

Good prescribing: where to next?

We have the tools to improve prescribing — the challenge is to use them

AUSTRALIA'S PLACE AMONG the world leaders in the quality use of medicines is exemplified by its National Medicines Policy, the framework of which was put in place over 10 years ago.¹ At the centre of the policy is the goal that medicines are used wisely — the Quality Use of Medicines (QUM) acronym has since become somewhat hackneyed and maybe the time is ripe to replace it by a less pretentious label.

This issue of the Journal contains three reports that address issues related to QUM. Liaw and colleagues (*page 203*) examined doctors' perceptions of the Authority Prescribing system of the Pharmaceutical Benefits Scheme (PBS) and found (among other things) that doctors generally do not perceive the system as promoting QUM.² South et al (*page 207*) describe how the use of laminated cards, which list guidelines for prescribing antibiotics for infections commonly seen in a paediatric hospital, significantly improved prescribing.³ Newby et al (*page 210*) found that computer-generated prescriptions in general practice are more likely than handwritten prescriptions to contain repeats, many of which are probably unnecessary.⁴ Each of these reports shows that, even a decade after the introduction of the National Medicines Policy, aspects of prescribing in Australia can be improved. Thus, it is timely to reflect on what we have been doing right, what we have not been doing right, and where there is still room for improvement.

We have developed robust structures to promote QUM in Australia. For instance, *Australian Prescriber* commenced publication in 1975, and, despite a rather stormy career, continues to provide independent information on issues related to drug therapy. The first edition of *Antibiotic Guidelines* was published in 1978, and the *Therapeutic Guidelines* series now covers all the major therapeutic areas. The *Australian medicines handbook* was first published in 1998.

An important initiative was the establishment in 1991 of the Pharmaceutical Health and Rational Use of Medicines (PHARM) Working Party (later Committee),⁵ which used its modest budget largely to fund projects studying QUM. This committee has been an important stimulus for QUM projects, rather like an "NHMRC" of drug prescribing. However, the committee did not have a mandate to fund ongoing programs. More recently, the National Prescribing Service (NPS) has been established. One of its major mandates is to put in place ongoing programs to improve prescribing, particularly of drugs listed on the PBS. Its continued funding depends on the demonstration of savings to the PBS. To date, the NPS appears to have largely managed to combine quality use with cheaper use, although it is the latter on which its survival depends. It has also managed its recent assimilation of *Australian Prescriber* in a

mature manner. However, the NPS might have increasing difficulty in the future combining its cost-saving mandate with QUM, as this is not necessarily synonymous with cheaper use of medicines. There is also still an element of being "the new (rich) kid on the block", and the NPS has yet to define fully its relationship with established organisations involved with QUM in Australia, such as Therapeutic Guidelines (centred in Victoria), the *Australian medicines handbook* and the Drug and Therapeutic Information Service (DATIS) group (centred in South Australia), and State groups such as the NSW Therapeutic Assessment Group and the Victorian Drug Usage Advisory Committee.

These have been some of the QUM successes, but what are the failures? Undoubtedly one has been the concentration of the Authority system of the PBS on cost saving rather than QUM.

This was probably inevitable given that the accelerating expenditure on the PBS cannot be offset by savings elsewhere in healthcare. However, it is a failed opportunity as far as QUM is concerned. Another failure has been the continuing secrecy of the data submitted by pharmaceutical companies to the relevant advisory committees (such as the Pharmaceutical Benefits Advisory Committee [PBAC]) and on which the decisions on registration of drugs, their scheduling, and subsidisation by the PBS are based. Most of this information is not in the public domain, yet would greatly assist doctors and organisations in making good decisions about whether or when a drug should be used. In short, there is no good justification for this bureaucratic secrecy, and it undoubtedly hinders QUM in Australia. The recent putative moves to open PBAC deliberations to public scrutiny are to be welcomed. Another failure is the dependence of our drug evaluation system on fees paid by the pharmaceutical company applicants. It is a tribute to the professionalism of the evaluators that they appear to have largely retained their independence (but the secrecy surrounding the system does not allow for a definitive judgement). However, no regulatory system dependent on fees can ignore the interests of its payers, which are not necessarily the same as those of the Australian public, whom the regulatory system is supposed to serve. A further failure has been our inability to grasp the opportunities presented for QUM by the introduction of computerised prescribing. Unfortunately, this strategy seems to be following the same path as the introduction of computing into hospitals, where it was introduced very much as a management tool and not as a means of improving the quality of clinical care.

So, where do we go next? First, the process to make bureaucracy more transparent should be vigorously pursued. Second, we should develop a national forum, for QUM issues. The NPS cannot provide that forum, as it has an overt cost-saving agenda, and its survival depends on it "blowing its own

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trumpet", sometimes at the expense of other bodies. Perhaps all the different organisations involved with QUM should form a QUM Society, and have national meetings to share results and experiences. Not only would that encourage cooperation rather than competition, it would also promote better recognition of the work of individuals involved in QUM. Most are in academic institutions, and QUM tends not to attract the research grants and publications that academia use to judge success. Third, we must quickly grasp the opportunities presented by computerised prescribing. Advertising must not be allowed to intrude into the prescribing process, automatic repeats for antibiotic prescriptions should not be allowed, and suitable incentives should be provided to ensure that decision support systems are embedded into prescribing software.

Last, and most important, we should not rest on our laurels. Australia has done well, but QUM is a fragile flower, easily crushed by other forces, such as the economic imper-

ative to support the pharmaceutical industry. My recent new experience in a country with far fewer resources than Australia has already taught me that much can be achieved with the wise use of resources (such as an essential drug list) I would previously have considered totally inadequate. We should not be in the thrall of the new — we already have the tools, and the challenge is to use them to maximum effect.

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Injecting drug use in Australia: needle/syringe programs prove their worth, but hepatitis C still on the increase

Needle/syringe programs have resulted in enormous savings in both lives and dollars

SIXTEEN YEARS after needle/syringe programs (NSPs) were first introduced in Australia, after a period of civil disobedience and amid intense controversy, the recent report *Return on investment in needle and syringe programs in Australia*¹ has convincingly confirmed the effectiveness of NSPs in reducing HIV and hepatitis C virus (HCV) infection among injecting drug users. The report also draws attention to the program's low cost and high cost-effectiveness.

Commissioned by the Commonwealth Department of Health and Ageing, the report summarises 778 years of data from 103 cities around the world. In cities that had ever had NSPs, there had been an average annual *decrease* in HIV prevalence of 18.6%, compared with an average annual *increase* of 8.1% in cities without such programs.

Australia's NSPs were estimated to have cost Commonwealth and State governments \$122 million by 2000, but the return on this investment was the prevention of an estimated 25 000 HIV and 21 000 HCV infections. By 2010, our NSPs will have prevented an estimated 4500 deaths from AIDS and 90 deaths from HCV. The savings to governments for HIV and HCV were estimated to be at least \$2.4 billion (allowing for conventional government 5% annual discounting of future costs) or as much as \$7.7 billion (without discounting). By any reckoning, this represents an enormous saving in both lives and dollars. In light of these outcomes, opposition to NSPs amounts to public health vandalism and financial recklessness with taxpayers' dollars.

HIV appears to have entered IDU populations in Australia

However, in spite of these gratifying health outcomes for investments in NSPs, the annual incidence of HCV in Australia continues to rise.

Hepatitis C is a very common chronic infection in Australia. At least 80% of infected people have acquired HCV through injecting drug use. A recent report² estimated that in Australia in 2001 there were about 210 000 people with HCV antibodies, of whom 53 000 had cleared their HCV infection, 151 000 were living with chronic HCV infection and 6500 were living with HCV cirrhosis.

Furthermore, according to the report, despite the effectiveness of NSPs in reducing HCV incidence among injecting drug users (IDUs), there were 16 000 people exposed to HCV during 2001, representing a 45% increase on the estimated 11 000 incident HCV infections in 1997.³ The report also projected that the long-term sequelae of HCV infection, such as cirrhosis, liver failure and hepatocellular carcinoma, would all treble by 2020.

These two reports^{1,2} raise several important questions. First, why have NSPs been so successful at limiting HIV infection among IDUs, but less effective in reducing HCV infection? One important reason for the apparent discrepancy is the greater infectiousness of HCV by blood-blood spread compared with HIV, and consequently its heightened transmission among IDUs. Another factor is the higher baseline HCV levels (of the order of 50%–70%) prevalent among IDUs when NSPs were introduced in Australia in the late 1980s.⁴ At that time, only one in 200 IDUs undergoing treatment in Sydney were infected with HIV.⁵ in the early 1980s, about 20 years after HCV.⁶