THE GP-PHARMACY INTERFACE: COMPETITION OR COOOPERATION?

Background Paper

GPDV Forum
February 2005

Why a pharmacy forum?

There were 104 medications recorded per 100 encounters with GPs in 2003-04.[1] All medications can have side effects, can produce adverse reactions, and may interact with other medications, food, or over-the-counter medicines. Consequently, medication management (especially in chronic illness) is recognised as an important area of medicine and failure to manage medication effectively leads to 2–4% of all hospital admissions in Australia and up to 30% for patients over 75.[2] Expenditure on pharmaceuticals in Australia has been increasing at an average rate of 14% per annum in the past 10 years.[3]

Given the extent of medication management issues, it is important that GPs and community pharmacists be provided with opportunities to combine their skills in order to address them. However, conflict between the two professions has arisen due a lack of shared understanding of the each other's roles at a time of great demand for quality medication management. Pharmacists are health professionals who provide primary care and who are called upon by consumers to provide advice and assistance in understanding their medicines. GPs' concerns about the perceived overstepping of professional boundaries have caused disquiet within both professions.

The purpose of this Forum is to explore the issues that have led to this disquiet, to provide the opportunity to understand each profession's point of view, and to consider the possibilities for working together more effectively. In particular we would like to identify the common areas of interest and consider ways of overcoming barriers to cooperation. Busy community pharmacists may not have the capacity to take up new initiatives just as some GPs struggle with EPC and 3+ plans, but this does not mean that both professions should not discuss ways to pursue interdisciplinary approaches in health care.

Issues that could inform this discussion are outlined briefly below.

Professional issues leading to change

Traditionally, the role of the community pharmacist has been that of medicine dispenser and small business operator. They have not had any formal role in health promotion or in the management or treatment of illness. In fact, it was not long ago that the professional codes of conduct for community pharmacists specifically

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[1] Britt H, Miller GC, Knox S, Charles J, Valenti L, Pan Y, Henderson J, Bayram C, O'Halloran J, Ng A 2004. *General practice activity in Australia 2003–04*. AIHW Cat. No. GEP16. Canberra: Australian Institute of Health and Welfare (General Practice Series No. 16).p. xvii

[2] Runciman WB, Roughead EE, Semple SJ & Adams RJ, 'Adverse drug events and medication errors in Australia', *International Journal of Quality in Health Care*, 15:149–159, 2003

[3] Austalian Institute of Health and Welfare, *Australia's health 2004*, Canberra: AIHW, 2004

forbade pharmacists to provide patient advice on their medicines! This has now turned full circle, and they are expected to provide advice on medicines.

In the last several years, the role of the community pharmacist has extended to incorporate roles in health promotion and medication management review. Examples include involvement in home medication reviews; promotion of the asthma 3+ visit plan; and involvement in weight loss program (health promotion, selling weight-loss drugs, and monitoring weight and BMI).

The Pharmacy Guild (the political voice for owners of community pharmacies) is interested in exploring new roles for community pharmacists. Studies overseas have shown positive patient outcomes where pharmacists have had extended roles in several areas. The Guild's research and development program has commissioned research into pharmacists' potential roles in various areas including: immunisation, asthma, care, diabetes care, continence care, pharmacy-based INR testing, and QUM for patients discharged from hospital. Furthermore, some community pharmacists are concerned (as are some GPs) at the potential for role diminishment within the Australian health care system. As an example, in the USA there are machines that automatically dispense medications and consumer information leaflets in doctors' surgeries upon insertion of prescription and credit card. Pharmacists have an interest in protecting the investments they have made in years of education and ongoing training as well as in their businesses, and also have a concern that the diminishment of their roles could lead to inferior health outcomes, particularly relating to the quality use of medicines.

The Pharmacy Guild's exploration of these issues has been given some urgency by the fact that it is due to sign the fourth Community Pharmacy Agreement with the Commonwealth, a five-year agreement that may incorporate funding for further exploration of expanded roles for community pharmacists).

Conflict or cooperation

At the core of this debate is the urgent need to address continuing problems associated with medication misadventure in the community setting, the residential care setting, or during transition from the acute setting. At present this is often done in an ad hoc way with little cooperation between the medical specialists and coordinators of care, GPs, and pharmacists. Divisions have an opportunity to lead by coming to local agreements about the best way that the professions can work together for the benefit of the local community. Alternatively, divisions can choose to continue with their current programs and allow the "big picture" debate to be resolved at the national level, where the AMA and the ADGP are taking markedly different approaches.

The AMA has reacted to the possibility of an extended pharmacist role with an active publicity and political program to discourage any overlap between the role of pharmacists and that of doctors. On 29 October 2004, the AMA called for a Senate Inquiry into the pharmacy industry in Australia, specifically into anti-competitive measures; whether it is appropriate that 20% of all PBS expenditures should go to dispensing fees for pharmacists; whether allowing pharmacists to become involved in chronic care would disrupt continuity of care; whether non-pharmacists should be allowed to own pharmacies. They repeated these messages in a January 2005 submission to the Productivity Commission on the review of national competition policy reforms[4].

[4] http://www.ama.com.au/web.nsf/doc/WEEN-698784

The ADGP, on the other hand, has taken a more conciliatory approach and is in discussion with the Guild on the possibility of establishing an MoU to define the boundaries and to discuss collaboration. The Victorian Branch of the Guild has also proposed an MoU with GPDV following the national agreement 'to further cement our good relationship with this branch.' There has been no discussion at present about the content of such an MoU.

Other cooperative work

There are several preconditions to an effective GP-pharmacist relationship but the key precondition is that GPs and pharmacists need to meet each other and understand each other's concerns. Some divisions have done this particularly well: e.g. West Vic ran a Guild-funded program; other MMR facilitators have brought the professions together in educational events. For example, Dandenong & District and Greater South Eastern divisions ran a successful meet-and-greet night with a scripted, acted HMR case study and quiz on medication management. The West Vic model is considered here in a little more detail as one to consider for adoption as a statewide model.

<u>The West Vic model</u>

West Vic Division of General Practice conducted a program in 2001 to develop the relationship between GPs and pharmacists. The project began by surveying local members of the two professions to identify the areas of common interest. Six potential areas were studied: Medication use, polypharmacy, drug-seeking behaviour, specific disease counselling, primary health care and health promotion.

Medication use was considered by both GPs (79%) and pharmacists (64%) to be the most important area with polypharmacy second.

The survey also identified barriers to cooperation. These were

- Time constraints (GPs 63% and pharmacists 58%)
- Lack of workforce
- Lack of face-to-face contact between GPs and pharmacists at work
- A need for greater clinical education of pharmacists in the rural setting (12.5% GPs; 15% pharmacists)
- Lack of effective communication skills of some in each profession
- Lack of understanding by GPs of the roles and responsibilities of pharmacists
- Lack of structured meeting time and place.

West Vic responded to the concerns with several important strategies implemented concurrently.

Strategy	**Activity**
Relationship building	Combined GP-pharmacist educational events
Discussion groups	Combined GP-pharmacist structured discussion groups
Capacity building	Establishment of local pharmacy group Weekly fax to all pharmacists
Advocacy	Appointment of pharmacist to division staff
Working party: local level	Address threat of pharmacy closure in a rural

	town
Working party: peak body level	Address problems of rural after-hours medication supply
Consumer education	Education on QUM, asthma & falls risk due to medications

The most significant of these strategies and the one underlying the success of all the others was the appointment of a pharmacist as the GP–pharmacist liaison officer. Single events that were most significant were the GP-pharmacist structured discussion groups (in some discussions referred to as focus groups). At these events, local GPs and pharmacists met over dinner and discussed case studies relevant to the work of both professions. One case study addressed polypharmacy issues, another focused on drug-seeking behaviour. The discussions highlighted similarities and differences in professional analysis of problems and raised issues for both groups about how they would communicate with the other. Both pharmacists and GPs felt much more positively about each other following these events. The discussions also gave rise to new ways of solving old problems at the local level.

The West Vic program will be discussed in more depth at the Forum as a possible model for other divisions. All divisions will have a chance to nominate potential positive models that divisions may wish to emulate, and to suggest how to work through some of the issues mentioned above.

Questions for discussion

The key questions for consideration at the Forum are:

- Should Victorian divisions support the development of an MoU with the Guild (and if so on what terms?);
- should all Victorian divisions adopt one or more of the existing models for cooperation undertaken at division level?
- If so, should this be ad hoc or should there be a statewide policy and strategy?

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