Improving prescribing for Indigenous Australians

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Interventions that encourage appropriate prescribing are required, including decision support systems and education about deprescribing

Two of the pillars of the Australian National Medicines Policy are that all Australians should have timely and affordable access to essential medicines, and that medicines should be prescribed and used appropriately.[1] Yet the reality is that these goals are not being met for Aboriginal and Torres Strait Islander (Indigenous) people to the same extent as for other Australians.

Much attention has been paid to ensuring that the first of these pillars applies equally to Indigenous and non-Indigenous Australians, and, despite the obvious difficulties of ensuring timely and affordable access to medicines for residents of remote communities, progress in this area has been made. Less obvious barriers, however, remain; in particular, inadequate service provision when a lack of cultural safety reduces genuine access. The second pillar, on the other hand, involves added dimensions of difficulty for all Australians.

Australia has much to be proud of with respect to promoting the quality use of medicines in the general community. Data from the Pharmaceutical Benefits Scheme[2] and, even more so, from the Department of Veterans' Affairs,[3] have facilitated excellent research into identifying areas of suboptimal prescribing, leading to many activities for improving prescribing. Some interventions have been administrative — for example, encouraging manufacturers to produce antibiotic pack sizes that better reflect the duration of therapy recommended in current guidelines — and some have been educational, with Australian organisations such as NPS MedicineWise (www.nps.org.au), Therapeutic Guidelines (www.tg.org.au), and the Australian Medicines Handbook (amhonline.amh.net.au) at the forefront of such activities.

Although the benefits of quality medicine use activities might differ in certain Indigenous communities from those elsewhere, specific studies in this area have been rare. The report by Page and colleagues[4] in this issue of the Journal, giving us more specific and detailed information on the quality of prescribing of medicines for older Aboriginal Australians in the Kimberley region of Western Australia, is therefore welcome.

For obvious reasons, retrospective assessment of the appropriateness of a prescription for a specific patient is not an exact science. However, the investigators had access to the comprehensive online medical records system that includes the relevant working diagnoses, comorbid conditions, and other drug therapies for most patients in the Kimberley, and they applied published criteria to these data to estimate rates of suboptimal prescribing. Their main findings are that polypharmacy, a known risk factor for adverse outcomes,[5] affected 53% of patients; 20% of patients were prescribed one or more drugs considered relatively contraindicated in older people; and under-prescribing is common in patients with coronary artery disease or stroke.[4]

Although not encouraging, the authors' findings do not markedly differ from those of other Australian studies,[6] which suggests Indigenous Australians may not be uniquely disadvantaged with respect to the quality of prescribing. However, such poor results demand a response, raising the question of whether interventions for improving prescribing in the general population would also benefit older Indigenous Australians.

Page and colleagues are correct in suggesting that multifactorial interventions will be required, and obvious possibilities include administrative and educative approaches. Decision supports, such as alerts, are not usually welcomed by prescribers; they have had a poor record, for example, in averting drug interactions, usually because overly frequent alerts irritate the prescriber to the point of turning them off.[7,8] However, at least in the Kimberley, the electronic records system should lend itself to suitably restrained alerts that draw the attention of prescribers to polypharmacy in individual patients, or to usual treatment (such as aspirin or a statin) not being prescribed for patients diagnosed with vascular disease. Formal review by a suitably trained pharmacist of the medications prescribed for selected patients might also help, but would be expensive and require formal evaluation in the target population before being considered for general implementation.

Polypharmacy made the largest contribution to the inappropriate prescribing identified by Page and her colleagues, so education activities could focus on stopping or reducing medications. Guidelines for deprescribing are difficult to formalise, and those that are available are often not relevant to all clinical situations. However, it is internationally recognised that deprescribing is important,[9] and it is likely that some existing programs, suitably adapted, would be relevant to prescribing for older Indigenous Australians.

Any intervention will cost money, and potential funders will have interests that influence their intervention priorities. However, trialling decision support systems tailored to specific situations, developing and assessing pilot programs for pharmacist review of medication prescribing, and developing, implementing, and evaluating education programs for deprescribing

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would be a good start. They will need to be accompanied by an Indigenous community-based assessment of the cultural safety of the service, from overall design to quality assurance for clinician–patient interactions.

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