PHARMACY PRACTICE IN AUSTRALIA

A placement at the University of Monash, Melbourne, has given Priyesh Rawal an insight on pharmacy practice in the land down under

Priyesh Rawal was a fourth year pharmacy student from the University of Bath, who completed a three-month placement at the Victorian College of Pharmacy, University of Monash, Melbourne, Australia

The current Australian healthcare system was started before the NHS. However, it is similar to the NHS system in terms of the model of operation and policy. It has been increasingly influenced by the American healthcare system in recent times, with the incorporation of medical insurance alongside socialist medical care.

The system is administered by individual states in conjunction with the territories and commonwealth government. Funding for the healthcare system is generated partly from prescription charges and partly from a health insurance scheme called Medicare, the money for which is collected through taxation. The commonwealth government administers Medicare and the Pharmaceutical Benefits Scheme (PBS), while the federal government oversees funding.

Medicare’s strategy is to provide open access to general and specialist care in public hospitals. The government taxes income automatically to include Medicare benefits package. Medicare is not fully comprehensive although it still covers expensive services like consultation fees, blood tests, pathology and x-rays, which otherwise would have to be paid for in full by the patient and, therefore, most patients also secure private insurance.

Medicare only pays A$25 towards each consultation and, if there is a charge gap, it has to be paid by the patient. Pharmacists get a dispensing fee of A$5.44, which appears generous. However, Australian pharmacists protest and think that dispensing margins are falling.

The Pharmaceutical Benefits Scheme

The Pharmaceutical Benefits Scheme is administered by the Department of Health and Ageing, and Medicare Australia. The Schedule of Pharmaceutical Benefits is the equivalent of the British Drug Tariff.

In comparison, it has broader contents, such as medical conditions, treatments, doses, quantities allowed, repeats allowed, special restrictions and prices the government will pay. The rule is that one month’s supply of medicines be prescribed, although there are exceptions. Should a doctor wish to prescribe larger quantities, he or she may do so but the patient must pay because the prescription is treated as private.

The patient’s subsidised payment varies between A$4.90 per prescription item for the elderly, pensioners, war veterans and others eligible for concessionary rates (concession cards are supplied as evidence of eligibility), and A$30.70 for all other patients. Once a monetary threshold is reached in a calendar year, PBS medicines are free for pensioners and non-concessionary patients pay A$4.90 per item for the rest of the year. Patients either pay the prescription charge or the cost of the medicine, whichever is the cheapest. PBS prescriptions are valid for one year from the date written. The Pharmaceutical Benefits Pricing Authority has a similar role to the National Institute for Health and Clinical Excellence in England, with more influential and implementational powers since it decides what goes on the PBS after an exhaustive drug analysis that could leave manufacturing companies in crisis if their drug is rejected for use on the PBS system. However, evidence of such analysis is not published, making it difficult to scrutinise its decisions. Section 100 of the schedule includes highly specialised medicines restricted to special facilities that can provide them with licensed professionals. These can be expensive and include drugs for HIV and cancer.

Since all claimable prescriptions comply with PBS regulations, computerisation means accurate and quick payment. Most pharmacists get paid in full within 21 days. Accurate records mean cash flow planning is made much easier. The PBS offers patients choice while controlling expenditure, reducing the use of inappropriate medicines and expensive drugs, supporting original pack dispensing and managing prescription repeats.

Community pharmacy

The annual report published by the Department of Health and Ageing suggests there is one pharmacy per 3,700 people in urban areas in Australia, in comparison with one per 4,500 in the UK. Ownerships over pharmacies are granted to registered pharmacists only. Even though this requirement has been challenged and deregulation has been called for due to competition restriction, seen through the eyes of commercialists, the government has stood its ground on its policies. Pharmacists are limited to owning three or fewer pharmacies in the state of Victoria,
therefore, 95 per cent of the pharmacies are independents. Only those pharmacies owned in larger numbers by friendly societies were exempt from this rule because they were established before the legislation was enacted. The government is under immense pressure to change this and allow companies to open chains of pharmacies. However, it is unlikely the government will succumb to such demands. As in the UK, the requirements to be certified as a pharmacist consist of four years university education and one year preregistration training.

Multiple giants, such as Boots and Superdrug, would be distraught to know that beauty sales are not a major source of income for retailers compared with medicines.

**Hospital pharmacy**

Many hospitals in Australia dispense prescriptions written by internal doctors only and avoid those written by prescribers in the community. This reduces their costs due to lower medicines turnover.

Most hospital pharmacies charge the medical units that prescribed the medicine directly and, therefore, the cost does not come out of the pharmacy budget. This practice leads to responsible prescribing on wards and mirrors medicines management in the UK, supported by encouraging use of patient’s own medicines once discharged.

Some hospital pharmacies take on the medicine costs when some patients are treated for conditions that are not permitted on the PBS. This ensures patients do not have to pay for certain expensive medicines.

There are less specialised staff in hospital pharmacies than in the NHS, for example, there are no checking technicians, which would otherwise enable pharmacists to spend more time on wards occupying a clinical role. Patients’ medical histories have to be obtained by pharmacists and recorded on a form before they can proceed with their usual clinical role and manage discharges. Many hospital pharmacies have a barcode medicines checking system. The patient’s medicine and label barcodes are scanned during the checking process to ensure that the correct drug is being dispensed for the right patient and the correct label has been attached to the packaging. The software is quick to flag up any incompatibilities and change in medicines by comparing with the patient’s medication records.

One of the newly adopted policies is standardising patient medical charts. The national inpatient medication chart has been created for use in all Australian hospitals, with the exception of intensive care units and emergency departments. This has promoted uniformity and ease of practice for various pharmacists wherever they are. A burning question in many pharmacists’ minds is money. In hospital, the salary is based on a four-level grading system (see Panel).

Most pharmacists are at grades 2 or 3. Grade 4 is relatively new and created for highly specialised professionals. Beyond grade 4, the roles lean towards administrative management. Preregistration trainees start off in the regions of A$30,000.

**Medicine categories**

The medicines categories are similar to those in the UK. However, over-the-counter medicines are split into three classes:

- **Pharmacist-only medicines**, which are sold in a pharmacy under the supervision of a pharmacist, may not be sold by an assistant. Examples include Xenical (orlistat), nystatin oral suspension, Lomotil (diphenoxylate hydrochloride), diclofenac, Loceryl nail lacquer (amorolfine), emergency contraceptive pill, hydrocortisone cream 1 per cent.
- **Pharmacy-only medicines**, for example, large packs of paracetamol or ibuprofen, some cough and cold preparations (eg, Dimetapp Elixir, which contains brompheniramine and pseudoephedrine; Bisolvon cough mixture, which contains bromhexine). These can be sold only in pharmacies but need not be placed behind the counter.
- **General sale list medicines**, which can be sold in other outlets, such as supermarkets, with no more than 12 tablets allowed (eg, ibuprofen, paracetamol).

Drug classification is divided into nine schedules, such as pharmacy-only, prescription-only medicines, poisons, and controlled and prohibited medicines. Prescriptions for controlled drugs are valid for six months as opposed to 28 days in the UK and registers have to be kept for seven years as opposed to two.

**Pharmacy practice and services**

Community pharmacies in Australia are commissioned to provide a range of additional services, including blood pressure measurement, cholesterol screening, advice on common ailments and participation in community health programmes. Medicines use reviews are actively practised in Australia. However, they are conducted in residential and patients’ homes, not in the pharmacy. There is a higher monetary incentive for pharmacists in Australia providing home medicine review services because the rebate is approximately £84 per patient (A$187.09). Unlike reimbursement policies in the UK, the patient’s GP also receives a fee for participating in the scheme.

Repeat prescription protocols differ from those practised in the UK. The doctor indicates how many repeats he or she would like his or her patient to be supplied with, and the patient can visit any pharmacy the number of times indicated. The prescription and repeats are valid for 12 months from the original prescription date. Also, the pharmacist is allowed to part dispense a prescription and refer the patient to another pharmacy for the rest of the items on the prescription in scenarios such as stock unavailability.

**Conclusions**

Working as a pharmacist in Australia mirrors practice in the UK. It is unfortunate reciprocity arrangements had to be terminated, especially when pharmacists in Australia have almost parallel education, practice regulation standards and clinical knowledge.

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**Panel:**

**Pharmacist base salaries as at October 2006 – hospital sector**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Salary Range</th>
</tr>
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<tbody>
<tr>
<td>Grade 1</td>
<td>A$42,400 – A$55,800</td>
</tr>
<tr>
<td>Grade 2</td>
<td>A$55,800 – A$65,100</td>
</tr>
<tr>
<td>Grade 3</td>
<td>A$67,700 – A$76,000</td>
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<tr>
<td>Grade 4</td>
<td>A$79,400 – A$91,200</td>
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