EDITORIAL

Quality use of medicines: ten years down the track

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(Aust Prescr 2001;24:106–7)

1991 was a significant year for medicines in Australia. The Baume Report was released foreshadowing major reform of the Therapeutic Goods Administration, with the expectation that the Australian market would have more timely access to new drugs of proven quality, safety and efficacy.[1]

Consumer groups were lobbying for improvements in the way medicines were prescribed, dispensed and used. In April 1991 the Consumers' Health Forum and the Australasian Society of Experimental and Clinical Pharmacologists and Toxicologists came together in a landmark workshop. 'Rational Prescribing: the challenge for medical educators' aimed to raise awareness of prescribing issues and was supported by the government of the day.[2]

In response, the Commonwealth Government established two advisory groups. Pharmaceutical education was the initial focus of the Pharmaceutical Health and Rational use of Medicines (PHARM) Working Party. This group went on to formulate the policy on the Quality Use of Medicines (QUM) in 1992.[3] To advise on policy and implementation, the Australian Pharmaceutical Advisory Council (APAC) was set up, representing the full range of professional and community organisations and the relevant parts of government.

The QUM policy went beyond rational prescribing to enshrine the goal of partnership between government, industry, consumers and the health professions. QUM became the fourth arm of a national medicinal drug policy, integrally linked to the other arms: timely availability of drugs through the Therapeutic Goods Administration, equity of access to drugs through the Pharmaceutical and Repatriation Benefits Schemes and a viable pharmaceutical industry through the Industry portfolio. By 2000, the revised policy had achieved bipartisan support at Commonwealth level. The new Australian Medicines Policy includes the non-prescription (self-medication) and complementary medicines industries.[4]

The Baume Report set out timelines for Consumer Medicine Information (CMI) to be produced for all drugs. Perhaps the first achievement of the new partnership under QUM policy was that consumers worked with government and the pharmaceutical industry to produce CMI leaflets. A decade later, CMI can be accessed by community and hospital pharmacies to print out at the time of dispensing. Use of the CMI by general practitioners is minimal but in the future the Royal Australian College of General Practitioners' web site will provide access to standard CMI.

Waste, hoarding, inappropriate demand and poor adherence to medicines regimens were all identified by the policy document as barriers to QUM. The government has funded many local projects* as well as successive national media campaigns to spread the catch cry of 'using medicines wisely' and the need for 'medicine check-ups'. National guidelines have been produced for medication management in aged care facilities and on hospital discharge. The National Medicines Disposal Program has also been put in place.

Gathering evidence from research was a key strategy for the new policy. By 1997, Australian trials funded by the QUM initiative had shown that effective educational techniques could influence general practitioner prescribing. A Cochrane review confirmed the importance of a social marketing approach, rather than one-off interventions.[5]

Evidence is one thing, putting it into practice is another. The original report of the PHARM Working Party recommended a national centre to co-ordinate quality use of medicines activity, to be set up outside government. Under the QUM

* See http://www.qummap.health.gov.au

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Ten years ago the Baume review set out to speed up the entry of new drugs into Australia. The new drug imatinib on page 129 is an example of a drug which has come quickly to the market because of a rapid evaluation. It is now also easier to market combination products, but Robert Moulds reminds us that these combinations do have some disadvantages.

The rapid approval of new drugs also means that their role in therapy may be unclear. Peteris Darzins shows us that the literature is not always helpful.

Government commitment to the quality use of medicines came at the same time as the Baume report. Andrea Mant reviews how this policy has developed over the past decade.

While there have been many changes in therapeutics these have been supported by changes in laboratory medicine. Don Bowden comments on the developments in testing for thalassaemia in the Australian population.

policy, PHARM undertook extensive consultation with general practitioners and other stakeholders. By March 1998, persistent and persuasive pressure led to the establishment of the National Prescribing Service (NPS), funded through the federal budget but with an independent board and constitution. The NPS has vigorously set about working with divisions of general practice (it has contracts with two-thirds of them) and has established its credentials through programs to support quality prescribing and use of medicines. The NPS has also pursued some long-hoped for initiatives to promote the quality use of medicines such as a national Therapeutic Advice and Information Service for health professionals. A nationwide Consumer Medicine Information Service is also close to being established.

An important part of the QUM policy is the production of professional drug information independent of industry sponsorship. Financial support was given to a joint venture to produce the *Australian Medicines Handbook* (www.amh.net.au). This reference, covering all pharmaceuticals marketed in Australia, has filled an essential gap. It complements *Australian Prescriber*, the national journal of therapeutics, and the *Therapeutic Guidelines* (www.tg.com.au) series. We are fortunate indeed in having these excellent resources. Finding time to use them, in a busy workplace, remains an issue, although information technology now makes them more readily accessible.

Ten years on, information technology has a greater role in encouraging the quality use of medicines in primary care through the use of electronic medical records and prescribing systems. An important step came earlier this year, with the requirement that the patient's Medicare number be recorded when a prescription is dispensed. Setting up electronic systems and solving the problems associated with them will take much energy in the next few years. It will take time before anticipated benefits flow.

What of the future? Continuation of government funding for the NPS promises that the social marketing of quality initiatives can be consolidated. A new prescribing course for medical schools developed by the NPS and universities is close to completion and will start to have an impact. QUM in pharmacy education will surely spread more widely. Collaboration between patients, pharmacists and doctors to manage multiple medication use is just beginning. In the information age, consumers and professionals already have access to more information and more marketing and promotion than ever before – will this lead to better health outcomes or just quality use of more medicines? A key research question will be to test whether better use of medicines achieves better health outcomes.

Partnership is at the heart of QUM and is likely to come under strain as society counts the cost of new and more expensive drugs. Looking back to see how much has been achieved encourages us to keep working at that partnership so as to minimise the harm and maximise the benefits from the use of pharmaceuticals. Much is at stake.

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Letters

Letters, which may not necessarily be published in full, should be restricted to not more than 250 words. When relevant, comment on the letter is sought from the author. Due to production schedules, it is normally not possible to publish letters received in response to material appearing in a particular issue earlier than the second or third subsequent issue.

Prevention of deep vein thrombosis

Editor, – I refer to G. Weisz' recent letter 'Economy class syndrome' (Aust Prescr 2001;24:52). My understanding is that a recent meta-analysis demonstrated no value in the use of aspirin for venous thromboembolism as prophylaxis and treatment, and a reported 3% chance of some degree of gastrointestinal bleeding. It would seem that the use of this drug is best left to the management of arterial problems. Recommendation as a therapy for prevention of deep vein thrombosis is not supported by the *Australian Medicines Handbook* ('Aspirin is probably ineffective in the prevention of venous thromboembolism'), and in view of the incidence of adverse effects I would not advise its use for this purpose.

I would be interested to learn of any studies which support the view that there is a place for aspirin in this setting, or indeed in any situation with a recognised risk of venous thrombosis.

Ashley Collard
General Practitioner
Fairlight, NSW

Agnes Vitry, Senior Editor, Australian Medicines Handbook, comments:

A recent editorial in the *Medical Journal of Australia* concluded that the evidence on the risk of venous thromboembolism associated with air travel was, as yet, missing.[1] Most of the evidence comes from case series and