A REPORT
ON THE
PRESCRIPTION
AND SUPPLY
OF DRUGS

The Parliament of the
Commonwealth of
Australia

House of
Representatives
STANDING COMMITTEE
ON COMMUNITY
AFFAIRS

PRESCRIBED HEALTH

PART 3

Pharmacy and Medicinal Supply

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CONTENTS

COMMITTEE MEMBERSHIP v

TERMS OF REFERENCE vi

ABBREVIATIONS vii

RECOMMENDATIONS viii

Chapter 1 - INTRODUCTION 1

CONDUCT OF THE INQUIRY 1
PRELIMINARY OBSERVATIONS 2

Chapter 2 - THE PHARMACY PROFESSION 4

NATURE OF THE PROFESSION 4
Drug dispensing 4
Providing drug advice to other health professionals 5
Providing drug advice to consumers 6
Recognition of the changing role of pharmacy 7
The Pharmaceutical Society of Australia 8
The Society of Hospital Pharmacists of Australia 8
Industrial organisations 9
UNDERGRADUATE EDUCATION 9
Scientific course content 10
Clinical skills 11
PRE REGISTRATION TRAINING 13
A FOUR YEAR PHARMACY COURSE 16
Strengthening the existing pre registration traineeships 17
Common courses with doctors 18

Chapter 3 - CONTINUING EDUCATION 21

The need for continuing professional education 21
The availability of continuing professional education 22
The Australian College of Pharmacy Practice 24
Participation in continuing professional education 25
Mandatory continuing professional education 26
National accreditation arrangements 27
The role of the pharmaceutical industry 28

Chapter 4 - HOSPITAL PHARMACY 30

Advice to the medical profession within hospitals 30
Advice to hospital patients 32
Pharmacy outreach for community prescribers 32
Liaison between hospital and community pharmacists 33

Chapter 5 - COMMUNITY PHARMACY 35

Cooperation between doctors and pharmacists in the community 36
Overlapping roles for pharmacists and doctors 38
The commercial role of community pharmacy 41

Chapter 6 - CONSUMER ISSUES 45

The role of the pharmacist in providing consumer information 45
Patient compliance aides 46
Public health campaigns 47
Drug disposal 48
Privacy issues 48
The Health Communications Network 50

Chapter 7 - THE FUTURE OF PHARMACY 51

CONSULTANT PHARMACISTS 51
Pharmacists and domiciliary health care 52
Community liaison pharmacists 53
Pharmacists in nursing homes 53
DEVELOPMENT OF NEW INITIATIVES 54
Recognition of local initiatives 54
Cooperation with other health professionals 55
Project evaluation 56
The Australian Pharmacy Research Centre 56
Conclusion 57

Chapter 8 - INQUIRY OVERVIEW 59

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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

ACPP	Australian College of Pharmacy Practice
AMA	Australian Medical Association
APRA	Association of Pharmacy Registering Authorities
CE	Continuing Education
CHPSANZ	Conference of Heads of Pharmacy Schools of Australia and New Zealand
DATIS	Drug & Therapeutics Information Service
PBS	Pharmaceutical Benefits Scheme
PHARM	Pharmaceutical Health and the Rational Use of Medicines working party
PGA	Pharmacy Guild of Australia
PSA	Pharmaceutical Society of Australia
PSWA	Pharmaceutical Society of Western Australia
RACGP	Royal Australian College of General Practitioners
SHAPE	September Health and Pharmaceutical Education strategy
SHPA	Society of Hospital Pharmacists of Australia

RECOMMENDATIONS

CHAPTER 2 - The Pharmacy Profession

1. In order to provide a stronger comprehensive educational base and to equip graduates for the realities of pharmacy practice, the Committee recommends that a four year undergraduate course in pharmacy be introduced to replace the current three year undergraduate course and the pre registration training year. (para 2.52)

2. The Committee recommends that preceptors in all States and Territories should have access to preceptor training services so that students and preceptors can gain maximum benefit from the pre registration year. This can be provided either by branches of the Pharmaceutical Society of Australia or pharmacy boards. (para 2.55)

3. The Committee recommends that harmonised standards for the pre registration training year be adopted by State and Territory pharmacy boards as a matter of priority. (para 2.57)

4. The Committee believes it incumbent on medical and pharmacy educators and registration boards to encourage greater cooperation between the disciplines and recommends that all pharmacy and medical trainees should receive some experience of working together as part of a team. While this will not guarantee that the various professions in community practice will work together, it will at least provide a degree of common experience and an expectation of future cooperation. (para 2.64)

CHAPTER 3 - Continuing Education

5. The Committee recommends that research be undertaken to determine the level of continuing professional education being undertaken by pharmacists nationally. Such research could be conducted by the Pharmaceutical Society of Australia, the Australian Pharmacy Research Centre or the Australian College of Pharmacy Practice. This research could be funded through the Federal Government's Pharmaceutical Benefits Scheme Education Program. (para 3.22)

6. The Committee recommends the early introduction of mandatory continuing professional education. (para 3.24)

7. The Committee recommends that the Australian College of Pharmacy Practice develop national standards for continuing professional education courses in conjunction with the Society of Hospital Pharmacists of Australia. Such standards should be adopted by the State and Territory pharmacy boards as appropriate standards for continuing professional education programs. (para 3.30)

8. The Committee recommends that the Australian Health Ministers' Conference encourage the Queensland Pharmacy Board to become a member of the Association of Pharmacy Registering Authorities. (para 3.32)

CHAPTER 5 - Community Pharmacy

9. The Committee recommends that the Australian College of Pharmacy Practice and the Royal Australian College of General Practitioners determine whether there are any continuing education programs that can be run conjointly. (para 5.14)

10. The Committee recommends that the Pharmaceutical Society of Australia coordinate or sponsor research to determine the number of patients presenting to doctors resulting from referral by pharmacists. (para 5.21)

11. The Committee recommends that the Pharmaceutical Society of Australia, in cooperation with the Royal Australian College of General Practitioners build on past work already undertaken and evaluate the feasibility and effectiveness of pharmacist referral forms. (para 5.23)

CHAPTER 6 - Consumer Issues

12. The Committee recommends that the Pharmacy Guild of Australia and the Pharmaceutical Society of Australia develop national guidelines on the uses to be made of patient medication records held on pharmacy computer databases. The guidelines should be developed after extensive consultation with appropriate privacy commissions or committees and in conjunction with appropriate consumer groups. (para 6.25)

13. The Committee recommends, in principle, the adoption of the Health Communications Network, conditional on privacy and confidentiality concerns being addressed. (para 6.28)

CHAPTER 7 - The Future of Pharmacy

14. The Committee recommends that the Department of Health, Housing & Community Services investigate extensions to current arrangements for funding nursing homes which would enable the remuneration of pharmacists conducting regular drug reviews in nursing homes and hostels. Such pharmacists could be hospital based, community pharmacists on contract, members of local Geriatric Assessment Teams or, potentially, on Nursing Home Medical Advisory Panels. (para 7.16)

15. The Committee recommends that the Department of Health, Housing & Community Services provide to the Australian Pharmacy Research Centre funds for a project designed to measure the contribution of pharmacy to reducing the costs of drug misuse in the community. This project could be used to provide empirical information about the value of counselling and other services provided by community pharmacy and demonstrate its benefits for the health budget. (para 7.35)

CHAPTER 8 - Inquiry Overview

16. The Committee recommends that the Department of Health, Housing & Community Services, as part of its health research activities, dedicate resources to investigate the overall savings to the community and the health system from the better use of drugs. (para 8.7)

Chapter 1

INTRODUCTION

1.1 On 26 July 1989, the Minister for Housing and Aged Care, the Hon Peter Staples, wrote to the then Chairman, Mr Neil O'Keefe, MP, referring an inquiry to the Committee. The specific terms of reference were for 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 determined that it would 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 The second report, titled "Prescribing and Medication Management", was tabled in Parliament on 8 October 1992 and discussed the current professional practices which influence the prescribing and consumption of pharmaceuticals and the range and quality of information and education on appropriate drug use as opposed to commercial promotion and marketing.

1.4 This, the final report, builds on the previous two and examines in detail current professional practices which influence the dispensing, retailing and supply of pharmaceuticals.

1.5 As outlined in the first and second reports, the Committee has conducted public hearings, inspections and informal discussions in a number of centres to assist in its investigations. These are set out in the previous two volumes.

PRELIMINARY OBSERVATIONS

1.6 As this report is looking at the third link in the distribution chain, namely the dispenser of medicines, it deals mainly with the nature of the pharmacy profession and the way pharmacy, in its various forms, is practised.

1.7 The report commences with a brief historical overview of drug dispensing and describes the changing nature of the profession and its different representative organisations. Any professional change in direction must be underscored and reinforced by professional training, both at the undergraduate and postgraduate continuing educational level. The Committee recommends that a more comprehensive four year undergraduate course be introduced to replace the existing three year course plus the pre registration training year. The Committee further recommends that some joint pharmacy - medical training occur to provide a degree of common experience between the professions.

1.8 In examining the area of continuing education, the Committee recommends that pharmacists be required to undertake professional continuing

education in order to be re registered. This should assist in keeping the professional knowledge base of all pharmacists current. Such continuing education should be regulated through the Association of Pharmacy Registering Authorities with courses developed by the Australian College of Pharmacy Practice.

1.9 The report also examines in greater detail the role of hospital and community pharmacy and the necessity for close cooperation and joint management of patients moving between the two settings. Recommendations are also made to acknowledge the role of community doctors in the pharmacist - doctor relationship.

1.10 As in the first two reports, the Committee has included a separate chapter dealing with consumer issues and makes specific reference to patient medication records and how these are to be used.

1.11 The report concludes by looking at the future role of pharmacy, including proposed new role diversification in community pharmacy. Specific reference is made to consultant pharmacists, community liaison pharmacist and pharmacist involvement in drug reviews in nursing homes and hostels. The Committee makes observations about the lack of a national peak body to represent the interests of all pharmacists and recommends that a project be funded to determine the value of pharmacy services to the community and Government.

1.12 Finally, the report provides a brief statement to consolidate the whole inquiry and stresses the need for a more comprehensive examination of the overall cost of drug misuse. This would involve a major exercise to gather data on costs, benefits and effectiveness of drug therapy and would help to bring existing data together in a cohesive way and supplement much of the information which already exists. Government decision making would benefit as a result of this.

Chapter 2

THE PHARMACY PROFESSION

NATURE OF THE PROFESSION

2.1 Pharmacists have a vital role to play in the cooperative team approach required to encourage the quality use of drugs. The health "team" in this context includes doctors, pharmacists, nurses, allied health professionals, pharmaceutical manufacturers, patients and their carers. The role of the pharmacist, within this team, is to provide expert advice on appropriate drug treatments for given conditions and the effects of drugs and their interactions with the human body. Pharmacy practice involves dispensing prescription and non prescription medication, preparing pharmaceutical products, assisting both health professionals and consumers with advice to optimise drug use and, in the case of community pharmacists, providing primary and preventive health care in the community.

Drug dispensing

2.2 The role of pharmacy has evolved considerably over the last four decades. Traditionally, the main function of the pharmacist was to formulate and compound medicines from ingredients held within the pharmacy. However, since the 1940's more and more medicines have been premixed and prepackaged by manufacturers, to the extent that pharmacists now rarely compound extemporaneous preparations. The emphasis of pharmacy practice has thus changed from drug formulation to drug dispensing.

2.3 Dispensing in the community setting has become a more complex activity, given the variety of Federal, State & Territory regulatory controls over the

sale of medications. Pharmacists are required to confirm the legality and validity of prescriptions, provide patient specific labels for medicines, counsel patients purchasing Schedule 3 non prescription drugs and maintain a register for dispensing certain drugs.

2.4 As already stated, modern pharmacists are still responsible for the legal, safe and efficient dispensing of medicines. However, this activity alone does not fully utilise their education and training, or recognise their potential contribution to the quality use of drugs.

2.5 As demand for their preparation skills has declined and the content of their training has changed, pharmacists have become well placed to satisfy the increasing requirements by other health professionals and consumers for expert drug advice.

Providing drug advice to other health professionals

2.6 The vast increase in the number of drugs, the range of possible doses and indications, their potency and the rate at which new drugs are emerging means that it is no longer possible for prescribers to remain fully informed of all drug treatments, doses and potential contra indications. The role of keeping up with this information now falls increasingly on pharmacists, who as drug experts, can provide prescribers with specialist advice on appropriate drug and non drug treatments.

2.7 This new advisory role for pharmacists is best illustrated by developments within the last two decades in hospital pharmacy. The teamwork between prescribers and pharmacists is now well established in hospitals, where doctors regularly consult clinical pharmacists on the most appropriate drug regimens. The Committee has been told that general practitioners are also increasingly using the drug expertise of pharmacists before prescribing.

2.8 This development has been recognised by the Pharmacy Guild of

Australia (PGA) which believes that the role of the pharmacist "as a medication consultant to doctors has been greatly expanded over recent years in both hospital and community pharmacy practice". (PGA: Submission, p 1854) Nonetheless, many community pharmacists remain concerned that their skills are still underutilised and under recognised by other health professionals. The causes of this dissatisfaction are examined in greater detail in Chapter 5, dealing with community pharmacy.

Providing drug advice to consumers

2.9 One of the most important responsibilities of a pharmacist has always been to ensure that consumers have enough drug information to take prescription and non prescription medication safely and correctly. This involves pharmacists counselling patients on how and when to take medication, as well as explaining possible side effects, adverse drug interactions and any precautions to be observed when taking a drug. Pharmacists are usually the last contact a consumer will have with health professionals before taking medication and the pharmacist is therefore able to reinforce any information already provided by the doctor to improve patient compliance.

2.10 The accessibility of community pharmacy gives it an important role in providing primary health care for the community. Pharmacists can provide advice on minor ailments and injuries and refer patients to other health professionals (usually doctors), when appropriate.

2.11 Pharmacists have also become involved in public education campaigns promoting healthier lifestyles, and preventive health. Pharmacy groups are now involved in the planning and implementation of their own and multi disciplinary health campaigns, such as the recent "Be Wise With Medicines" promotion in September 1992.

Recognition of the changing role of pharmacy

2.12 The Pharmaceutical Society of Australia (PSA) has recognised the changing nature of the profession and the new roles being undertaken by pharmacists:

> "pharmacy has developed from being a skilled para-professional occupation concerned with the formulation and compounding of elegant preparations of mineral and herbal drugs, to being an information and knowledge based profession concerned not only with the preparation and supply of potent therapeutic substances, but also with ensuring that those therapeutic drugs are used effectively, safely and economically". (PSA: Submission, p 496)

2.13 The Pharmaceutical Society of Western Australia (PSWA) also commented on the changing role of pharmacists:

> "The time which may previously have been spent with the ointment slab or mortar and pestle is now spent at the pharmacy counter or on the telephone discussing medication and simple illnesses with patients, doctors and other health professionals". (PSWA: Submission, p 1136)

2.14 The School of Pharmacy at the University of Tasmania sees this shift in emphasis from "a compounding role" to a "professional advice-counselling-drug expert role" where pharmacists are "no different from specialists", having "a medical specialty which is drug expertise". (School of Pharmacy, University of Tasmania: Transcript of evidence, p 752)

2.15 Being drug specialists, pharmacists have expanded into other areas of employment where such expertise is required, including industry, academia, and government. However, the majority of pharmacists practise in the community setting and, to a lesser extent, in hospitals. The most recently tabulated information indicates that as at 1986, 80% of pharmacists work in community pharmacies, 13%

in hospitals and nursing homes, 2% in industry and 5% work in other areas.[1]

The Pharmaceutical Society of Australia

2.16 The Pharmaceutical Society of Australia is the principal national professional association representing pharmacists. It currently represents about 8 500 members, or approximately 80% of registered pharmacists. Professional societies have existed in each State for many years, but with the formation of the PSA in 1977, this has provided the profession with a national organisation, both to assist it in regulating its own affairs and to provide a focal point for contact with government, industry and other professions. The State professional societies are now branches of the PSA, with the exception of the Pharmaceutical Society of Western Australia, which remains separate due to the PSWA's unique statutory obligations.

2.17 The PSA is responsible for, inter alia, promoting the professional role of pharmacists, determining the ethical and professional standards and responsibilities of the profession, running continuing education programs and ensuring representation of pharmacists in all areas concerned with health care provision, planning and development.

The Society of Hospital Pharmacists of Australia

2.18 The Society of Hospital Pharmacists of Australia (SHPA) is the other major national professional organisation representing pharmacists. It was established in 1961 to promote the professional interests of pharmacists practising in hospitals or similar institutions. Its major objective is to provide opportunities for members to improve their professional practices through additional study and training.

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[1] Australian Institute of Health, Pharmacy Workforce 1986: Health Workforce Information Bulletin No 23, AGPS, 1986, p 10.

2.19 The SHPA has State and Territory Branches and in November 1992 had a membership of 1 400 pharmacists, which represents approximately 80% of hospital pharmacists.[2]

Industrial organisations

2.20 The principal industrial organisation representing pharmacists who own independent community pharmacies is the Pharmacy Guild of Australia (PGA). Formed in 1928, the PGA represents its members in industrial relations matters, marketing, staff training, health economics and pharmacy management.

2.21 The PGA has a federal structure and in 1991 had some 5 000 members representing approximately 87% of pharmacists owning community pharmacies.[3]

2.22 The Extended Hours Pharmacies Association promotes the commercial and professional interests of extended hours pharmacists. In addition, there are a number of regional associations of pharmacists in urban and rural areas.

UNDERGRADUATE EDUCATION

2.23 Pharmacists do not work in isolation and need to see themselves and be recognised by other health professionals and the public, as integral members of a team contributing to quality drug use. Whether working in hospitals or the community, pharmacists contribute to such teams by dispensing medication and providing advice to health professionals and consumers alike.

2.24 To perform these functions, all practising pharmacists need a comprehensive knowledge of drugs and their interactions with the human body and an ability to critically evaluate new drug information. Pharmacists also need a

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2 Figures supplied to the Committee by the SHPA, October 1992.

3 PGA, Annual Report 1991, p 59.

general knowledge of common disease states, the ability to recognise and treat minor ailments, good counselling and communication skills and good judgement about when patients should be referred to other health professionals.[4]

2.25 To gain these skills and be registered to practise, pharmacists currently need to pass a three year Bachelor of Pharmacy course and complete a one year pre registration graduate traineeship under the control of the appropriate State or Territory pharmacy board.

Scientific course content

2.26 Witnesses before the Committee are satisfied that the current undergraduate courses offered in Australia provide pharmacists with a solid grounding in pharmacy science and, as befitting their status as drug experts, with more detailed drug knowledge than found in medical courses. The PSA told the Committee that:

> "Pharmacy students receive considerably more tuition in pharmacology, pharmaceutical chemistry, pharmaceutics, human therapeutics and associated disciplines than all other health professionals, including medical students". (PSA: Submission, p 492)

This comment was reinforced by the Chairman of the Australian Pharmacy Examining Council:

> "The amount of pharmacology, therapeutics that didactically pharmacy students get is about 250 per cent more than the medical practitioners get in their course". (Prof Sansom: Transcript of evidence, p 1347)

2.27 Witnesses before the Committee have also confirmed that the undergraduate courses offered around Australia are producing graduates of a

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[4] Pharmaceutical Society of Australia, A Set of Competencies for Australian Community Pharmacy Practice, March 1989.

uniform quality. The Chairman of the Australian Pharmacy Examining Council stated that "basically the quality of graduates around Australia is equal". (Prof Sansom: Transcript of evidence, p 1345) The Victorian College of Pharmacy and the Pharmacy Board of Victoria supported this view, stating that the different State courses "reflect differences in emphasis in certain other areas but, in essence, the core material is the same throughout the country". (Victorian College of Pharmacy & Pharmacy Board of Victoria: Transcript of evidence, p 1241)

Clinical skills

2.28 While there appears agreement that students graduate as high quality pharmaceutical scientists, there are doubts about whether they are trained adequately for the changed and changing role of pharmacy. The profession now requires pharmacists to possess effective communication skills to impart their knowledge to patients and other health professionals. The Pharmacy Guild of Australia has warned that undergraduate courses need to reflect this new requirement:

> "There is no doubt pharmacy will change its direction from one of supply to one of professional advice and counselling... and without the appropriate level of education, communication skills and people skills, pharmacists will not be able to contribute to the level that they should". (PGA: Transcript of evidence, p 99)

2.29 The Conference of Heads of Pharmacy Schools of Australia and New Zealand (CHPSANZ) expressed concern that the current curricula do not provide the appropriate emphasis in these areas:

> "there is... a very large gap between pharmacy education and pharmacy practice which is not being addressed in the overall pharmacy education process at the present time". (CHPSANZ: Transcript of evidence, p 1517)

As a consequence, students are not graduating with the appropriate skills:

"It is the almost unanimous opinion of pharmacy academics that students have the necessary level and coverage of knowledge but they do not know how to use it".[5]

2.30 As a result, pharmacists may not have the skills to communicate effectively with consumers and other health professionals. According to a former National Director of the PSA, this may be one reason why prescribers do not fully utilise the drug expertise of pharmacists. He believes there has been:

"the graduation of pharmacists who were unable to effectively communicate with other health professionals. Therefore these practitioners were, and largely still are, ignorant of the benefits that the pharmacist knowledge could be to their patients".[6]

2.31 The PGA believes that any changes to undergraduate courses should address these issues:

"We feel very strongly that in any restructuring of the pharmacy courses there should be an endeavour to expose the pharmacist to the practice situation as early as possible... so that they are able to relate the theoretical base that they are acquiring with the actual drugs that they are handling, and are able to develop skills in communicating information on those drugs as early as possible". (PGA: Transcript of evidence, p 100)

2.32 The Committee notes that a number of pharmacy schools have recognised the need for undergraduates to be taught within the client oriented environment in which they will work. In South Australia, the University of South Australia and the nearby Daw Park Repatriation General Hospital have created a joint clinical appointment that allows undergraduates a greater exposure to clinical

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5 Conference of Heads of Australian Pharmacy Schools, The Degree of Bachelor of Pharmacy Course Length: A Submission to the Higher Education Council of the National Board of Employment, Education & Training, 1990, p 15.

6 Stock B, The Future Professional Role of Pharmacists, Presented at a seminar on "Pharmacy - The Future of an Industry and a Profession" by the Australian Institute of Political Science, Sydney 24 July 1989, p 3.

pharmacy within a hospital. (DATIS: Transcript of evidence, p 1338 & Prof Sansom: Transcript of evidence, p 1347)

2.33 At the University of Sydney, undergraduates spend half a day per week in community pharmacies for part of their course and the University's Pharmacy Practice Foundation has secured a Chair of Pharmacy Practice for undergraduate and postgraduate teaching. (Australian College of Pharmacy Practice & Pharmacy Practice Foundation: Transcript of evidence, pp 1541-42)

2.34 However, academic pharmacists who spoke to the Committee were concerned that there was little scope left in the current three year syllabus to fit in enough behavioural science and communication skills to reflect adequately the importance of these disciplines to pharmacists. As the Chairman of the Pharmacy Examining Council told the Committee:

> "the undergraduate pharmacy program is so full of high quality material that kids cannot cope with any more. We cannot push any more material in unless we drop it off the bottom end". (Prof Sansom: Transcript of evidence, p 1347)

2.35 The PGA also acknowledges that "unfortunately, the academics feel that the years are very crowded as they are..." (PGA: Transcript of evidence, p 100) and the PSA believes that "undergraduate curricula have long since become saturated with essential course content".[7]

PRE REGISTRATION TRAINING

2.36 Currently, pharmacists are expected to gain practical and clinical experience in a one year supervised graduate traineeship. Exact requirements range from 2 000 to 2 500 hours of supervised work experience depending on the State.

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[7] PSA, Pharmacy and The Quality Use of Medicines: Response to the Commonwealth Department of Health, Housing & Community Services' Draft Policy on the Quality Use of Medicines, 1992, para 1.6.3.

In several States a portion of the supervised work experience can be completed at the undergraduate stage.[8] Graduates in all States and Territories are required to complete the training period to gain registration and to be able to practice independently.

2.37 Each graduate is paid a wage and works under the supervision of a registered pharmacist (preceptor). Placements must be approved by the appropriate pharmacy board, but may be in community pharmacies, hospitals or industry, with training opportunities varying from State to State. While the traineeships are under the control of the relevant State or Territory pharmacy board, pharmacy schools usually arrange the graduate placements.

2.38 A number of criticisms have been made of the current State pre registration programs. Pharmacy schools are concerned that the hiatus between the theoretical and practical elements of pharmacy training reduces the quality of graduate education. According to two academics:

> "The current isolation of the major component of professional training in the fourth year from the academic content included in the first three years with the award of the degree after the first three years fragments pharmaceutical education". (Sunderland, V & Berbatis, C: Submission, p 2172)

2.39 The problem is compounded because preceptors select themselves on economic rather than educational grounds since trainees expect to be paid. Thus, in the community setting, the best preceptors may not be able to afford to train graduates who may not be as productive as full-time employees. Similarly, hospitals are also finding it increasingly difficult to take on new pharmacy graduates as funding for non essential positions is reduced.

2.40 The shortfalls of the current system are recognised by the pharmacy boards themselves. The Pharmacy Board of Victoria admitted:

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[8] Survey conducted for the Committee by the Association of Pharmacy Registering Authorities (Inc), October 1992 and the Pharmacy Board of Queensland, November 1992.

> "Most tutors are conscientious and attempt to provide a reasonable programme of training. It is acknowledged however, that commercial and economic realities intrude into this relationship, with the result that some trainees may receive a good deal of experience, but the content of the actual training they receive is not optimal". (Pharmacy Board of Victoria: Submission, p 2134)

2.41 Another criticism is that the quality of the pre registration training and the range of professional experience a graduate is exposed to will vary, depending on the preceptor and whether the traineeship is undertaken in a pharmacy, a hospital or in industry. As a corollary, a new graduate trained in a hospital setting is unlikely to have received any experience of community pharmacy. The same applies in reverse.

2.42 The situation is compounded by varying training requirements between States. For example, the requirement for trainees to attend seminars and write papers during the year and to sit final oral and practical exams varies from State to State.[9]

2.43 The PSA has expressed its dissatisfaction at the lack of uniformity between States:

> "The one-year post-graduation practice experience program, required by State Boards of Pharmacy, has been, at best, patchy, and at worst ineffective, in providing appropriately skilled community or hospital pharmacists".[10]

2.44 If pharmacists are to maximise their emerging professional role, they will need to be increasingly competent at providing appropriate written and verbal advice. To fulfil this professional potential, there is a need for better integration of the theoretical and practical aspects of pharmacy training.

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9 Ibid.

10 PSA, Submission to the Higher Education Council on Course Length and Nomenclature, November 1989.

A FOUR YEAR PHARMACY COURSE

2.45 Pharmacy academics are aware of the criticisms of the pre registration training year and the practical difficulties of including more clinical experience within the current three year undergraduate courses. The Conference of Heads of Pharmacy Schools of Australia & New Zealand believes that these problems can be overcome if the current three year undergraduate courses and pre registration training year are incorporated into a four year undergraduate program run by the University pharmacy schools under the auspices of the relevant pharmacy boards.

2.46 The Conference considers that under the present arrangement "we are dealing with a course that certainly in the fourth year is out of our control... we believe that it can be so much better". (CHPSANZ: Transcript of evidence, p 1538)

2.47 The Conference also thinks that a four year undergraduate course could offer a better blend of theory and clinical practice in the one degree. Such a course would enable students to gain supervised experience in both community and hospital pharmacies under appropriate mentors. Additionally, an integrated course would allow greater formal teaching of communication and counselling skills than is available currently in three year courses.

2.48 Support for a four year undergraduate course appears unanimous within the profession. The School of Pharmacy at the Curtin University of Technology believes that "the Government should seriously look at combining those two elements, that is the academic component and the training component, to give a four-year overall qualification". (School of Pharmacy, Curtin University of Technology: Transcript of evidence, p 579)

2.49 The PSA has stated that it:

> "firmly believes that the Australian community will not gain the benefits that it should be receiving from pharmacists until the present deficiencies in the undergraduate education of pharmacists are addressed".[11]

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[11] Ibid.

2.50 The CHPSANZ is currently conducting negotiations with the Federal and State authorities on the introduction of a four year undergraduate course and the cessation of the pre registration training year. The negotiations hinge on the provision of extra funds to cover the increased costs of a four year undergraduate course. (CHPSANZ: Transcript of evidence, pp 1523-24)

2.51 As pharmacists have an important role to play with other health professionals in encouraging the quality use of medicines, they need an education that combines sufficient background knowledge, supervised clinical experience and skills to effectively impart their knowledge. The Committee believes that these requirements could be met more successfully through an integrated four year undergraduate course than through existing arrangements.

2.52 Accordingly, in order to provide a stronger comprehensive educational base and to equip graduates for the realities of pharmacy practice, the Committee recommends that a four year undergraduate course in pharmacy be introduced to replace the current three year undergraduate course and the pre registration training year.

Strengthening the existing pre registration traineeships

2.53 In the event that the current economic situation may prevent the immediate implementation of a four year course, the Committee believes that steps can be taken to improve the quality and uniformity of existing pre registration training programs.

2.54 The Committee notes the inconsistencies between State requirements for graduates in their pre registration year. This applies to different requirements for attendance at seminars and lectures, the submission of written papers and final exams. The current programs of lectures and exams should be standardised to reinforce undergraduate knowledge and provide a continuing balance to the actual practical experience being gained.

2.55 It is encouraging to note that by 1993, nearly all States and Territories in Australia will offer training to preceptors. **The Committee recommends that preceptors in all States and Territories should have access to preceptor training services so that students and preceptors can gain maximum benefit from the pre registration year. This can be provided either by branches of the Pharmaceutical Society of Australia or pharmacy boards.**

2.56 In some of the smaller and more centralised States, formalising existing arrangements may seem an unnecessary burden. However, in the interests of professional development on a national basis, the Committee believes it necessary to implement formal, harmonised arrangements and standards in each State and Territory.

2.57 The Association of Pharmacy Registering Authorities is preparing a national training manual to harmonise standards for pre registration training between the pharmacy boards. **The Committee recommends that harmonised standards for the pre registration training year be adopted by State and Territory pharmacy boards as a matter of priority.**

Common courses with doctors

2.58 The importance of a team approach aimed at improving the quality use of medicines has already been stressed throughout the Committee's inquiry.

2.59 The Committee has been told that one of the most effective ways of improving cooperation between future doctors and pharmacists is for undergraduate pharmacy and medical students to share lectures and clinical classes in subjects common to both degrees. As a clinical pharmacist explained:

> "one of the things which one might wish for is to have those bonds with community pharmacists and doctors strengthened through a closer liaison, especially in the early phases of education in both professions". (DATIS: Transcript of evidence, p 1331)

2.60 This idea was reinforced by a Professor of Pharmacy at the University of South Australia:

> "when a clinical pharmacist is in a hospital environment there is an ethos of team... In community practice that will never happen unless we educate at the undergraduate level... you will not get a team in health and in drug use unless you educate them together... You cannot teach people in isolation and then tell them to go out into the community and interact as a team. It just does not happen". (Prof Sansom: Transcript of evidence, p 1354)

2.61 Other educators believe that the common training should not occur until the pre registration training stage:

> "Just putting pharmacy students and medical students together in the same lecture I do not think is a guarantee that they will come out loving each other and using each other at the end of the process. If it has to occur, it has to occur a bit later in their professional development, maybe at the early postgraduate stage...". (Prof Birkett: Transcript of evidence, pp 1375-76)

2.62 A member of the Conference of Heads of Pharmacy Schools of Australia and New Zealand concurred:

> "I would have thought actually that the most valuable interaction would have been at the pre-professional level at somewhere like the ward rounds, interactions of clinical pharmacy and clinical pharmacology, rather more than the undergraduate areas". (CHPSANZ: Transcript of evidence, p 1532)

2.63 The Committee fully supports any initiatives to increase the cooperation between doctors and pharmacists which allow mutual recognition of the contribution that both groups of professionals can make to encouraging the better use of medicines.

2.64 The Committee believes it incumbent on medical and pharmacy educators and registration boards to encourage greater cooperation between the disciplines and recommends that all pharmacy and medical trainees should receive some experience of working together as part of a team. While this will not

guarantee that the various professions in community practice will work together, it will at least provide a degree of common experience and an expectation of future cooperation.

Chapter 3

CONTINUING EDUCATION

The need for continuing professional education

3.1 In its second report, the Committee stressed that all prescribers have a professional responsibility to undertake some form of continuing medical education, in order to stay abreast of the constant introduction of new drugs and the rapid advances in patient treatment. This applies equally to pharmacists who also have a responsibility to maintain and update professional standards and knowledge.

3.2 There is widespread recognition within the profession that all pharmacists should be involved in some form of continuing education to maintain their knowledge base, particularly those pharmacists who received their formal education several decades ago. The requirement for graduate entry into the profession became mandatory in most States in 1960 and was in place in all States in 1972. Less rigorous diploma qualifications were required before the advent of the degree courses. In the most recently tabulated figures (1986), 58% of pharmacists had completed at least a Bachelor of Pharmacy while 42% of pharmacists had qualified under diploma requirements.[1]

3.3 The Australian College of Pharmacy Practice (ACPP) believes:

> "all pharmacists should be involved in continuing education in order just to keep up to date... with current trends and new drugs and so on because there is a constant turnover of medicinal products". (ACPP & Pharmacy Practice Foundation: Transcript of evidence, p 1567)

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[1] Australian Institute of Health, Pharmacy Workforce 1986, Health Workforce Information Bulletin No 23, AGPS, 1986, p 9.

3.4 The Conference of Heads of Pharmacy Schools of Australia & New Zealand agrees, arguing that:

> "there have to be mechanisms and procedures in place to ensure that the knowledge level of all currently registered pharmacists having been established is maintained on an on-going basis". (CHPSANZ: Transcript of evidence, pp 1516-17)

3.5 The position of The Pharmacy Board of Victoria is that:

> "Just having knowledge does not necessarily mean that [pharmacists] practice competently, but we are quite firmly of the opinion that, unless they have up-to-date knowledge, they would not be able to practise competently". (Pharmacy Board of Victoria: Transcript of Evidence, p 1231)

3.6 The PGA also "support totally the continual training and education of pharmacists" because:

> "Without continuing upgrading, particularly of the older pharmacists who have been qualified probably 20 or 30 years, pharmacy cannot offer the necessary level of professional service - particularly in the direction that pharmacy is now heading". (PGA: Transcript of evidence, p 99)

The availability of continuing professional education

3.7 There is a wide range of professional development activities available to pharmacists. These include: enrolment in fellowship courses; attendance at conferences, seminars and correspondence courses run by professional bodies and pharmaceutical manufacturers; audio, audiovisual and satellite television programs ("Insight" & "Pharmavision"); self assessment exercises distributed by professional bodies and State pharmacy boards; and, of course, professional journals.

3.8 The PSA, through its State Branches, runs the majority of formally and self assessed continuing education options available to pharmacists. However, there are a number of other sources of formal continuing education for pharmacists. In

Western Australia, the Pharmacy Council runs a "Professional Development Assurance Programme" over two years where pharmacists accrue points for completing continuing education options.

3.9 The Society of Hospital Pharmacists of Australia conducts a "Certified Hospital Pharmacist Programme" and courses and seminars of particular relevance to pharmacists working in hospitals and nursing homes. The Australian College of Pharmacy Practice administers a "Continuing Education Self Assessment Programme" and a range of seminars and the University of Sydney's Pharmacy Practice Foundation offers seminars on new developments in pharmacology.

3.10 Many of the options are designed for distance education. While such courses are of particular benefit to pharmacists in rural and remote areas, they also allow urban pharmacists who work long hours and cannot attend regular lectures to undertake education programs. There are also specific initiatives to assist rural pharmacists, including, for example, the "Society Area Coordinator" teams of the Victorian Branch of the PSA who promote continuing education programs in rural Victoria.

3.11 While it is not compulsory for SHPA members to undertake continuing professional education, the Society grants the title of "Certified Hospital Pharmacist" to members who undertake a minimum of 30 hours study per year.[2] In addition, the Society offers a distance education fellowship course that takes four years part-time to complete and covers hospital pharmacy administration and clinical pharmacy.

3.12 The Pharmacy Guild of Australia and the Australian Institute of Pharmacy Management offer courses to assist pharmacists with the commercial aspects of running a pharmacy.

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2 SHPA, Professional Development for Hospital Pharmacists, 1989.

3.13 Attendance or participation in many of the continuing education programs earns participants cumulative points or certificates in recognition of their educational efforts.

3.14 It is encouraging to note the increasing range of continuing professional education options available to pharmacists and the Committee acknowledges the efforts undertaken by the various professional bodies to provide these options. The Committee is also pleased that the National Secretariat of the PSA is moving to coordinate the programs run by the various PSA State Branches.

The Australian College of Pharmacy Practice

3.15 The Australian College of Pharmacy Practice (ACPP) was established in 1983 by the PSA in recognition of the need for a national body within the profession dedicated to raising the standards of pharmacy practice through continuing professional education. As such, its activities are directed towards maintaining and raising the standard of pharmacy practice, and the public's perception of the professional status of the pharmacist. In 1992 the College had 1 300 members.

3.16 The College requires members to complete 20 hours of approved continuing education per year under its national continuing professional education accreditation scheme, of which only half can be self assessment. Members must also subscribe to at least two professional pharmacy journals.

3.17 The ACPP offers a Fellowship course for members, involving almost 2 000 hours of study over four years and completion of compulsory and elective units. The Fellowship course can be conducted as a distance education option. The ACPP also offers specialised certificate courses.

3.18 The Committee believes that these, or similar courses, would be appropriate qualifications for accrediting consultant pharmacists. This is developed

later in this Chapter.

Participation in continuing professional education

3.19 There has been little rigorous research into the number of practising pharmacists who undertake continuing education programs. However, one study conducted in Tasmania in 1988 indicated that only 25% of pharmacists participated at or above the level of continuing education considered necessary by the Tasmanian Pharmacy Board. Approximately 25% of Tasmanian pharmacists surveyed undertook no formal continuing education at all.[3]

3.20 Other data is more encouraging. In 1989, Victorian pharmacists conducted a total of 13 275 "pharmacist hours" of PSA (Victorian Branch) organised continuing education courses. In 1990 the figure was 19 915 pharmacist hours and in 1991 had risen to 30 400 pharmacist hours.[4] In Western Australia, the Pharmaceutical Society of Western Australia (PSWA) reports that 73% of practising pharmacists have enrolled in the Society's Professional Development Assurance Program.[5] While these figures can only provide a guide to the involvement of pharmacists in continuing education undertaken in Victoria and Western Australia, they do indicate a substantial trend toward greater participation.

3.21 The paucity of accurate data on a national basis makes it difficult to extrapolate from the above information. However, if the Tasmanian results reflect the national situation, there is cause for major concern.

3.22 The Committee recommends that research be undertaken to determine the level of continuing professional education being undertaken by pharmacists

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3 Polack A, Pharmacist participation in, and attitude towards, postgraduate professional education, Australian Pharmacist, August 1990, 9 (4), pp 113-122.

4 Figures supplied to the Committee by the Director of Continuing Education, PSA Victorian Branch.

5 *Data supplied to the Committee by PSWA.*

nationally. Such research could be conducted by the Pharmaceutical Society of Australia, the Australian Pharmacy Research Centre or the Australian College of Pharmacy Practice. This research could be funded through the Federal Government's Pharmaceutical Benefits Scheme Education Program.

Mandatory continuing professional education

3.23 The Committee believes that all health professionals have a responsibility to maintain professional standards and demonstrate ongoing professional competency. This can be achieved best if pharmacists, in line with other health professionals, have a commitment to undertaking continuing education.

3.24 **The Committee recommends the early introduction of mandatory continuing professional education.** However, its introduction needs a national approach if consumers and the profession as a whole are to benefit. As a first step, this will require the State and Territory pharmacy boards and professional associations to agree on harmonised continuing education and quality assurance standards.

3.25 Currently, most State and Territory pharmacy boards are strongly encouraging pharmacists to undertake continuing education. For example, the Tasmanian pharmacy board allocates points to pharmacists who attend seminars and complete questionnaires mailed out each quarter by the Board to all pharmacists in the State. The Victorian pharmacy board has advised practising pharmacists in Victoria that they should aim to complete at least 20 hours professional continuing education per year. However, no State pharmacy board yet requires pharmacists to undertake continuing education as a pre requisite for re registration.

3.26 Many witnesses before the Committee appeared to anticipate the introduction of mandatory continuing education requirements. The Chairman of the Australian Pharmacy Examining Council believes "Mandatory CE, mandatory

development, is inevitable; and it will happen, I am sure". (Prof Sansom: Transcript of evidence, p 1351) Similarly, the PGA commented that:

> "We support totally the continual training and education of pharmacists... It may well come to the point...where postgraduate education is mandatory". (PGA: Transcript of evidence, p 99)

The Australian College of Pharmacy Practice (ACPP) reported:

> "the view within the pharmacy community that it is almost inevitable that mandatory continuing education will be with us within a two- to five- year timeframe...". (ACPP & Pharmacy Practice Foundation: Transcript of evidence, p 1565)

3.27 Pharmacists, like other health professionals, should be prepared to undertake minimum requirements of continuing professional education as a demonstration of their commitment to keeping up to date. Such a requirement would also act as an additional indicator to other health professionals, consumer groups and government agencies of the increasing professionalism of pharmacists.

National accreditation arrangements

3.28 Before any requirements for mandatory continuing professional education can be implemented, national accreditation arrangements must be developed.

3.29 The majority of existing continuing education programs are run on a State or Territory basis and vary in their requirements and standards. Mandatory continuing education will require the development of national, harmonised programs adopted by all States and Territories to ensure profession-wide standards. The organisation most appropriate to develop these national standards is the Australian College of Pharmacy Practice in conjunction with the Society of Hospital Pharmacists of Australia.

3.30 Accordingly, the Committee recommends that the Australian College of Pharmacy Practice develop national standards for continuing professional education courses in conjunction with the Society of Hospital Pharmacists of Australia. Such standards should be adopted by the State and Territory pharmacy boards as appropriate standards for continuing professional education programs.

3.31 The Association of Pharmacy Registering Authorities (APRA) has an important role to play in coordinating the implementation and later compliance with national standards for continuing professional education courses. Any potential national coordinating role for APRA is currently limited as the Queensland Pharmacy Board is not represented on the Association. The Committee believes that it is in the interests of the profession that the Queensland Pharmacy Board become a member of APRA so that the State and Territory Pharmacy boards can coordinate their education and registering standards on a national basis.

3.32 The Committee therefore recommends that the Australian Health *Ministers' Conference encourage the Queensland Pharmacy Board to become a* member of the Association of Pharmacy Registering Authorities.

The role of the pharmaceutical industry

3.33 A number of pharmaceutical manufacturers provide educational grants, sponsorships or awards for various continuing education programs run for pharmacists. The Committee acknowledges the important role that the pharmacy industry plays in assisting to promote the quality use of drugs through sponsoring continuing education programs for pharmacists.

3.34 The role and potential further involvement of the pharmaceutical industry in continuing education programs is examined in Chapter 3 of the Committee's second report. Although comments were directed at continuing education for prescribers, they apply equally to programs for pharmacists.

3.35 The Committee encourages professional associations of pharmacists to seek further sponsorship arrangements with pharmaceutical manufacturers for company support for programs run by the profession or for courses organised by the industry.

3.36 It is important to stress, however, that any pharmaceutical company sponsored continuing professional education program should be evaluated by the ACPP, the SHPA or any other appropriate professional body to ensure scrutiny of the educational content.

Chapter 4

HOSPITAL PHARMACY

Advice to the medical profession within hospitals

4.1 As mentioned in Chapter 2, the professional role of clinical pharmacists, as providers of expert drug advice to prescribers, has evolved most clearly in the last two decades within the hospital setting. In most hospitals, pharmacists work with doctors on drug committees to develop hospital formularies, provide advice to doctors on the choice of drugs for individual patients and provide a drug education service for hospital staff and patients. As one pharmacy academic noted:

> "Clinical pharmacy in hospitals has blossomed... It has really become established in the last decade... We are seeing now... a hospital service where the clinical pharmacy service is such an integral part of patient care...". (Prof Sansom: Transcript of evidence, p 1355)

Another explained:

> "The hospitals recognise the value of the pharmacists and their knowledge... It is really a knowledge based role that hospital pharmacists play now. The supply role is still there, but they have full time people working providing drug information". (School of Pharmacy, University of Tasmania: Transcript of evidence, p 753)

4.2 While pharmacists remain responsible for drug distribution within hospitals, clinical pharmacists are increasingly responsible for providing advice on dosage and drug compatibility to hospital prescribers. One hospital pharmacist commented:

"I do not think [doctors] like to start their ward rounds without us. If you are not there, they will ring us up and say, 'Where are you?'... they really do depend on us for currency of information...". (DATIS: Transcript of evidence, pp 1337-38)

4.3 The Society of Hospital Pharmacists of Australia believes hospital pharmacists are:

"a useful source of information in the therapeutic decisions that the medicos are making. They are quite willing in this, and approach pharmacists frequently for advice regarding their therapeutic decisions with respect to patients". (SHPA: Transcript of evidence, p 344)

4.4 The Acting Chief Pharmacist at Alice Springs Hospital described the impact of including pharmacy staff on ward rounds with doctors:

"There has been a measurable decrease in medication errors in the one ward where we have been spending most of our time, so we can show that we can make that sort of difference". (Pharmacy Department, Alice Springs Hospital: Transcript of evidence, p 1451)

4.5 Not only do hospital pharmacists provide prescribers with information on appropriate drug regimens, but they can also promote cost effective prescribing. The Committee was given the example of one hospital pharmacist on contract who was told: 'Save your salary in 12 months and you can have another contract for 12 months'. The pharmacist saved $60 000 in four months on the use of one drug alone, by rationalising the prescribing choice of that particular drug using the hospital drug guidelines. (Prof Sansom: Transcript of evidence, p 1357)

4.6 The role of clinical pharmacists is evolving further in major hospitals as pharmacists specialise in providing drug advice in certain areas, such as oncology or cardiovascular disease.

Advice to hospital patients

4.7 Hospital pharmacists also have an important role to play in educating patients on how to manage their drug schedules. Some hospitals encourage patients to be responsible for their own drug administration during their hospital stay, for example by providing patients with "on demand" parenteral analgesic administration (PRN). Such patients will be directly supervised by pharmacists.

4.8 Hospital pharmacists also provide patients with enough information to enable any discharge medication to be taken safely and correctly. Pharmacists may provide written as well as verbal advice and, increasingly, make use of patient medication cards to remind patients of their medication regimens.[1]

Pharmacy outreach for community prescribers

4.9 A number of pilot projects have been established whereby hospital pharmacists provide drug advice to community prescribers. These projects are usually termed "academic detailing".[2]

4.10 In the Drug and Therapeutics Information Service (DATIS) pilot study, pharmacists based at the Daw Park Repatriation General Hospital in Adelaide visit local community doctors and discuss the appropriate use of non steroidal anti inflammatory drugs and alternative therapies. DATIS also offers a telephone based drug and therapeutics information service for doctors as well as a therapeutic drug monitoring consultancy service. As one of the pharmacists involved explained:

> "We are really offering services which are parallel to those which we provide within the hospital itself... They consist principally of information and

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1 See Chapter 7 of the Committee's second report for a discussion of consumer medication cards.

2 The potential of academic detailing is discussed in greater detail in Chapter 5 of the Committee's second report.

support for doctors as they try to make good decisions for their patients in the matter of treatment". (DATIS: Transcript of evidence, p 1324)

4.11 The positive response by community doctors to the service provided by DATIS indicates the important role that pharmacists can play in providing all prescribers with information to assist and improve prescribing decisions.

Liaison between hospital and community pharmacists

4.12 Traditionally, there has been limited liaison between hospital and community pharmacists upon patient discharge from hospitals.[3] However, due to budgetary constraints, discharge prescriptions dispensed by hospital pharmacists are now kept to a minimum in most hospitals. Consequently, patients are having to visit community prescribers and pharmacists shortly after discharge for any repeats and the reissuing of pre admission medication. This has highlighted the need for close coordination between hospital and community health professionals as patients move between the two groups.

4.13 As a result, there have been a number of local initiatives to improve communication between hospital and community pharmacies. One such initiative has been started by the Pharmacy Department of Greenvale Campus of the North West Hospital in Broadmeadows, Victoria.

4.14 When a patient is being discharged, the Pharmacy Department contacts the patient's regular community pharmacist and advises the pharmacist of the patient's discharge medication. This complements existing discharge arrangements between the hospital medical staff and community doctors and minimises the possibility of contra indicted or inappropriate prescribing.

4.15 In a true example of multi disciplinary cooperation, the Pharmacy

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[3] Liaison between hospital and community prescribers is discussed in Chapter 8 of the Committee's second report.

Department of the Nepean Hospital in NSW runs monthly evening seminars on drug use for both hospital and local community based doctors, pharmacists and nurses. The speakers at each seminar are organised by the Pharmacy Department and the associated evening meals are provided by the hospital, but sponsored by drug companies.

4.16 These projects bring together hospital and community health professionals (and pharmaceutical manufacturers) in a good example of the cooperation needed to foster a team approach.

4.17 As an example of greater consumer involvement in decision making, St Vincent's Hospital in Sydney is encouraging the participation of a consumer representative on its drug committee.

4.18 There is, however, a perception by some of a developing rift between hospital and community pharmacists which has also been reinforced in informal conversations held with the Committee. The Chairman of the Australian Pharmacy Examining Council commented:

> "There is talk about elitism... with some of the hospital pharmacy people, who are starting to see themselves as an elite group. I think that is potentially dangerous for them: 90 per cent of the drugs which are administered in hospital are also administered in community practice - the same drugs". (Prof Sansom: Transcript of Evidence, p 1357)

4.19 The further development of the profession will require cooperation by all branches of pharmacy. The Committee sees cooperation between hospital and community pharmacists as important for the profession as well as for patient health.

4.20 In particular, the Committee believes the profession should ensure close cooperation between the Society of Hospital Pharmacists of Australia and the Australian College of Pharmacy Practice. Joint development of a continuing education accreditation system applicable to both hospital and community pharmacists would be a useful product of such liaison.

Chapter 5

COMMUNITY PHARMACY

5.1 Hospital pharmacy illustrates the modern professional role of the pharmacist. However, the majority of pharmacists work in community pharmacies dispensing the vast bulk of prescriptions and having direct contact with the general public.

5.2 There are distinct differences between hospital and community pharmacy practice. In hospitals, pharmacists have regular contact with prescribers, nurses and patients, within the same location. In the community setting, consumers can visit one of many doctors and receive a prescription and have it dispensed at one of many pharmacies. As a consequence, a community pharmacist is far less likely to have been involved in deciding which drug to prescribe, may not know the prescriber and have no idea of a consumer's previous medication history.

5.3 These factors result in fragmented health care and a potentially higher incidence of inappropriate prescribing, patient non compliance and adverse drug outcomes.

5.4 As the previous chapters have stressed, a coordinated approach by health professionals is important in ensuring the quality use of drugs in the community as well as in hospitals. This has been acknowledged by the PSA, which sees that:

> "Pharmacy's professional future will be increasingly reliant on establishing ongoing integrated care relationships with other health providers and consumers".[1]

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[1] PSA, Pharmacy and the Quality Use of Medicines: Response to the Commonwealth Department of Health Housing and Community Services' Draft Policy on the Quality Use of Medicines by the Pharmaceutical Society of Australia, July 1992, para 1.4.1.

Cooperation between doctors and pharmacists in the community

5.5 The previous Chapter described the joint approach to prescribing by hospital based pharmacists and doctors. This level of close cooperation is not matched by community health professionals where there is far greater professional demarcation between community based prescribers and pharmacists. This ultimately affects the quality of drug use. A member of the Pharmacy Board of Tasmania commented:

> "I think where [pharmacists] have actually had more interface in hospitals and things, the situation is working very well and they are getting far more rational use of medication and far better compliance from the patient... but, as yet, I do not believe that has happened to any great extent out in the greater community".(Pharmacy Board of Tasmania: Transcript of evidence, p 687)

5.6 The PSA believes:

> "There needs to be a whole new relationship, which has started to develop in the institutional settings but needs to continue to develop there and be transplanted into the community setting - a different relationship between doctors and pharmacists". (PSA: Transcript of evidence, p 70)

5.7 Some general practitioners value the advice of community pharmacists when making prescribing decisions, while other doctors and pharmacists see the role of pharmacists as limited to dispensing medication and encouraging patient compliance. The Chairperson of the Pharmaceutical Health and the Rational Use of Medicines (PHARM) Working Party pointed out that:

> "There are some GPs whom [community pharmacists] work extremely closely with and there are others that are very difficult to work with". (PHARM: Transcript of evidence, p 1653)

5.8 The Chairperson concluded that "we need to do a lot more work to facilitate those relationships and get them working well". (PHARM: Transcript of evidence, p 1653) A professor of community medicine at Monash University agreed:

"Often there is a barrier between the pharmacist and the doctor... Perhaps it is to do with professional jealousies or perceived competition". (Prof Carson: Transcript of evidence, p 1282)

5.9 The PGA concurs, believing "that the community pharmacists' professional role is inadequately recognised...". (PGA: Submission, p 1857)

5.10 There are signs that cooperation between community pharmacists and doctors is improving, as newer graduates in both professions enter community practice. Many witnesses before the Committee believed that the close cooperation in hospitals between hospital pharmacists and new doctors will encourage the doctors, when practising in the community, to seek advice from community pharmacists. The Dean of the Australian College of Pharmacy Practice (ACPP) commented:

"I think that the barriers are certainly breaking down and in large part this is due to the fact that the newer doctors particularly are going through a hospital system where the hospital pharmacists are with them on the wards and they get used to talking to pharmacists and seeking advice and acting as a team. That is beginning to show in the community now". (ACPP & Pharmacy Practice Foundation: Transcript of evidence, p 1570)

5.11 Others noted that pharmacists and doctors are aware that they need to cooperate to ensure compliance by consumers with complicated medication regimens. The President of the Australian College of Pharmacy Practice gave the example of asthma treatment:

"I know there is an increasing awareness, both in the medical profession and in the pharmacy profession in having to ensure how medications are utilised... I know with some pharmacies the doctors who have prescribed the medication are insistent that their patients go to that pharmacy to have instruction...". (ACPP & Pharmacy Practice Foundation: Transcript of evidence, p 1564)

5.12 It is likely, however, that this attitudinal change will take time to become commonplace. The Society of Hospital Pharmacists of Australia sees the development of an ethos of cooperation between general practitioners and

community pharmacists as a slow process:

> "I think it is something that will develop over time... one would hope that, when [medical interns] go out to practise in the community as medical officers, they have a different appreciation of the advice and consultation role that a pharmacist can take. But that will be a slow, evolutionary process". (SHPA: Transcript of evidence, p 343)

5.13 One way to foster closer ties between doctors and pharmacists would be for community pharmacists and doctors to jointly attend continuing education seminars and programs of mutual interest.

5.14 Accordingly, the Committee recommends that the Australian College of Pharmacy Practice and the Royal Australian College of General Practitioners determine whether there are any continuing education programs that can be run conjointly.

Overlapping roles for pharmacists and doctors

5.15 Pharmacists have always had a role in providing consumers with initial advice and treatment for minor ailments. This remains an important service, particularly given the easy public access to pharmacists. The PSA has codified the competencies required of community pharmacists and expects that they:

> "should be able to evaluate symptoms and circumstances as they are presented by clients, propose an appropriate regimen of care for the identified condition, including reference to a medical practitioner or other health professional if necessary".[2]

5.16 Community pharmacists are also expected to promote health education in the community and provide advice on how to improve the health of consumers. This has logically extended to pharmacies offering services such as screening tests

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2 PSA, A Set of Competencies For Australian Community Pharmacy Practice, op cit, p 2.

for hyperlipidaemia, hypertension, blood glucose levels and pregnancy.

5.17 Surveys indicate, however, that doctors and pharmacists have differing opinions about the role of pharmacists in answering prescription related questions, treating patients in response to symptoms and helping to monitor stable chronic diseases.[3] Doctors also appear "generally opposed" to pharmacists becoming involved in the management of major diseases, even in a supporting role, and are also opposed to pharmacists carrying out most screening tests.[4]

5.18 The Australian Medical Association (AMA) has produced a policy statement on the relationships between medical practitioners and pharmacists which states that:

> "Diagnosis is not the province of the pharmacist because diagnosis requires accurate history taking, examination, and a knowledge of differential diagnosis for none of which a pharmacist is trained. Not being in a position to evaluate the whole patient, or provide adequate follow-up could cause serious results for the patient".[5]

Furthermore:

> "Chemical testing or even physical testing (B.P. estimation etc) are only aids to diagnosis... The ability to adequately interpret a test requires clinical expertise".[6]

5.19 It is ultimately the consumer who decides whether to visit a pharmacist or doctor for initial medical advice. If the patient's choice is the pharmacist, then

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3 Ortiz M et al, Physicians - Friend of Foe: Comparisons between Pharmacists' and Physicians' Perceptions of the Pharmacist's Role, Journal of Social and Administrative Pharmacy, 6(2), 1989, pp 59-68.

4 Ortiz M et al, Attitudes of Medical Practitioners to Community Pharmacists giving Medication Advice to Patients: Findings of a Pharmacy Practice Foundation Survey, The Australian Journal of Pharmacy, 66, October 1985, pp 803-810.

5 AMA, Policy statement on role of pharmacist and the relationship between medical practitioners and pharmacists, 1988, p 1.

6 AMA, Policy Statement, op cit, p 2.

the pharmacist must be able to assess whether, or when, a referral to a doctor is necessary.

5.20 There is anecdotal evidence that a large number of patients presenting to doctors have in fact been referred by pharmacists.[7] If this is correct, then it indicates the important role of the pharmacy profession in primary health care. This could encourage doctors to share more of the responsibility for providing drug advice, primary health care, screening services and counselling.

5.21 As a first step, the Committee recommends that the Pharmaceutical Society of Australia coordinate or sponsor research to determine the number of patients presenting to doctors resulting from referral by pharmacists.

5.22 One method of improving doctor-pharmacist communication would be to provide pharmacists with patient referral forms. The forms could be filled out and given to patients to present to their doctor where the pharmacist felt a referral was necessary. The forms could be designed to allow a range of matters to be brought to the doctor's attention and would, hopefully, encourage discussion about individual cases. Patients given a referral form to reinforce verbal advice from the pharmacist might also be more likely to see a doctor. Such forms have already been successfully used in pilot studies in the United Kingdom.[8] They have also been trialled by the PSA. However, the further development of this idea has not continued.

5.23 The Committee recommends that the Pharmaceutical Society of Australia, in cooperation with the Royal Australian College of General Practitioners build on past work already undertaken and evaluate the feasibility and effectiveness of pharmacist referral forms.

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7 Murphy B, An exploration of the relationship between general practitioners and pharmacists in patient education: conducted for the RISK Study and the HEART Study, National Heart Foundation of Australia & Monash University, November 1991.

8 Joint Working Party on the Future Role of the Community Pharmaceutical Services, Pharmaceutical care: The future for community pharmacy, 1992, UK Department of Health, pp 6-7.

The commercial role of community pharmacy

5.24 While community pharmacists are health professionals, they are also operators of small businesses. As the PGA explained:

> "Despite its primary health care role, [community] pharmacy is not a charitable non-profit institution. As well as being health professionals, pharmacists need to survive in the business world with all its associated risks and rewards".[9]

5.25 Community pharmacists' remuneration principally comes from dispensing "ready prepared" (packaged by the pharmaceutical manufacturer) and "extemporaneously prepared" (prepared by the pharmacist) prescriptions, selling non prescription medications, health aides and associated products.

5.26 The remuneration received by community pharmacists for dispensing ready and extemporaneously prepared Pharmaceutical Benefits Scheme (PBS) prescriptions is currently calculated on the basis of a product mark up and a dispensing fee. The product mark up that can be charged is calculated on a sliding scale determined by the cost of the pharmaceuticals to the pharmacist. The percentage mark up, dispensing fee allowed and indexed adjustments are calculated under an agreement reached between the PGA and the Commonwealth Government.[10]

5.27 The fees that pharmacists can charge for dispensing private, non PBS prescription items, are not regulated.

5.28 In 1990-91, 53% of sales revenues received by the average pharmacy

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9 PGA, 1992 Guild Digest: A survey of independent pharmacy operations in Australia financial year 1990-91, 1992, p 23.

10 The two part Agreement on Remuneration and Structural Reform between the Minister responsible for the Pharmaceutical Benefits Scheme, the Honourable Peter Staples and the Pharmacy Guild of Australia, 6 December 1990.

came from dispensing prescriptions while the remaining 47% came from sales of non prescription medicines and merchandise.[11]

5.29 Community pharmacists argue that as they are remunerated for the supply of drugs, there is no financial incentive for providing counselling, non drug alternatives and advice to consumers. Pharmacy groups claim that community pharmacists will not be able to afford to fulfil their professional potential for providing drug advice unless the remuneration structure is changed. The PGA states that:

> "Under the PBS, there is no financial incentive for community pharmacists to provide additional pharmaceutical services nor to use the expert skills they possess in areas such as drug utilisation review". (PGA: Submission, p 1857)

5.30 The PSA has reinforced this view, commenting that the current system:

> "leaves pharmacists with little scope to provide an effective contemporary service to the Australian community, and discourages them from assuming a level of professional responsibility appropriate to the role for which they were trained". (PSA: Submission, p 495)

5.31 The School of Pharmacy at the University of Tasmania believes:

> "community pharmacists are now seen as people who are fractionally retailers and fractionally professionals and they just have not got the time to be full time professionals because of the nature of the remuneration. They have to devote a considerable amount of their time to activities which are not professional activities in order to keep their income to the appropriate level". (School of Pharmacy, University of Tasmania: Transcript of evidence, p 749)

5.32 The Pharmaceutical Society of Western Australia (PSWA) sees that the current payment for dispensing system is:

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[11] PGA, 1992 Guild Digest: A survey of independent pharmacy operations in Australia financial year 1990-91, July 1992, p 18.

"not taking into account this counselling role, the health care role, the after care role, and the continuing education role...". (PWSA: Transcript of evidence, p 636)

5.33 The Committee acknowledges that the current system of remuneration principally based on dispensing prescriptions does not encourage community pharmacists to extend their professional roles. In fact, many of the consumer based initiatives developed by the PSA and other professional bodies have been implemented by pharmacists for little immediate financial reward. The Committee recognises the professional endeavour of community pharmacists and the PSA's claim that:

"there is a strong general desire among pharmacists to significantly further the profession's role in helping the public use drugs more effectively". (PSA: Submission, p 474)

5.34 One of the major professional goals of pharmacy is to improve the outcomes of drug therapy. It is up to the profession to quantify the contribution community pharmacists are able to make to optimising drug use. In the current economic climate, such contributions will need to be clearly demonstrated on a national basis before the profession can expect new formulae for remuneration.

5.35 As the Chairperson of the Pharmaceutical Health & the Rational Use of Medicines Working party has remarked:

"We are concerned to see some programs which show us the effect that a pharmacist working to that professional standard has on contributing to the quality of drug use... We need to have much better evidence that the things that [pharmacists] are doing produce a certain result. I think that pharmacy has sold itself short. It has thought through many of the issues and come up with very innovative programs but it has not taken the final step to demonstrate the effect that that has". (PHARM: Transcript of evidence, pp 1640-41)

5.36 This point has been reinforced by a former National Director of the PSA:

"Individual pharmacists must accept that if a scheme that rewards them for the provision of the types of professional services described were to be introduced they could not expect to get a higher level of remuneration by default simply because they felt they were worth it. Some of them will have to "lift their game". The profession at large cannot support higher remuneration levels for those who are acting at basic technician levels.[12]

5.37 Therefore, the Committee encourages further research work to be undertaken by the Pharmaceutical Society of Australia and the Pharmacy Guild of Australia to provide a better basis for restructuring present remuneration arrangements to take account of value added services provided to health consumers and their cost effectiveness. This work will be assisted by the proposal in paragraph 7.35 of this report.

[12] Stock B, The Future Professional Role of Pharmacists, op cit, p 14.

Chapter 6

CONSUMER ISSUES

6.1 All health professionals share the common goal of trying to improve health outcomes for consumers. One of the key contributions pharmacists make to this goal is providing consumers with enough advice to take drugs safely and correctly. The provision of advice encourages patient compliance which, in turn, should lead to improved health outcomes.

The role of the pharmacist in providing consumer information

6.2 To encourage compliance with drug regimens, consumers need to: a) know why they are taking medication; b) be given enough information to take the right medication in the right doses at the correct times; c) be alerted to any special precautions to observe when taking the medication; d) know what to do if they miss a dose and; e) be aware of any common adverse drug reactions and appropriate action to take.

6.3 In the community setting, it is primarily the responsibility of the general practitioner to provide consumers with information about the name of any drug prescribed, the purpose of the drug, dosage rates, possible common side effects and potential contra indications.

6.4 Pharmacists play an important role in reinforcing the drug advice provided to patients by doctors. Such reinforcement can be necessary, as one pharmacist described:

> "there are many studies that demonstrate that the patients, when they leave the doctor's surgery, are suffering an information overload... If they are sick,

> they are worried about their illness more than their treatment... patients tend to forget a large proportion of what they have been told in the doctor's surgery about their medication. Consequently, as the last health professional in this drug information chain, the pharmacist has a most important role to reinforce what the doctor said...". (ACPP & Pharmacy Practice Foundation: Transcript of Evidence, pp 1547-48)

6.5 The pharmacist's role becomes particularly important if the patient is on a complex medication regimen or has to be taught how to correctly use a device, such as an asthma inhaler.

6.6 The pharmacist can also provide information to consumers that is less likely to have been dealt with by a doctor. For example, consumers should be advised on storage conditions for their medication, told to take the full course of medication and not to hoard expired medication. The pharmacist may well provide patient information handouts to reinforce verbal counselling.[1]

6.7 Of course, pharmacists need to counsel consumers fully on the correct use of non prescription medication and any medical devices sold in the pharmacy.

Patient compliance aides

6.8 While verbal counselling and written advice given by the pharmacist encourages patient compliance, greater assistance may be required by those on multiple medication or for those who are physically or mentally handicapped.

6.9 As a result, a number of devices are on the market to assist patients take the correct medicine at the correct time of day. These are usually in the form of containers subdivided into a number of smaller unit dose compartments labelled by day and administration times. The packs can be pre-loaded by a health professional and may be of particular benefit in nursing homes and hostels where

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[1] Consumer product information and the potential of pharmacy computer printouts are discussed in Chapter 5 of the Committee's first report.

patients are more likely to be on multiple medication.

6.10 One unit dose system of tablet/capsule calendar packaging is known as the "Webster Pak". In one controlled trial of the effectiveness of this system, researchers concluded that the pack "significantly improves the rate of successful self medication in elderly patients discharged from hospital".[2]

6.11 The filling of unit packs can be part of a total pharmacy service, where pharmacists preparing the packs for consumers on a regular basis can monitor patient compliance and easily conduct drug utilisation reviews.

6.12 Disadvantages with such unit dose packs are that they are time consuming to fill and that, as yet, there has been little research done to determine the stability of medicines stored together in these containers. Furthermore, some of the units are not child proof, others are bulky, and a number do not allow labelling of contents.

6.13 Nonetheless, the Committee believes that the use of unit dose packs can significantly improve compliance by certain groups of consumers and, as such, should be supported.

Public health campaigns

6.14 Pharmacists can play an important role in public health promotion campaigns. This has been recognised by the profession which is taking an increasingly active role in health education promotions including the provision of in-store written information (Self Care Fact Cards) and presentations to community groups by local pharmacists. The PSA and its State branches assist pharmacists by providing a range of resource kits on popular drug related topics, with instructions for their use.

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2 Ware G et al, Unit dose calendar packaging and elderly patient compliance, New Zealand Medical Journal, 104 (924), 27 November 1991, p 496.

6.15 The profession also coordinates national drug education programs such as the as the Pharmacy Self Care "Med-Aware" campaign in 1991. Pharmacy groups have also contributed to various government campaigns to promote better drug use including the "Be Wise with Medicines" campaign for September 1992 and the compilation of "Medi-Whyz" information kits on behalf of the Federal Department of Veterans' Affairs.

Drug disposal

6.16 One factor contributing to adverse drug outcomes is the use by consumers of hoarded pharmaceuticals after the expiry of their use by date. In recognition of this problem, pharmacy groups have run a number of campaigns encouraging consumers to return unused or out of date medication to their pharmacist for disposal.

6.17 These campaigns have several advantages as the Pharmaceutical Society of Western Australia (PSWA) pointed out:

> "The campaigns have proved to be very positive in the sense that they have made people aware of what is in their medicine cabinets; they have brought things to the pharmacy and have discussed some of their medication problems". (PSWA: Transcript of evidence, p 639)

6.18 It is acknowledged that pharmacists themselves have difficulties correctly disposing of unused medication. However, by participating in "MediDump" style campaigns, pharmacists make a useful contribution to alerting consumers to the dangers of using potent but out of date medicines inappropriately.

Privacy issues

6.19 Over 95% of community pharmacists now use computers to assist in the operation of their pharmacies. One use of most pharmacy computers is to maintain patient medication histories.

6.20 Use of these records can be invaluable to the pharmacist when filling scripts or answering queries from regular customers. The records can be used to check whether a patient is being prescribed contra indicated drugs or unusual dosages and may be the one comprehensive patient medication record held by any health professional.

6.21 Holding data on individual patients in pharmacy computers raises questions of consumer privacy and the use made of these data bases. Ethical questions could arise, for example, if a pharmacist used his data base to mail a letter to all patients who had recently received lipid lowering drugs to invite them to a seminar on low cholesterol foods. Alternatively, problems could also arise if a pharmacist granted a doctor access to data about a patient's medication not prescribed by that doctor and without the consent of the patient.

6.22 The PSA's Code of Ethics provides general advice to pharmacists faced with these questions by stating that, "A pharmacist shall respect the trust and confidentiality of professional relationships with patients".[3]

6.23 However, the Committee believes that the profession needs to develop specific guidelines on access to patient medication records held on pharmacy computer databases and the uses made of this information. Guidelines should be based on the principle that patient records are kept by the pharmacist on behalf of the patient. Furthermore, pharmacists should not use patient data for any purpose, outside normal medication checking purposes, without the consent of the patient.

6.24 The NSW Branch of the PSA has a Computer Users Committee which is examining the potential of computers to improve the professional service pharmacists can offer, but at this stage the Committee is not national nor does not include consumer representatives.

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[3] PSA, Code of Ethics for Pharmacists, No 5.

6.25 The Committee recommends that the Pharmacy Guild of Australia and the Pharmaceutical Society of Australia develop national guidelines on the uses to be made of patient medication records held on pharmacy computer databases. The guidelines should be developed after extensive consultation with appropriate privacy commissions or committees and in conjunction with appropriate consumer groups.

The Health Communications Network

6.26 The Federal Department of Health, Housing & Community Services is conducting feasibility studies to explore the potential of a national health communications network. This proposed network is an electronic facility allowing health professionals to communicate or transfer authorised health care information and images to each other. The Network would allow, for example, doctors and pharmacists in a major hospital to transfer specialist drug information or a patient's medication history instantaneously to a doctor in an isolated town.

6.27 Given the team approach necessary to encourage the quality use of drugs, any technology which can assist improve communication within the professions is welcome. The Network is still in an embryonic stage and further development needs to be done in conjunction with all health professionals and consumers to address the related privacy issues.

6.28 The Committee recommends, in principle, the adoption of the Health Communications Network, conditional on privacy and confidentiality concerns being addressed.

Chapter 7

THE FUTURE OF PHARMACY

7.1 Pharmacy organisations are now examining a number of potential roles for pharmacists to fully utilise their training and knowledge. These roles mostly expand the opportunities for pharmacists to provide advice on drug therapy management and drug utilisation review. If the potential of these new roles is realised there will be better health outcomes for consumers, additional professional opportunities for pharmacists and a clearer distinction between dispensing and other professional activities.

7.2 The future direction of pharmacy is very much in the hands of the profession. It depends on the profession's ability to convince other health professionals, government and consumers that pharmacists can make a greater contribution to ensuring the quality use of medicines with ensuing benefits for the community and individuals.

CONSULTANT PHARMACISTS

7.3 Currently, representatives of all major pharmacy organisations, under the auspices of The Upjohn Education Committee, are examining the potential of "consultant" pharmacists.[1] As yet, consultant pharmacists have a clearly defined role only in the United States where they provide, inter alia, drug regimen reviews for patients in nursing homes.

7.4 In an Australian context, consultant pharmacy could also potentially encompass pharmacists specialising as academic detailers, hospital-community

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[1] The Upjohn Education Committee is funded by the Upjohn Pty Ltd pharmaceutical company.

liaison pharmacists, providers of domiciliary pharmacy services for patients at home or community drug education specialists.[2]

7.5 The profession, in discussing the potential of various forms of consultant pharmacy should confer with consumer groups, other health professionals and government. Issues to be resolved include determining the demand for consultant pharmacists, their cost effectiveness, methods of remuneration and relationships with other health professionals. As the profession explores its options, it will also need to define standards of competence for the various consultant roles, appropriate performance indicators and determine quality assurance processes.

7.6 The Committee believes that consultant pharmacists will need some form of specialist graduate training, along with mandatory continuing professional education.

Pharmacists and domiciliary health care

7.7 Hospital budgetary restraints, early hospital discharges, advances in medical technology and the belief that as many patients as possible should be treated in the community, mean that more and more people on complex medication regimens are being treated at home. Furthermore, many of these people are unable to travel, thereby limiting direct access to a full range of pharmacy services.

7.8 There are both professional and commercial opportunities for pharmacists to provide pharmaceutical products, services and advice directly to those receiving treatments at home. Pharmacists in this situation could: provide products ranging from wheelchairs and non prescription medication to machines administering parenteral antibiotics, analgesics and cytotoxic drugs; dispense prescription drugs; provide medication advice to consumers, carers and community nurses; and potentially conduct medication reviews and coordinate other health services.

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[2] There is a discussion of the potential role of consultant pharmacists in Holland R, Consultant Pharmacy in Australia: A report to the Upjohn Education Committee, September 1991.

7.9 The PGA, the PSA and the SHPA are all investigating the potential of pharmacists to extend their professional activities into pharmaceutical home care.

Community liaison pharmacists

7.10 An extension of the home health care pharmacist model is that of the "community liaison" pharmacist.

7.11 A major limitation of the effectiveness of health care teams in hospitals is poor coordination with community based health professionals, both before and after patient admission.[3] In recognition of this problem, the notion of community liaison pharmacists has been suggested. These specialists would oversee a patient's total medication regimen in the time from hospital discharge until management by community health professionals.

7.12 These pharmacists would liaise with hospital and community health professionals, consumer support groups and carers to identify patients at significant risk of medication misadventures and arrange monitoring to ensure that inadvertent mismanagement did not occur.

7.13 The NSW Branch of the PSA is currently proposing a pilot study to examine and evaluate the potential role of community liaison pharmacists.

Pharmacists in nursing homes

7.14 The National Health Strategy has identified a need for better drug use review procedures in Australian nursing homes and hostels. Research has indicated that inappropriate medication use is a major problem for patients in these

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[3] Liaison between hospital and community prescribers is discussed in Chapter 8 of the Committee's second report.

institutional care settings.[4] Such inappropriate drug use is more common in nursing homes than the wider community because residents are more likely to be on a high intake of medicines, are often not subjected to regular medication reviews, and due to poor coordination between nursing staff, doctors and pharmacists.[5]

7.15 In the USA, pharmacists are legally required to review drug use in the equivalent of nursing homes and hostels. In England and Scotland, the National Health Service pays pharmacists to review drug regimens and educate staff on drug use in nursing and residential homes.

7.16 The Committee recommends that the Department of Health, Housing & Community Services investigate extensions to current arrangements for funding nursing homes which would enable the remuneration of pharmacists conducting regular drug reviews in nursing homes and hostels. Such pharmacists could be hospital based, community pharmacists on contract, members of local Geriatric Assessment Teams or, potentially, on Nursing Home Medical Advisory Panels.[6]

DEVELOPMENT OF NEW INITIATIVES

Recognition of local initiatives

7.17 The Committee has been impressed with the quality and variety of initiatives by hospital and community based pharmacists to improve the quality of drug therapy management. Many of these projects have been developed at the local level in response to local needs. The Committee believes the various professional

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4 National Health Strategy Issues Paper No 4, Issues in Pharmaceutical Drug Use in Australia, June 1992, pp 71-77.

5 ibid, pp 25-26

6 The establishment of Nursing Home Medical Advisory Panels has been proposed by the Australian Medical Association (AMA). See AMA, A draft proposal to establish nursing home medical advisory panels towards securing high quality outcomes for elderly Australians requiring hostel and nursing home accommodation, Prepared by the AMA's Care of the Aged Committee, 1991.

bodies should foster such local initiatives, help develop funding proposals and assist in rigorous program evaluation. With this approach, new initiatives to extend and enhance the role of the profession can retain relevance and practicality. At the same time, the projects can remain part of coordinated national initiatives to further utilise the knowledge and resources of pharmacists.

Cooperation with other health professionals.

7.18 As pharmacy defines and explores the potential of the profession, it will inevitably encroach on areas considered the responsibility of other professionals. There may be tension between the pharmacy and medical profession if doctors perceive that community liaison pharmacists are usurping the traditional coordinating role of the general practitioner. Similarly, peak nursing organisations may perceive the development of the community liaison pharmacist role as duplicating many of the functions proposed for nurse practitioners. The PSA has recognised this and has pointed out:

> "most of the apparent concerns from other health professions about pharmacists role are based upon misunderstandings that can be readily resolved. Only in relatively few instances is there likely to be any substantial conflict of interest and it is unlikely that these cannot also be resolved by mutual discussion and agreement".[7]

7.19 Pharmacy will need to define its further contribution to quality drug use in cooperative consultation with other health professionals and consumer groups. This needs to be done both at the national level between peak organisations and at the local level between individual pharmacists, doctors, nurses and community groups.

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[7] PSA, Pharmacy and the Quality Use of Medicines, op cit, para 1.4.3.

Project evaluation

7.20 For the profession to extend new services beyond pilot projects and seeding grants, governments, other health professionals and pharmacists themselves will have to be convinced of the clinical and economic benefits of new roles.

7.21 National peak organisations have an important role to play in encouraging the rigorous and scientifically sound analysis of pharmacy initiatives.

7.22 Government funding may result if pharmacy demonstrates that it can provide cost effective improvements in drug use. Furthermore, individual community pharmacists will be encouraged to extend their services if the professional and economic viability of pilot studies is demonstrated, as outlined in Chapter 5.

The Australian Pharmacy Research Centre

7.23 The Australian Pharmacy Research Centre is an independent research facility established in late 1990 as an initiative of the Pharmacy Practice Foundation of the University of Sydney.

7.24 The objective of the Centre is to conduct and promote research into economic, social and administrative aspects of pharmacy, the pharmaceutical industry and the use of medication in the community. In particular, the Centre is encouraging research which aims to quantify and address the policy issues involved in determining the value of medicines in the community, the value added benefit of pharmacy services and how the pharmacy profession can optimise provision of its services to the community. To further its aims, the Centre has already provided a number of research seeding grants.

7.25 The Centre has national representation and would be the most appropriate pharmacy organisation to promote research and encourage the rigorous

and scientifically sound analysis of pharmacy initiatives already mentioned.

Conclusion

7.26 The Committee, in this report, has documented the range of activities currently being undertaken to respond to the challenges posed for the pharmacy profession.

7.27 Pharmacy is undergoing a revolutionary period, with major attention being given by all groups representing the profession to its further role. The beginning of a new role for community pharmacists is already emerging with proposals for consultant pharmacists and other roles which have been canvassed in Chapter 5.

7.28 Over the period of this inquiry, other developments directly influencing the way pharmacy is practised now and in the future include the agreement between the PGA and Government, the work of the PHARM Working Group which has assisted in focussing the attention of Government on the quality use of medicines, the SHAPE program and, indeed, the work of this Committee.

7.29 One of the greatest impediments to the definition of a new role for pharmacy would appear to be the lack of a single peak organisation, representing the interests of all pharmacists at the national level. The creation of such a peak national body would have to take account of the differences between State organisations, as well as integrating the interests of already existing national organisations such as the PSA, SHPA and PGA.

7.30 This lack of a national organisation was addressed in the opening remarks of the National President of the PSA to the Pharmaceutical Societies of Australia and New Zealand Conference in Perth in November, 1992. In the Committee's view, until such an organisation is achieved, pharmacy will have difficulties in defining its true professional role and in asserting its important

position as part of the health care team.

7.31 The Committee has already recommended in this report that the Association of Pharmacy Registering Authorities provide the national focus for professional accreditation. This should be underpinned at the national level by continuing education courses conducted through the Australian College of Pharmacy Practice.

7.32 This will require a commitment by State and Territory pharmacy boards and PSA branches to supporting such a nationally based model.

7.33 Ultimately, a peak representative pharmacy organisation would be in a more powerful position to represent its membership, develop comprehensive standards and play a larger role in health policy formulation.

7.34 A nationally based organisation would also be in a better position to focus attention on research designed to measure the benefits of increased professional involvement of its members in the health system.

7.35 In the absence of such a peak organisation, the Committee recommends that the Department of Health, Housing & Community Services provide to the Australian Pharmacy Research Centre funds for a project designed to measure the contribution of pharmacy to reducing the costs of drug misuse in the community. This project could be used to provide empirical information about the value of counselling and other services provided by community pharmacy and demonstrate its benefits for the health budget.

Chapter 8

INQUIRY OVERVIEW

8.1 Since the commencement of this inquiry, there have been many developments influencing the prescription and supply of drugs in Australia. The conduct of the first part of the Committee's inquiry coincided with a major overhaul of the drug evaluation system and intense scrutiny of the regulatory framework governing access to drugs through the Pharmaceutical Benefits Scheme. The Committee's first report complemented and extended other inquiries which were specifically looking at the role of the pharmaceutical industry and the Therapeutic Goods Administration.

8.2 The recently tabled second report on the inquiry, dealing with the role of prescribers, was tabled at the time changes to the structure of general practice were being announced by the Government. The second report attempted to take account of these changes and developments and integrate these initiatives into a structure for improving the quality use of drugs. The second report focused strongly on the notion of the health team and stressed that doctors have a pivotal role in guiding the work of this health team and ensuring that medicinal products are used effectively.

8.3 This third report, dealing specifically with the role of pharmacists in the health care team and the contribution they can make to improving medicinal use in the community, completes the Committee's inquiry. The report is being tabled at a time when the pharmacy profession is itself conducting a major examination of its present and future role. The Committee's report is responding to the pharmacy profession's concerns about its restricted role, imposed by the PBS remuneration system. There is a need to develop ways of demonstrating to Government, other

health professionals and the community, that other services provided by pharmacy are of financial and general health benefits to the whole community.

8.4 One of the major shortcomings identified throughout this inquiry has been the lack of adequate data and empirical information on which to make informed judgement about the benefits of changing the present arrangements. Ideally, the Committee would have liked to have commissioned a major consultancy review to examine and analyse the overall cost to Government of drug use through the PBS, through State private hospitals and through other Government subsidies. This analysis would also have encompassed, through case studies, an examination of the benefits of optimal drug use, including reduction of hospital stay, improved productivity and improved quality of life. Unfortunately this has not been possible.

8.5 No comprehensive quantitative information in a form which is accepted by all health professionals currently exists of the cost to the health system of drug misuse. As indicated in the Committee's second report, some data now exists on the cost of drug related admissions to hospitals and it is possible to extrapolate from this. However, a realistic cost benefit analysis of overall savings from better use of drugs would need to include the costs already referred to, as well as the cost of educational initiatives and strategies for improving drug use. A cost effectiveness analysis of the overall savings from better use of drugs would enable decisions to be made on the basis of quantifiable health outcome measures.

8.6 In the Committee's view, until this kind of research and analysis is carried out and a data base provided it is not possible to make policy decisions which take account of all variables.

8.7 **Therefore, the Committee recommends that the Department of Health, Housing & Community Services, as part of its health research activities, dedicate resources to investigate the overall savings to the community and the health system from the better use of drugs.**

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(Chairman)
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