Pharmaceutical Defence Limited chairman John Coppock

Earning professional trust

I was pleased to note that pharmacists had maintained their position near the top of the latest Morgan Poll which rates the trust that people have in the various professions. This position is likely to be due mainly to the faith that our patients have in our role as their advisers on medicines. Part of that role is about effective counselling on healthcare matters, especially when they are related to medication issues.

However, I've also noted with concern that pharmacy has recently been the target of negative comments that question whether pharmacists actually deliver the level of advice they are supposed to. These comments come at a time when pharmacy is fighting to keep medicines out of supermarkets and about to negotiate the Fourth Community Pharmacy Agreement. Whether there is a connection to the timing of these accusations from various quarters is for others to judge, but my biggest concern is that they could damage the compact of trust that pharmacists have with their customers or patients.

Now more than ever does the profession need its members to pay careful attention to the counselling and advice side of the practice of pharmacy. Our reputation stands and falls on the presence and quality of this advice.

But if helping to maintain the integrity of the profession isn't enough to encourage increased vigilance in some people, then the legal ramifications of sub-standard counselling need to be understood.

The relationship between pharmacist and patient is viewed legally in much the same way as the relationship between a doctor and patient, or a lawyer and client. Legally, pharmacists are expected to take all reasonable measures to carefully explain any health risks that might be associated with the use of each medication being sought by the patient. This is seen as a pharmacist's duty to their patient.

Every time a new or existing patient seeks a medicine, reasonable efforts must be made to understand the patient's medical history and the medicines they might currently be taking.

Not only does this relate to undertaking the correct process of counselling (see Pharmaceutical Society of Australia Professional Standards), but also the expectation that the pharmacist has made reasonable attempts to maintain an appropriate level of knowledge expected of a professional. This means having access to and understanding how to use reference materials recommended by the various state registering authorities as well as being committed to ongoing education.

Now more than ever does the profession need its members to pay careful attention to the counselling and advice side of the practice of pharmacy

In a court of law, pharmacists are expected to have taken reasonable measures to maintain a current knowledge base on the medicines they dispense. This means knowing and understanding any new information that might alter or add to advice on a particular medication. For example, if the results of a trial were published about a particular drug with implications that alter its risk profile, and these results had been disseminated widely among the professional publications, then the pharmacist will be reasonably expected to have appropriately acted upon that knowledge.

We are professionals— we don't operate milk bars and hand out lollies, we dispense medicines.

The withdrawal of Vioxx from the market reminds us of the importance of keeping up to date with such knowledge. A recent conversation with PDL's lawyers at Wisewoulds gave rise to some concern that there may be a degree of liability for any pharmacist who failed to warn a patient of the potential adverse cardiovascular profile of the drug.

Despite the fact that the US Food and Drug Administration (FDA) and our own Therapeutic Goods Administration failed to withdraw the drug, there had been concerns for some time that trials of the drug had demonstrated an excessively risky cardiovascular profile. These concerns had been widely reported in the professional press and even caused the FDA to force manufacturer Merck Sharpe and Dohme to provide additional warnings on the drug's packaging. Therefore, a pharmacist may be found negligent if they failed to adequately explain this risk to patients being dispensed the drug.

I don't wish to unnecessarily alarm pharmacists—we are way down the pecking order as targets for the various class actions being organised against Merck in this country—but a situation may arise where a patient seeks legal redress from a pharmacist alleged to have failed in their duty to warn about a product's potential risk.

The situation with non prescription medications is just as important, if not more so. Because these drugs can be dispensed without a script, the process no longer has the doctor in the equation as an additional level of expertise and safety.

So if you want to help maintain the profession's integrity, reduce the chance of legal action and, most importantly, do your best to look after the health of your patient, make sure you understand and implement fully your professional counselling obligations.

While we've worked hard to earn the trust of the public, it doesn't take much for it to be withdrawn. ■

pdl

pdl risk management news

Pharmaceutical Defence Limited chairman John Coppock

Implementation is king

THE issue of how pharmacy deals with products containing pseudoephedrine has once again surfaced, and this time there is the very real threat that further restrictions will be placed on the ability of pharmacists to supply this reasonably safe and very efficacious drug. Pharmacy's challenge now is to demonstrate in a short time that it can meet the demands placed on them by the police and various other drugs and poisons bodies.

Whether the demands represent a fair trade-off between the benefit of reducing levels of the illicit manufacture of 'speed' and the potential cost to the health of customers is no longer the point. Despite the very real efforts of so many pharmacists to remain alert for people seeking these products without a discernable therapeutic need, obviously the actions (or lack of them) of a few pharmacies continue to let down the rest of the profession. I have no doubt that very few knowingly assist, or even turn a blind eye to the efforts of these 'speed' runners. But the problem remains and it is because not everyone follows the protocols that have been set.

In many ways it mirrors the broader issue of how pharmacies manage the supply process for pharmacy and pharmacist-only medicines (PMs and POMs). Everyone who works in a pharmacy knows that there are specific protocols on how to supply PMs and POMs, yet the danger remains alive that community pharmacy will lose them.

Remember Rhonda Galbally and her review of the drugs, poisons and controlled substances? Pharmacy was given time to demonstrate that its counselling and information support for these medicines justified the monopoly it has in their supply. This time passed last year and since then pharmacy has had a roasting from a report in the Australian Consumer Association's *Choice* magazine about inadequate counselling interventions. I wait with a degree of trepidation for the next move in the Galbally Review process because I know that John Corbett and his team from Woolworths are waiting, ready to be given the green light. Indeed there was a report in the NSW Guild *Bulletin* that Woolworths were now training staff on the supply of PMs.

Pharmacy is certainly good at devising professional standards and protocols—the Pharmaceutical Society of Australia has done a fine job formulating them—but that means nought if they're not implemented. In this, like many cases in life, implementation is king.

> If we fail to win support for pharmacy's ability to add value to these medicines, then much of this business will be lost to pharmacy

Pharmacists and especially pharmacy owners must remember that they are responsible for the way in which these products are managed within pharmacies. They cannot blame errors on a wayward assistant nor can they plead any degree of ignorance about the protocols. Pharmacists and assistants have all the protocols and training required to meet the demands and responsibilities placed on them. Courts of law and pharmacy boards will recognise this—pleading ignorance is the quick way to an adverse finding. We need, however, to be more vigilant as a profession on how we meet these professional responsibilities because some are still lagging well behind competent practice, let alone best practice.

For this reason I welcomed news from the Council of Pharmacy Registering Authorities (COPRA) (see *AJP* January 2005, p5) that foreshadowed greater interest in the role and competence of non-pharmacist staff in the delivery of pharmacy services. In taking a greater interest in the performance of pharmacy assistants, the boards, however, will not look to take action against assistants—that's not in their purview. They will, however, take action against pharmacists who do not effectively supervise assistants.

That's the stick approach and it's a necessary part of the makeup of any profession that takes responsibility for the actions of its members. We all need to know that punitive action is not far away when we fail to meet our professional obligations and responsibility to the public. The carrot is already with us. This is the hundreds of millions of dollars worth of business that pharmacy has a monopoly over. If we fail to win support for pharmacy's ability to add value to these medicines, then much of this business will be lost to pharmacy.

So it was great to see the arrival of a kit sent jointly by the Guild and the PSA called the Quality Use of Pharmacy Medicines and Pharmacist-Only Medicines Initiative. The kit contains materials and terrific in-store tools to ensure that pharmacy performs at the highest level and meets all public safety and quality use of medicines requirements when supplying PMs and POMs. I urge all readers to take a close look at the material and make effective use of the tools because we cannot underestimate the importance of how the profession handles this challenge. Much of the future we wish for pharmacy may depend on it and we know there are numerous bodies watching closely.

We must remember that pharmacy receives a number of privileges under pharmacy legislation. But these are offset by professional responsibilities and obligations that extend to the whole of pharmacy. ■

pdl

pdl risk management news

Pharmaceutical Defence Limited chairman John Coppock

When to say 'sorry'

PDL has for some time advocated the use of the 's' word—sorry—as a means of recognising a patient's situation when a dispensing error may have ocurred, without admitting any liability. We recently commissioned an article from Guild Insurance on the topic and, guess what? It appears the law has caught up with the PDL position.

The following article was written by Guild Insurance's legal advisers—Marianne Nicolle, principal of Guild Legal offers sound advice—and I commend it to your attention.

Can I say sorry?

When a patient complains about a dispensing error it is important to listen to the patient and record the complaint. Even if unsure whether a dispensing error had in fact occurred, you should allow the patient to air his or her concerns. Then inform the patient that you will investigate the complaint and respond as soon as possible. This will allow some 'breathing space' to assess the complaint and obtain professional and legal advice.

If it is obvious that a dispensing error has occurred, then in most situations it is appropriate to apologise. There is a difference between an apology and an admission of liability. Historically, there has been a reluctance to offer an apology to a patient on the basis that it may be misconstrued as an admission of guilt and possibly jeopardise the cover provided by a professional indemnity insurer.

A recent wave of legal reform in Australia has helped bring an end to that tension by introducing legislation which essentially provides that an apology is not an admission of liability. Some of the legislation goes so far as to define an apology.

In Victoria an apology is defined under the *Wrongs Act 1958* to be: 'an expression of sorrow, regret or sympathy but does not include a clear acknowledgement of fault'.

In NSW an apology is defined under the *Civil Liability Act 2002* as: 'an expression of sympathy or regret, or of a general sense of benevolence or compassion, in connection with any matter whether or not the apology admits or implies an admission of fault in connection with the matter'.

This legislation now protects a pharmacist in the event that a patient construes an apology as an admission of fault. Further, the effect of an apology should not be underestimated in connection with any possible review of the pharmacist's conduct by the Pharmacy Board. In this regard, a Pharmacy Board will review not only the facts of the dispensing error but how the pharmacist dealt with the patient after the dispensing error was identified.

A practical example

Here is a simple example of how an apology can be used to convey sympathy and, avoid creating an expectation in the patient's mind that the pharmacist will meet any claim for compensation:

The patient, an elderly lady, presents a prescription for Lanoxin PG 62.5mcg but Lanoxin 250mcg tablets are dispensed in error. The patient returns to the pharmacy two days later, complains that she feels tired and dizzy, and wants to know whether this was the result of the dispensing error.

In this factual situation the dispensing error is obvious but the cause of the complaint of lethargy and dizziness is not. In this situation it would be appropriate for the pharmacist to use words to the following effect:

'I am sorry to hear that you have been feeling unwell and I will of course review what happened the other day in order to ascertain how you were provided with the incorrect medication. If it is okay with you, I would also like to notify your doctor that you may have been taking the wrong medication for the last two days. It is very important that we look after you so let's get you the correct medication now and I will try and sort this out over the next day or so. Is that okay?'

Here the pharmacist has acknowledged the possibility of the error, shown sympathy towards the patient but made no admission of responsibility for any injury that may flow from the dispensing error.

Many potential claims can be avoided by the pharmacist resolving the complaint directly with the patient at an early stage. This does not mean that the pharmacist does not notify his or her insurer of the complaint. To the contrary, the insurer should be notified and legal advice obtained as soon as possible.

It is obviously prudent from a professional, legal, business and social perspective to deal with a complaint expeditiously and use the 's' word. ■

What to do when a patient complains of a dispensing error

It is recommended that you take the following steps when a patient complains of a dispensing error:

1. Discuss the complaint with the patient as described above.
2. Record the patient's complaint and speak to the relevant staff involved in order to ascertain the facts.
3. Notify the patient's doctor.
4. Contact PDL in order to obtain professional peer advice and counselling.
5. Notify your professional indemnity insurer of the incident.

pdl

pdl risk management news

Pharmaceutical Defence Limited chairman John Coppock

Risky negotiations

PHARMACEUTICAL Defence Limited provides significant levels of sponsorship to pharmacy every year and, as chairman, one of my favourite tasks is to help identify pharmacy activity that deserves support from PDL. One of our measuring sticks is whether the activity or event will potentially have an impact on reducing professional risk factors within pharmacy. Our motivation is transparent: we want to reduce the potential for errors within pharmacies and, thus, reduce pharmacy's risk against legal action.

For this reason I was delighted to inform national president of the Pharmacy Guild of Australia, John Bronger, that PDL would provide financial support for the Guild's efforts to negotiate a successful Fourth Community Pharmacy Agreement with the Federal Government. The board at PDL has been concerned for some time that this Agreement would prove difficult to negotiate for the Guild. We've all heard the reports over the past few years from the Government that it would present a much tougher line during its remuneration negotiations with pharmacy.

In making the decision to support the Guild in the negotiations, PDL was concerned that the prospect of a reduction in pharmacy remuneration would place a significant burden on pharmacy's risk profile. We all know the pressure being felt by many community pharmacies due to falling margins and higher fixed costs, such as rent and wages. When that pressure starts impacting on the workflow, especially within the dispensary, a pharmacist is only a split-second away from being distracted and making an error in judgement, counselling or dispensing.

If this situation is exacerbated by the Government winning its imposed reduction in remuneration, then the impact of higher risk will be felt nationally—not just in isolated cases nor simply among poor commercial operators. Such a nation-wide burden on pharmacy won't come without significant risk to workflow and, of those pharmacies who do survive, many will be forced to implement significant cost-cutting measures, such as reductions to staff and services. When these measures start to bite, then the risk of harm to the public due to professional error becomes even more likely; the potential for patient harm correlates strongly with the potential for pharmacy risk.

It is understandable that governments and pharmacy won't always see eye to eye. After all, governments and ministers come and go, as do their bureacrats. So there is always a need to educate new ministers and key bureaucrats about the context of community pharmacy operations in relation to the regulatory regime.

A good example is the move to encourage pharmacy discounts on the patient copayment of a prescription. All pharmacists understand this policy is not in the best interests of the large majority of patients and only in the interests of a few low-cost pharmacy operators. Pharmacy has had to knock this policy idea on the head before. It's an issue that pharmacy needs to win on behalf of the public, the Government's own National Medicines Policy, and especially that policy for which pharmacy provides the strongest advocacy—Quality Use of Medicines.

> Such a nation-wide burden on pharmacy won't come without significant risk to workflow...

However, I find it difficult to understand why pharmacy finds itself the brunt of a concerted campaign by the Australian Medical Association to undermine the confidence of the public and the Government. As fellow health professionals who work closely with pharmacists, doctors surely understand the relationship between patient trust and healthy outcomes.

Equally curious is the Government's apparent comfort with these AMA attacks—there appears to have been no attempt to dissuade the AMA against them. Perhaps it signals a level of collusion? The attacks appear to have been timed perfectly to injure pharmacy in the lead up to, and during, the Guild's negotiations with the Government.

Of course, it is in the interests of the patient for all health professionals to work cooperatively. And it is in the interests of the Government to encourage such cooperation. After all, one would expect that the Government would be interested in managing risk to the healthcare of its voters.

Impact of generics on packaging errors

AS the volume of scripts we dispense for generic medicines increases, the risk of error in the dispensary also rises. This is because of an increased likelihood that the patient may double up on the same drug, thus potentially leading to medication misadventure. It also adds more products to the dispensary mix that pharmacists must deal with, also adding confusion to the process.

As representatives from the pharmaceutical industry also read the *AJP*, I'd like to commend to them, and anyone else involved with packaging and labelling design, a one-day symposium on the topic. Packaging, Labelling and Marketing of Medicines is a symposium being held by the Victorian Branch of the Pharmaceutical Society of Australia on 27 May at the Melbourne Convention Centre. See p378 for more information on this event.

pdl

pdl risk management news

Pharmaceutical Defence Limited chairman John Coppock

Careful collaboration reduces patient risks

HAVING recently attended the Australian Association of Consultant Pharmacy (AACP) conference, ConPharm'05, I was deeply impressed by the enthusiasm with which delegates embraced the excellent program of speakers and discussed among themselves—pharmacists and doctors alike—their professional challenges.

While the issue of medication management reviews in both the home and residential facilities of course dominated proceedings, the number of doctors attending the conference also gave rise to numerous discussions on the broader, but related, issue of multidisciplinary care in the primary setting. From the perspective of the profession's future, I was comforted that these doctor delegates and speakers, many of them general practitioners, shared the enthusiasm of their pharmacy colleagues for a future of greater collaboration for the benefit of the patient.

It reasserted my confidence that relations between pharmacists and doctors at the coalface of community healthcare were as they should be. Certainly, anyone following media coverage of the aggressive stance taken by the Australian Medical Association (AMA) against the Pharmacy Guild of Australia could be forgiven for thinking doctors and pharmacists were natural enemies.

Most health professionals would agree that multidisciplinary care in the primary setting is the way to go in order to maximise health outcomes for the patient, especially for those with chronic conditions. Governments are also urging health professionals to collaborate more and are empowering the patient to take greater control of their own health. The more power the patient has in the process of caring for their health, the more the patient will demand effective cooperation among their health service providers.

Yet, the current tension between professions at the 'official' end has no doubt stymied efforts to advance the cause of multidisciplinary care in the community.

However, with the overt enthusiasm demonstrated between doctors and pharmacists at ConPharm'05 for working together to get the best outcome for the patient, perhaps through medication management reviews we have that 'thin edge of the wedge' to start driving behavioural change at the official end of medicine and pharmacy.

Some pointers to encouraging better relationships were offered during the course of the conference, such as careful interprofessional communication and not straying from one's area of expertise.

Diagnosis, for instance, is the domain of the medico. While pharmacists have been trained to understand and identify disease-state risk factors, and know when to refer patients to their doctor, we have not been trained to make diagnoses.

> ...any involvement in the delivery of new services requires careful analysis of risk factors and a strategy to minimise them

This is an important consideration, not just a 'turf' one for our doctor cousins, but also for Pharmaceutical Defence Limited. By making a diagnosis and having the patient act on that diagnosis, a pharmacist puts him or herself at risk of legal action should anything untoward occur as a result of, or following, the diagnosis. Most importantly, though, an unqualified diagnosis places the health of the patient at risk.

Hopefully, positive communication like that seen at ConPharm'05 can lead to even greater cooperation developing in areas such as diabetes, asthma, weight control, pain management and woundcare. (I'm sure the list of areas for future cooperation can be expanded to include numerous other conditions, but these might be a starting point.)

We know that there are examples of multidisciplinary collaboration already occurring in community pockets around the country, but what we need is to identify the most successful models and have them adopted as a mainstay of both medical and pharmaceutical care in the primary setting. Certainly the Guild is working on models to support the case for extending pharmacy's primary healthcare role, but without supportive involvement from the medicos, any such work is pretty much redundant.

Which is why a concerted effort must be made by official pharmacy to control its professional destiny. This means fostering the relationships we have with doctors and helping to advance the issue by demonstrating the health outcome values that can be delivered with the active involvement and support of community pharmacy. (The Guild's relationship with the Divisions of General Practice, with which it recently signed a *Memorandum of Understanding,* will be vital in this process.)

But before this can occur, we need to ensure all of pharmacy supports both the direction towards greater collaboration with other health professionals and how we intend to get there. Of importance in this process is consultation with PDL and Guild Insurance and Financial Services because any involvement in the delivery of new services requires careful analysis of risk factors and a strategy to minimise them.

We must remember that by working more closely with the patient, there are potentially greater professional liability risks. By minimising these risks, communicating effectively with professional colleagues and the patient, and sticking to our areas of expertise, pharmacy's professional future will not only be extended, it will also better provide for ballooning number of pharmacy students being educated in our universities. What's the risk if this doesn't occur? ■

Guiding principles to medication management

THE Federal Government recently released *Guiding principles to achieve continuity in medication management*, an important document relevant to all healthcare professionals, especially pharmacists.

The new national guiding principles aim to encourage safer use of medicines for consumers as they move through different health situations, whether they be hospital, residential or community-based care. The document was developed by the Australian Pharmaceutical Advisory Council and is an update of the 1998 document, *National guidelines to achieve the continuum of quality use of medicines between hospital and community*. The timing of its release would not surprise health professionals operating in Queensland, especially those working in a hospital setting.

Queensland's Morris and Foster inquiries have the potential to dramatically affect the way in which all health services are delivered. The *AJP's* Hospital Talk columnist, John Low, reported in August (p619) on the potential for these inquiries to affect the future delivery of services in hospitals, including pharmacy, not just in Queensland but around the country. I'd like to take that a step further. It wouldn't surprised me if these inquiries triggered similar investigations in other states or even at the national level and, perhaps, impact on primary care in the community. You see, one of the recurring themes of the inquiries is the importance of shared information between health carers to overall health outcomes.

Which brings me back to the timely release of the *Guiding principles*. An important sentence in the document is: 'Achieving continuity in medication management depends on commitment, cooperation and coordination among all partners in QUM (quality use of medicines).' The *Guiding principles* document defines QUM as 'selecting management options wisely, choosing suitable medicines if a medicine is considered necessary and using medicines safely and effectively'. Most pharmacists understand that QUM is one of the central objectives of Australia's National Medicines Policy.

Importantly, the document also advocates 'a partnership approach to QUM and recognises that governments, healthcare professionals and providers, consumers and/or their carers and others have a shared responsibility in this endeavour'. Such a partnership approach would help to ensure greater continuity of care between heathcare settings and episodes of care.

Also significant, the document acknowledges the growth in community-based health service delivery and that the boundaries between such services and those in hospital and/or residential settings are becoming blurred. Indeed, it states 'the risk of discontinuity at the interface between hospital and other settings remains a particular concern'.

> Achieving continuity in medication management depends on commitment, cooperation and coordination among all partners in QUM

Therefore, the original guiding principles have been broadened to apply across all health settings in the hope that it will 'facilitate wider uptake and implementation across the healthcare system, including community practice'.

Highlighted was the emerging evidence that a lack of continuity of care often led to significant harm. Examples offered included:

- On admission to hospital, up to one in two patients had an incomplete medicine list provided, resulting in a medicine not being administered during the hospital stay.
- 1.6 per cent of hospital admissions are associated with the occurrence of an adverse medicines event, and medicines are considered to be the causal agent of 10 per cent of all adverse events experienced in hospitals.
- 78 per cent of GPs were not directly informed that their patient had been admitted to hospital.
- 73 per cent of GPs did not directly receive discharge summary information.
- 12 per cent of patients had an error in their discharge prescription.
- Omission of medicine from the discharge summary list sent to community healthcare professionals was associated with an increased risk (by a factor of 2.3) of hospital or adverse medicine event.
- 14.5 per cent of consumers were on four or more medicines.

The Federal Government views the healthcare continuum as a series of cycles, each relating to an episode of care for which there is a corresponding medication management cycle. With each management cycle there are nine key components:

- decision on appropriate treatment and decision to prescribe medicine;
- record of medicine order/prescription;
- review of medicine order/prescription;
- issue of medicine;
- provision of medicine information;
- distribution and storage;
- administration of medicine;
- monitor for response; and
- transfer of verified information.

This document will help to drive improved cooperation and communication between GPs and pharmacists in the community setting. Optimal health outcomes for the patient can only occur when all health providers accept their responsibility for their role in the healthcare continuum and are committed to respecting and communicating with their fellow healthcare team members.

Every pharmacy should have a copy of *Guiding principles to achieve continuity in medication management* and understand its relevance to their practice.

An electronic version is available at: www.health/gov.au/internet/wcms/publishing.nsf/Content/nmp-guiding ■

Pharmaceutical Defence Limited chairman John Coppock

Throwing the baby out with the bathwater

THE pharmaceutical wholesaler issue has me concerned as both a pharmacist and also as chairman of Pharmaceutical Defence Limited.

Most experts seem to agree that Australia has one of the world's best healthcare systems. Okay, we know there are numerous elements which need reform, especially within the hospital system. But we've developed world's best practice in terms of achieving fair and equal access to medicines and doing so in a timely manner.

Our National Medicines Policy has a lot to do with this and its focus on quality use of medicines provides us—health professionals and policy makers alike—with a guiding light to remind us where the goal posts are. And they're supposed to be directly in front of the patient. I'm sure this is a situation that all Australians would wish to preserve.

However, this world-leading position is in jeopardy now that the Federal Cabinet appears to be supporting a wholesaler payment approach that will completely alter pharmacy's playing field and reposition the goalposts, not in front of the patient but in front of the bean counters. Any diminution of the value placed on timely access to medicines has the potential to exacerbate health problems and increase the likelihood of misadventure. As a consequence, I would expect to see a rise in the incidence of health itigation.

While Cabinet's favoured option provides for margins and further fee provisions for products with special handling needs, it simply focuses on the product and does not acknowledge the importance of the actual system of distribution in achieving fair and equal access in a timely manner. Our system allows for daily delivery and all pharmacists know how important this can be for sick people who urgently need access to medicine, especially those in rural and remote areas. Cabinet seems preoccupied with market forces but when you let loose market forces on healthcare delivery, medicines become a commodity. When this occurs, we lose focus on issues such as fair and equal access, and timely and appropriate dispensing. Instead administrative efficiencies and competitive environments become the guiding light. It's a bit like throwing the baby out with the bathwater.

> ...it may well lead to increased litigation against the pharmacist

Particularly galling is that Cabinet has ignored the advice of pharmacists and the full-line wholesalers—those people and organisations who have the expertise and understanding of the system which places the patient at front and centre. Both pharmacy and the full-line wholesalers have told Government that the option largely favoured by pharmaceutical manufacturers and bureacracy will place in jeopardy the ability to maintain the availability of all PBS medicines to pharmacies within 24 hours. Of particular concern are those patients with urgent medication needs in rural and remote areas.

Instead it has preferred to take the advice of pharmaceutical companies whose focus has to be on shareholder returns within market dynamics, and on bureaucrats whose interests lie with administrative ease and efficiency. Health Minister Tony Abbott was reported in an article in the *Sydney Morning Herald* (21 September) to be challenging pharmacy's concerns while a 'Government source' was said to dismiss the claims by pharmacy as simply 'bluffing'. Perhaps it discounts pharmacy's position as based on self-interest or an intrasigence to change. I wonder whether Australian taxpayers agree with them. I know for certain that once patients start being denied access to their medicines, everyone will lose out.

For this reason I've written a letter of concern to the Pharmacy Guild of Australia about this development and asked how PDL might assist in preserving fair, equal and timely access to medicines. As I pointed out, PDL considers that the proposed change will be a retrograde step and one which has the potential to cause serious harm to patients through failure to supply in a timely fashion. We believe that if such incidents were to occur it may well lead to increased litigation against the pharmacist.

Now I don't begrudge the interest of the Government to ensure that taxpayer dollars are being used wisely and efficiently, but when it comes to healthcare delivery, the economic benefit of National Medicines policy can't be easily identified within the annual budget statements of departmental silos. It takes a longer-term and broader view to understand the economic ramifications of our current system of distribution for medicines. Fortunately the Productivity Commission recently released a statement supporting the value of pharmaceuticals to the economy.

Hopefully the Cabinet will take account of this advice and review its decision. If they get this decision wrong, the worst potential outcome for the Government is that their electoral position is weakened at the next election. The downside for Australians is that people will become sicker than necessary and some will even die because the system would not allow medicines to reach them in a timely manner. ■