has been recognised by general practitioners, and the AMA

believes:

> "it would be a lot better if the hospital and the consultants saw it as their job - unless it is urgent to prescribe that medication - rather than adding to the confusion, to be bolstering the role of the doctor as being the person who is in control of the overall medication with the patient". (AMA: Transcript of evidence, p 1127)

8.24 The Committee believes that the lack of communication between outpatient clinics and general practitioners remains an issue of concern.

8.25 **The Committee accordingly recommends that the communication links between outpatient clinics and general practitioners be a focus of further research and that funds be provided under the Federal Government's 1992-93 Budget allocation for further incentives to improve continuity of care by general practitioners. Such research should determine the extent of this problem.**

8.26 The Committee hopes that the establishment of general practice divisions will provide the opportunity for increasing communication and coordination between outpatient clinics and general practitioners to resolve this lack of liaison.

The role of nurses

8.27 Nurses, whether working in institutions or the community, have a vital and often understated role in ensuring the quality use of medicines.

8.28 Nurses play an important role in ensuring patient compliance, including the administration and monitoring of drug treatments prescribed by doctors. For example, in the community setting, the Royal District Nursing Service conducts a medication review for each of its patients and provides an assessment of the patients' knowledge of the name, action, dosage and side effects of these medications. Nurses administer, or assist in the administration of, medications

where patients are not able to do so themselves.

8.29 Working so closely with patients, nurses are often the first health professionals to detect any adverse drug reactions. This is particularly important where a patient is seeing a number of doctors and the nurse may be the only health professional aware of the patient's total drug intake.

8.30 Nurses are also important sources of drug information for consumers, as the Australian Nursing Federation (ANF) told the Committee:

> "in our experience the medical practitioner is the one that writes the prescription but is rarely the one that answers the questions arising from that prescription. So the information about the drug has to be able to be accessed by nurses, amongst a range of other people, because they are the people that are asked the questions...". (ANF: Transcript of evidence, p 405)

8.31 There are circumstances, principally in remote areas where access to doctors is limited, where nurses diagnose illnesses and dispense prescription medication "as a daily occurrence". (Central Australian Aboriginal Congress: Transcript of evidence, p 1398) A spokesman for the Northern Territory Department of Health & Community Services admitted that:

> "Remote area nurses to all intents and purposes do work as medical practitioners in remote areas, and I think there is insufficient recognition of their role". (Northern Territory Department of Health & Community Services, Transcript of evidence, p 1427)

8.32 A Royal Flying Doctor Service (RFDS) Flight Nurse Manager confirmed this practice:

> "I think our role as nurses working for the Flying Doctor Service is very similar to that of any remote area nurses... in that we tend to have much greater dealings with prescribing drugs... We are in situations where we are prescribing drugs or giving out drugs that normally nurses who are in a more urbanised area are not".(RFDS: Transcript of evidence, p 1444)

8.33 However, nurses are not legally authorised to dispense prescription medication, except under very strict conditions in the Northern Territory and Tasmania. The Central Australian Rural Practitioners Association (CARPA) explained the implications of this:

> "A lot of nurses feel very insecure working out in the bush, treating conditions and using medications that they, in fact, have no legal authority to do... It is just part of their daily work, but a lot of them are very concerned: 'Well, what if one day somebody decides to sue us about this - where do we stand?'". (CARPA: Transcript of evidence, p 1421)

8.34 The issue of nurse prescribing rights is also a relevant issue to nurses in less isolated areas. The ANF believes that nurses should be given limited prescribing rights, allowing them, for example to dispense oral contraceptives in family planning clinics. The ANF pointed out the absurdities of the current system in health clinics:

> "What happens is that the woman comes to the health service, she is seen by a nurse, she is assessed by a nurse on an ongoing basis, and then she is referred for five seconds to a doctor for the prescription to be completed... So the majority of the assessment, determination of the problem and discussion about how to solve the problem occurs in the patient nurse interactions". (ANF: Transcript of evidence, p 416)

8.35 The Committee acknowledges the reality that in some areas nurses already diagnose illnesses and dispense prescription drugs in limited circumstances and that this has the tacit approval of both nurses and medical practitioners.

8.36 **The Committee accordingly recommends that individual nurses with specific training be licensed to dispense a limited range of prescribed drugs at specific locations. For example, in an urban context, nurses could dispense oral contraceptives through family planning clinics. In remote areas, nurses could dispense antibiotics when a doctor is not available or contactable. The Committee appreciates that implementation of this recommendation requires amendments to State and Territory legislation.**

8.37 There is current discussion of the potential of expanding the role of "nurse practitioners" in Australia. Nurse practitioners receive extra training and have limited rights to prescribe and initiate diagnostic procedures[5]. The Committee believes that the establishment of a nurse practitioner accreditation scheme could provide an appropriate mechanism through which nurses could be licensed to dispense prescription drugs under specialised arrangements and with appropriate safeguards.

Conclusion

8.38 A recurrent theme running through this report has been that of team work and close cooperation between all professionals and participants in the health system. In many instances, this will require that the attitudes of many health professionals change, in order to break down long established practices and to foster new linkages within broader more cooperative structures in a way that has not happened before. This requires an ongoing commitment by all players to maximising quality health care for all Australians.

8.39 In the next and final report on this inquiry, the Committee will examine the role pharmacists can play in the health care team, including proposals to expand their role in the provision of education about medicines to the general community. Pharmacists are an important link in the distribution chain and more effective use of their professional skills and knowledge will assist in the general improvement of the quality use of medicines.

Harry Jenkins, MP
(Chairman)
16 September 1992

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5 NSW Health Department, Nurse Practitioners in New South Wales: Discussion Paper, June 1992.

APPENDIX 1

DETAILS OF PUBLIC HEARINGS AND WITNESSES

MELBOURNE - 6 APRIL 1992

Pharmaceutical Society of Australia (Victorian Branch)

- Prof Colin Chapman, Dean and Director, Victorian College of Pharmacy
- Mrs Jennifer Gowan, Graduate Training Officer
- Mr Alistair Lloyd, Executive Director
- Mr Stephen Marty, Education Field Officer, Pharmacy Board of Victoria
- Mrs Margaret Matthews, Councillor

Springvale Community Aid and Advice Bureau

- Ms Merle Mitchell, Director
- Ms Franca Pupillo, Health Issues Worker
- Ms Deborah Rosenberg, Migrant Social Worker

Pharmaceutical health and the Rational Use of Drugs Working Party

- Prof Neil Carson, Member

The Society of Hospital Pharmacists of Australia

- Ms Pamela Nieman, Vice President
- Mr Michael Ryan, Federal Councillor

Victorian Government

- Ms Mary Hemming, Executive Pharmacist, Victorian Drug Usage Advisory Committee
- Mr John Pead, Director of Clinical Services, Drug Services Victoria
- Dr Garry Jennings, Director, Alfred Baker Medical Unit, Baker Medical Research Institute
- Ms Deborah Homburg, Project Director, Older Persons Action Centre
- Mr Martin Turnbull, Senior Policy Officer, Victorian Drug Strategy Unit, Health Department Victoria
- Mr David Thompson, Executive Director, Victorian Medical Postgraduate Foundation Inc

ADELAIDE - 7 APRIL 1992

Drug and Therapeutics Information Service

- Dr Andrew Gilbert, Lecturer, Department of Community Medicine, University of Adelaide
- Mr Frank May, Chief Pharmacist, Pharmacy Department, Repatriation General Hospital, Daw Park

University of South Australia

- Prof Lloyd Sansom, Professor in Pharmacy

Flinders University of South Australia

- Prof Donald Birkett, Department of Clinical Pharmacology

ALICE SPRINGS - 8 APRIL 1992

Central Australian Aboriginal Congress

- Dr William Bartlett, Senior Medical Officer
- Ms Kathryn Monger, Registered Nurse in Charge, Imanpa Health Service
- Miss Lynnette Stuart, Clinic Coordinator

Central Australian Rural Practitioners Association

- Ms Sabina Knight, Member
- Dr Steven Skov, Secretary

Northern Territory Department of Health and Community Services

- Ms Vicki James, Registered Nurse, Rural
- Dr Steven Skov, Senior District Medical Officer
- Dr John Wakerman, District Manager

Royal Flying Doctor Service

- Miss Gerardine Malone, Flight Nurse Manager
- Miss Lynnette Stuart

Department of Health and Community Services, Alice Springs Hospital

- Ms Maria Giacon, Acting Chief Pharmacist

Individuals

- Mrs Shelley Forester, Retail Pharmacist

SYDNEY - 21 APRIL 1992

St Vincent's Hospital

- Prof Richard Day, Director, Department of Clinical Pharmacology
- Ms Roberta Lauchlan, Director of Pharmacy

Conference of Heads of Pharmacy Schools of Australia and New Zealand

- Prof Colin Chapman, Dean and Director, Victorian College of Pharmacy
- Dr Alan Polack, Head, School of Pharmacy, University of Tasmania
- Dr Adrian Ryan, Head, Department of Pharmacy, University of Sydney

Australian College of Pharmacy Practice

- Dr Ross Holland, Dean
- Mr Warwick Wilkinson, President

Royal Australian College of General Practitioners

- Dr Barbara Booth, Director of Quality Assurance
- Dr John Gambrill, Honorary Chairman, Ethics Committee

IMS Australia Pty Ltd

- Mr Phillip Hart, Marketing Director
- Mr John Strang, Managing Director

CANBERRA - 9 JULY 1992

Department of Health, Housing & Community Services

- Dr Tony Adams, Chief Medical Adviser
- Mrs Joan Lipscombe, Assistant Secretary, General Practice Branch
- Mr Peter McManus, Secretary, Drug Utilisation Subcommittee
- Ms Denise Swift, Acting Head, Pharmaceutical Benefits Branch
- Dr John Dowden, Executive, Editorial Board of Australian Prescriber

Pharmaceutical Health and Rational Use of Medicines (PHARM) Working Party

. Ms Mary Murray Hodge, Chair

Health Insurance Commission

. Dr Susan Crosdale, Assistant Medical Director (Utilisation)
. Ms Jane Parker, Pharmacist Adviser, Professional Review Division
. Mr Warren Turk, Manager, Pharmaceutical Benefits Branch

Australian Medical Association

. Associate Prof Barry McGrath, Federal Councillor
. Dr Brendan Nelson, Vice President
. Dr Peter Wilkins, Assistant Secretary General (Health Services)

Consumers' Health Forum of Australia

. Ms Phillipa Lowrey, Deputy Director
. Ms Kate Moore, Executive Director