

# **GAP Taskforce on Self Care**

**Towards Responsible Self Care:  
The Role of Health Literacy, Pharmacy  
and Non-Prescription Medicines**



**Final Report  
June 2015**

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Postal address            PO Box 978 Strawberry Hills NSW 2010 Australia

Telephone                +61 2 8303 2420  
Facsimile                +61 2 9319 5754  
Email                      info@globalaccesspartners.org

# Towards Responsible Self Care: The Role of Health Literacy, Pharmacy and Non-Prescription Medicines

Final Report of the GAP Taskforce on Self Care

Prepared by Global Access Partners Pty Ltd

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Sydney, Australia

## **Abstract**

This paper outlines the pressures and opportunities facing Australia's health system and offers self care and improved health literacy as a 'win-win' solution delivering better outcomes and lower costs for consumers, health professionals and the Federal Budget.

## **Disclaimer**

This document summarises the deliberations of the GAP Taskforce on Self Care - a cross-disciplinary group brought together in 2014 by public policy institute Global Access Partners to examine the potential of self care to improve individual and public health outcomes and play a greater role in health policy.

The report highlights the importance of health literacy and the role pharmacies and non-prescription medicines can play in supporting responsible self care and reducing government expenditure. As well as enabling a more efficient health system, these factors are consistent with a growing desire by health consumers to become more involved in their own health care.

The paper represents the diverse range of views and interests of the individuals and organisations involved. Given the different perspectives of Taskforce members, it should not be assumed that every member would agree with every argument or recommendation in full.

The report has been prepared in good faith on the basis of information available at the time of writing and sources believed to be reliable. However, it should not be used as a substitute for independent professional advice and further consultation with industry experts. Evaluation of the material is the sole responsibility of the reader.

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## Terms & Abbreviations

**ARTG** - Higher risk medicines must be registered on the **Australian Register of Therapeutic Goods**. Each product's quality, safety and effectiveness are individually evaluated. Lower risk medicines, containing preapproved, low-risk ingredients and making more limited claims, can also be listed on the ARTG (See Listed Medicines and Registered Medicines below).

**ASMI** - The **Australian Self Medication Industry** represents the interests of companies manufacturing and distributing consumer health care products in Australia.

**COAG** - The Council of Australian Governments

**GP** - General Practitioner

**HeLP** – The **Health Literacy in Pharmacy** research project was led by a consortium of academics from five universities - Monash University, Curtin University, University of Sydney, University of Technology Sydney, University of Queensland, and James Cook University - and the Victorian branch of the Pharmaceutical Society of Australia.

**Listed medicines** carry little risk of misuse and can be purchased from pharmacies and non-pharmacy retail outlets. Listed medicines are assessed by the Therapeutic Goods Administration (TGA) for quality and safety, but not efficacy. Some over-the-counter (OTC) medicines and most complementary medicines are listed in this way.

**NSAIDs** - **Nonsteroidal anti-inflammatory drugs** such as aspirin, ibuprofen and naproxen can ease pain, lower fever and, in higher doses, reduce inflammation. They offer a non-addictive alternative to opiates, but can provoke gastrointestinal problems such as dyspepsia.

**OTC** or **Over-the-Counter** medicines include Schedule 2 (Pharmacy Medicines) and Schedule 3 (Pharmacist Only Medicines) drugs which can be purchased from pharmacies without a prescription. Other medicines, exempt from scheduling, can be purchased from pharmacies, supermarkets and other retailers.

**PBS** - The **Pharmaceutical Benefits Scheme** is subsidised by the Australian Government and ensures timely, reliable and affordable access to essential medicines through the community pharmacy network.

**Prescription only (Px or Rx)<sup>1</sup>** medicines are termed Schedule 4 medicines by the TGA. They require a prescription from a prescriber authorised by relevant State or Territory legislation before they can be bought from a pharmacy. Such prescribers can include medical practitioners, nurse practitioners, optometrists, dentists and podiatrists.

**QUM - Quality Use of Medicines** is an integral part of the Australia's National Medicines Policy. It encourages the judicious, appropriate, safe and efficacious use of medicines by the general public and stresses the importance of communication between patients and health professionals.

**Registered medicines** are assessed by the TGA for quality, safety and efficacy. All prescription medicines, most OTC medicines and some complementary medicines are registered in this way.

**Self care** encompasses the activities people undertake to stay fit and maintain good physical and mental health, prevent illness and accidents and avoid unnecessary risks. It includes self-medication for minor ailments and chronic conditions and actions taken to recover after acute illness or discharge from hospital. Responsible self care requires good health literacy and communication with health professionals including pharmacists and GPs.

**Self-medication** involves the treatment of health problems by individuals with home remedies or products bought from pharmacies and other retail outlets.

**Schedule 2 or Pharmacy Medicines** are only available from a pharmacy. Licences for the supply of S2 medicines from other sources are issued by State and Territory governments in the absence of a pharmacy - typically, when no pharmacy exists within 25km, although this can vary between jurisdictions. Such licences do not permit other retailers to offer advice on their safe use as this is a professional responsibility for which health professionals are indemnified. In a pharmacy, the pharmacist assumes responsibility for the actions of their staff.

**Schedule 3 or Pharmacist Only Medicines** are only available from a pharmacy. They do not require a prescription, but the pharmacist is obliged by law to be involved in their sale and offer professional advice as required to ensure safe and effective use. Under the Pharmacy Guild of Australia's Quality Care Pharmacy Program, all pharmacy staff must complete mandatory training on handling S2 and S3 medicines.

**Schedule 4 (Prescription Only) and Schedule 8 (Controlled Drug)** medicines require a prescription by a medical practitioner.



**‘Switching’** means the reclassification or rescheduling of a medicine by the TGA. This can involve Prescription Only Medicines (Schedule 4) being rescheduled to Pharmacist Only (Schedule 3) status, or from Schedule 3 to Pharmacy Medicine (Schedule 2). Medicine schedules are published in the Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP or The Poisons Standard)<sup>2</sup> which is underpinned by State and Territory poisons legislation.

**Therapeutic goods** are broadly defined as products used to prevent, diagnose, cure or alleviate a disease, ailment, defect or injury. Such goods can influence, inhibit or modify a physiological process or test susceptibility to a disease or ailment. They may also influence, control or prevent conception or test for pregnancy. Such goods include the ingredients or components of consumer products or those used to replace or modify parts of the anatomy.

**TGA** – The **Therapeutic Goods Administration** regulates therapeutic goods in Australia. It monitors their use through reporting systems for defects and adverse reactions, conducts auditing and sampling and monitors advertising claims. It regularly issues warnings about unlicensed products which may pose risks to public health.

**WHO** – The **World Health Organization** directs and coordinates health-centred activities within the United Nations. It offers leadership on global health issues, shapes the health research agenda, sets norms and standards, presents evidence-based policy options, monitors and assesses health trends and delivers technical and practical support to health systems and organisations.

*“There is going to be a big shift in power,  
control and authority of health data  
from the doctors to patients...*

*Regardless of how doctors or anyone else  
may feel about it, this type of innovation is going to  
happen, and probably needs to happen.”*

**Andy Ellner**  
**Physician, Co-director of the**  
**Harvard Medical School Center of Primary Care,**  
**New Yorker, 15 December 2014**

## Executive Summary

*“Self care in health refers to the activities individuals, families and communities undertake with the intention of enhancing health, preventing disease, limiting illness, and restoring health. These activities are derived from knowledge and skills from the pool of both professional and lay experience. They are undertaken by lay people on their own behalf, either separately or in participative collaboration with professionals.”*

World Health Organization, 1983<sup>3</sup>

This report addresses three of the multiple components of self care – access to medicines within the context of Australia’s National Medicines Policy<sup>4</sup>, the role of community pharmacy in primary health care delivery, and health literacy as a universal enabler of greater self care.

Responsible self care, founded in health literacy and informed by two-way communication with health professionals, plays an ever more important role in health delivery around the world. Expanded self care and improved health literacy would ease the burden borne by Australia’s hard-pressed health services and Federal Budget, while improving health outcomes, consumer convenience and quality of life for all.

Responsible self care offers advantages for all stakeholders – consumers, GPs, pharmacies, the pharmaceutical industry and the public purse – and builds on powerful social and political trends towards individual choice and government deregulation. This broad social support should spur its success and maximise its benefits for the nation. Expanded self care would also reduce the pressure faced by health services in rural areas and help those who find them difficult to access.

**Self care and health literacy will therefore help unlock the full potential of the health system’s largest resource - the Australian public itself.**

Publicity campaigns and health professionals should encourage healthy lifestyles for long-term wellbeing and a ‘pharmacy first’ policy for minor short-term ailments to free GP and hospital resources for more serious cases. Community pharmacies are an integral part of the health system, rather than a simple repository where prescriptions are filled, and more use should be made of their highly trained staff. Consumers should be encouraged to seek pharmacist advice, while pharmacists must ensure that consumers with greater needs are directed to their GP. Consumer interactions at the pharmacy generate benefit at no extra cost as pharmacists, unlike GPs, do not claim Medicare

reimbursement for the time they spend with consumers. Health system reforms must be embraced by those they affect to be successful, and the better utilisation of skills and reduction of waste will always prove more popular – and therefore long-lasting and efficacious – than budget-driven reductions in frontline services.

Ongoing rescheduling ('switching') of medicines should continue to increase access to non-prescription medicines where appropriate. Health and product information should be offered in a wider range of media and styles to ensure their safe and sensible use throughout Australia's increasingly diverse population. If the costs of some PBS medicines are to be transferred to individuals, the benefits of access, convenience and choice they gain at a local pharmacy must outweigh the extra expense to retain public backing. Better access to effective medicines, improved clinical outcomes and greater involvement by consumers in their health will generate significant benefits for both the consumer and the health system as a whole.

## Taskforce Recommendations

1. Stakeholders must publicly reaffirm COAG's 1996 goals for the Australian health care system – in particular, the need to “*provide incentives for preventive health and cost effective care, and give better value for taxpayers' dollars*”.<sup>5</sup> A new culture among health professionals and political leaders should encourage the community to assume more responsibility for their health and become less dependent on the public health system.
2. Increased investment in health literacy and preventive health will both maximise public health benefits and control overall expenditure. Australian Federal and State governments should integrate self care into health policy, and health policy into every aspect of public life. There should be bi-partisan support for sustained, evidence-based reform to improve health provision and efficiency.
3. Health care professionals should be offered incentives to encourage and support self care, as its success relies on partnership, communication and cooperation with patients and the wider community. General practitioners should offer self care solutions where appropriate while retaining their central role in diagnosing and treating more serious problems and caring for vulnerable people. Community pharmacists should work with GPs as part of multidisciplinary care teams and current progress in this area should be supported, systemised and standardised.

4. The Health Literacy in Pharmacy (HeLP) program<sup>6</sup> should be extended from its current trial to the broader pharmacy community.
5. Curricula must be developed to improve school-age children's health literacy. The material developed by Life Education<sup>7</sup>, an Australian health and drug education provider for school children aged 5-13 years, offers a positive role model.
6. Opportunities for private health insurance could expand into payments for better integrated primary care to encourage and promote its development.
7. Pharmacies should play a greater role in delivering primary health care, promoting health literacy and supporting responsible self care. A 'pharmacy first' policy for short-term self-limiting ailments would free GP and hospital resources to concentrate on more serious cases. Pharmacists should triage consumers and recommend appropriate non-prescription medicines or referral to a GP as required. This intervention need not include the recommendation of a product if advice to self-monitor and consult a health care professional if required will suffice. As self care expands, a greater investment will be required in preparing the pharmacy to conduct private discussions with consumers, ensuring adequate staffing levels, training and professional development of staff and continually reviewing and assessing its services for quality improvement.
8. Existing regulatory controls of access to non-prescription medicines can contradict the National Medicines Policy of ensuring "*timely access to the medicines that Australians need, at a cost individuals and the community can afford*".<sup>8</sup> An urgent and coordinated review of scheduling arrangements, policy development and oversight should explore avenues to improve consumer access and streamline business processes.
9. A "switch agenda" and reform of the regulatory framework could be pursued through the establishment of a small working party of relevant technical specialists to oversee the review process and report to the Australian Health Minister's Advisory Committee.
10. The TGA should implement a regulatory model that will permit consumer communication in relation to Pharmacist Only Medicines.

11. Australia's personally controlled electronic health records (PCEHR) could be utilised to record the use of all medicines to treat chronic conditions, including OTC products. The advice and referrals for minor ailments provided by pharmacists and not linked to product supply could also be usefully captured in the PCEHR.
12. Health information materials, both in print and online, should take demographic, educational, behavioural and cultural factors into account to ensure their messages are appropriately presented, understood and acted upon. The relevance, quality and volume of information should be assessed to maximise its real-world effectiveness.
13. Health reform, like any other change, is best encouraged by incentives. Health system stakeholders should be offered incentives to encourage self care, while health care consumers could be encouraged, through tangible benefits, to document their symptoms, progress and self-management regime.
14. The Government should support the Self Care Alliance - a new entity comprising health care professionals, consumer representatives and patient groups, the pharmaceutical industry, private health insurers and health researchers. This body will advocate preventive medicine, health literacy and self care as approaches to ease increasing financial and patient pressure on the health system.

# 1 Why Change the Status Quo?

## Introduction

Access to a good standard of health care is a fundamental human right. However, increasing public expectations regarding the provision of affordable, accessible and high-quality health care in Australia face a number of significant challenges.

This chapter details the budgetary pressures facing the Australian health sector and the impacts of an ageing population and advances in modern technology. It also outlines the opportunities for a more person-centred approach as new information services allow consumers to take more control of their health care.<sup>9</sup>

The ubiquity of the internet, the development of new apps and smart wearable devices and the electronic integration of patient medical records mean that consumers have increasing scope to make more informed judgements on their health and care options. The traditional asymmetry of information which has maintained the authority of professionals over the public is eroding in health, as well as every other sphere. The future of health care will increasingly be shaped by the myriad decisions of innumerable consumers, rather than a small number of powerful producers or political decision makers.

Later chapters consider the scope for a number of initiatives under the self care banner to improve health outcomes at no additional cost to the Commonwealth. A growing number of consumers already seek alternatives to, or changes in, the health care system and practise forms of self care. Rather than stymie such trends, more opportunities for consumers to better manage their own health should be offered with the support of the health sector. Self care does not imply that people are left alone to cope with their ailments - indeed, responsible and effective self care depends on the health sector playing a more supportive role to ensure the maintenance of individual and public health and safety.

## The budgetary challenge

There has been much comment over the last decade regarding the sustainability of Australia's health system and concern that its increasing cost undermines the bipartisan objectives of a strong economy, healthy population and balanced budget. The cost of the health portfolio, the second largest item of Commonwealth expenditure, is steadily increasing<sup>10</sup> with the equivalent of \$120 spent on health care for every man, woman and child in the country every day<sup>11</sup>.

342,000 Australians visit a GP on any given day, 742,000 medicines are dispensed by community pharmacies, 23,000 people are admitted to hospital and 17,000 people present to an emergency department at a major public hospital. Inflation adjusted government spending on hospitals increased by nearly 90% between 2002-2003 and 2012-2013, with an increase of 65% for pharmaceuticals and medical services.<sup>12</sup>

The incidence of chronic diseases such as type 2 diabetes, cardiovascular conditions and age-related dementia also continue to rise. Chronic complaints now account for 70% of the total disease burden, a figure set to reach 80% by 2020.<sup>13</sup>

## The international context

However startling they appear in isolation, these figures should be set in their international context. Australia's problems are far from unique among developed countries and its position is not disastrous. Just as other comparable nations are improving service efficiency and health outcomes, so effective action can be taken in Australia to deliver better value and prepare for inevitable change.

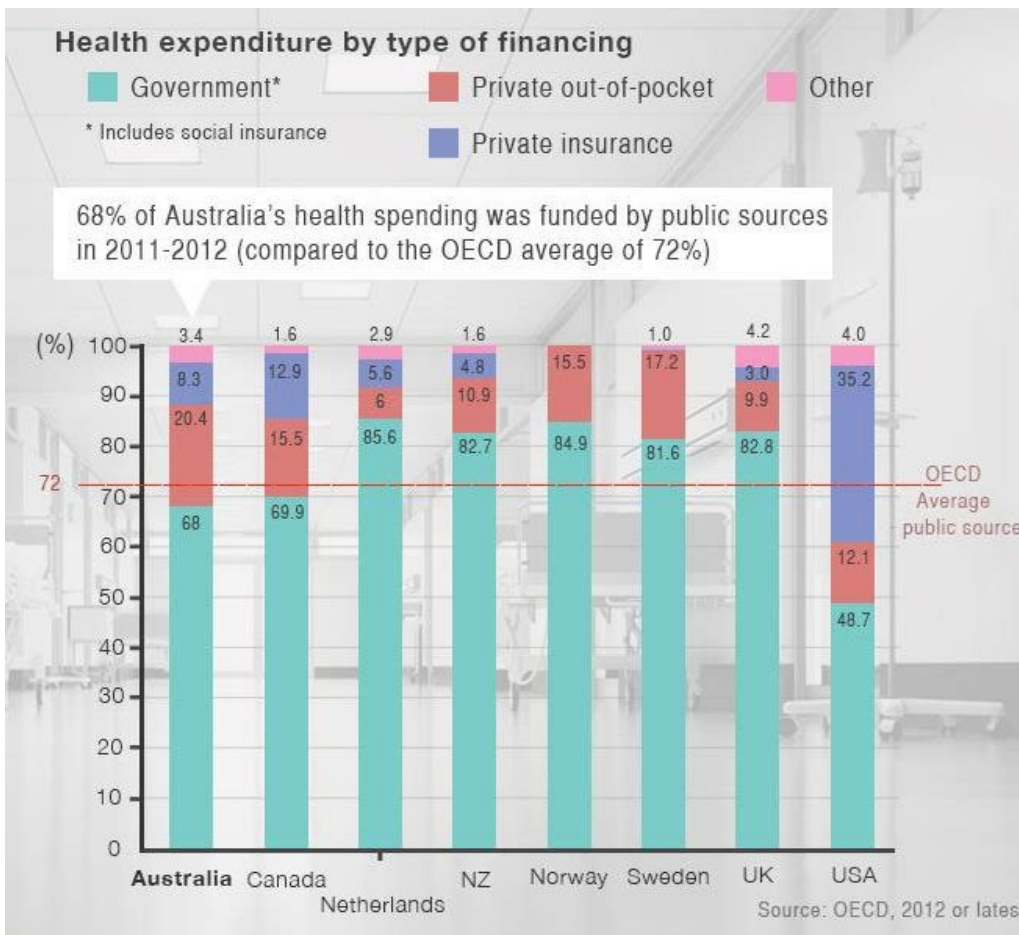
At 9.1% of its gross domestic product, Australian health expenditure remains slightly below the 2012 OECD average of 9.3%<sup>14</sup>. As noted by Stephen Duckett of the Grattan Institute, "*Australia's (health) system is one of the world's best on objective criteria. It costs less than the OECD average and the outcomes, in terms of life expectancy, are better than the OECD average.*"<sup>15</sup>

Furthermore, although public authorities paid for 68% of the nation's health care through tax and social insurance in 2011-2012, governments in many comparable countries cover a considerably higher percentage. The government paid for 69.9% of health care in Canada, 82.7% in New Zealand, 82.8% in Britain and 85.6% in the Netherlands, for example. Given its reliance on private insurance, the American government paid just 48.7%, although this figure is increasing with the implementation of 'Obamacare'.



20.4% of Australian health care was paid for by consumers out of their own pockets, a much higher proportion than in Canada (15.5%), New Zealand (10.9%), the UK (9.9%) and the Netherlands (6%). Just 12% of US health expenditure is directly met by individuals, with 35.2% of the US total covered by private insurance, compared to 8.3% in Australia.

**Figure 1. Health expenditure by type of financing (OECD 2012)<sup>16</sup>**



The relatively low figure of 8.3% borne by private health insurance in Australia reflects the strict legislation restrictions applied to this sector. Private health insurance pays for 41% of all hospital admissions (both public and private, surgical and medical) and for 55% of all surgery (both public and private) because these are the areas in which it is allowed. The private health insurance industry is prevented by law from being reimbursed for engagement with the primary care sector and, given the widely accepted importance of expanding and promoting integrated primary care, the benefits of revisiting these restrictions would be significant.

Australians paid an average of US\$731 in out-of-pocket medical expenses in 2012, compared to an OECD average of US\$590. The British paid US\$297, the Dutch US\$347 and the Canadians US\$690. Although Nordic health systems are traditionally dominated by the state, Swedes paid US\$678 and Norwegians US\$829 because these nations lack private insurance schemes. Americans paid US\$1,045, in part because their nation spends a much higher percentage of its GDP on health overall.

**Figure 2. Household out of pocket payments per capita (OECD, 2012)<sup>17</sup>**



## The cost conundrum

Australian health spending grew from 4.5% of GDP in 1970 to reach 8.2% in 2001 and 9.1% today. A 2014 Parliamentary Budget Office Report<sup>18</sup> predicts that overall government spending will grow in line with the economy over the coming decade<sup>19</sup>, with health remaining the largest single item of expenditure for state governments. The 2015 Intergenerational Report<sup>20</sup> projects that government health expenditure per person will more than double over the next 40 years from around \$2,800 to around \$6,500 in today's dollars.

In common with other developed nations, budgetary pressure will grow as the Australian population ages and the proportion of workers to dependents declines. Increases in health expenditure will also be driven by greater demand for services, reflecting the growing prevalence of chronic disease and advances in modern medicine. New techniques, including tailored cancer therapies and novel pharmaceuticals, medical devices and surgical techniques will all tend to increase costs as well as improve health outcomes.

Recent efforts to restrain public health expenditure include the comprehensive 'big bang' hospital reforms of the Rudd administration in 2012, changes to PBS subsidies and the Coalition's proposed introduction of \$7 co-payments for Medicare services. However, increasing the upfront costs imposed on consumers may incur serious health penalties as well as political pitfalls. In addition to the backlash from voters, 16% of Australians already report barriers to accessing health care because of its cost<sup>21</sup>. This is far higher than the UK (4%), Sweden (6%), Norway (10%) and Canada (13%), though below the 21% of New Zealand, the 22% of the Netherlands and the 37% of the USA.

Whilst federal and state governments and agencies search for reductions in major areas of expenditure, they risk missing opportunities to use existing products and services more effectively. Although the Federal Minister for Health has spoken of the need to reduce regulatory burdens and share the costs of health care<sup>22</sup>, opportunities for reform and fresh approaches remain.

Existing regulatory structures can unnecessarily restrict access to a range of health services which could improve health outcomes, and an interventionist mindset persists when prevention and improved health literacy could increase outcomes at lower cost. While the dangers of smoking are well publicised, for example, the dangers and prevalence of obesity continue to be underappreciated by the general public. Obesity is associated with poor standards of health and a wide range of expensive and debilitating

chronic conditions. 28.3% of Australians were considered obese by the OECD in 2012, compared to an OECD average of 22.7% and just 11% of the population in the Netherlands and Sweden.<sup>23</sup>

Progress is being made. A recent government statement on innovation<sup>24</sup> signaling the acceptance of international standards and accredited test results could significantly improve access to the latest technology. Similarly, 2014 saw the start of an independent review of the regulation of medicines and medical devices to “ensure Australians can access the latest treatments in a timely manner, [...] encourage greater competition and innovation in the medicines and medical devices sectors”.<sup>25</sup>

Measures to simplify access to a range of safe treatments for common complaints are urgently required. As the National Statement on Health Literacy notes, “the complexity of the health system is challenging for everyone who uses it and works in it, and this complexity contributes to poor quality and unsafe care”. Only 40% of Australian adults can “understand and follow health messages in the way in which they are usually presented”.<sup>26</sup> Limited health literacy is associated with higher rates of hospitalisation and emergency care and a wide range of adverse health outcomes.

## The rise of person-centred health care

Just as the internet, new apps and mobile devices have transformed entertainment, retail and a host of other services, the health market is being revolutionised in turn. While traditional health services have struggled to progress the electronic integration of patient medical records, vibrant new commercial solutions are offering consumers greater opportunities to monitor and make health choices on their own.

People increasingly rely on health information sourced through the internet and social networking tools.<sup>27</sup> According to recent studies, 34% of people already search for health information using social networking tools, while 36% of sales in the US are researched online and 22% of consumers in Europe and 13% in the US compare prices on their cell phones<sup>28</sup>. Apple, Google and other tech giants are rapidly developing health platforms that may soon offer all-in-one health solutions for consumers and medical professionals based on the generation, recording, analysis and storing of patient health data to improve the diagnosis, monitoring and management of disease.

Siri, Google Now and Cortana may become the most important health advisors of the future, available at the touch of a button 24 hours a day. People may increasingly accept the convenience afforded by the collection and storage of their health data as they do the tracking of their purchasing decisions and personal relationships today. Individuals may soon have their entire genome analysed and stored in the cloud, for example, to allow their phone or smart watch to instantly cross-reference a prospective medicine purchase to check its efficacy with their particular genotype. New apps, seamless cloud storage and ubiquitous connectivity may see fast-growing and nimble technology companies unlock the potential of pharmacogenomics long before the public health system even begins to try.

Three quarters of internet users already expect a 'personalised' experience online and 45% of users claim the internet 'knows them best'.<sup>29</sup> Self care and health literacy will be powered by the smart devices carried by ever more people, and the power of the web and cloud services they access instantaneously. People increasingly act as active health consumers, making individual purchasing choices from a wide range of options to suit their individual and evolving needs.

Traditional health services and pharmaceutical retailers risk being bypassed by customers with an increasing range of price and service options. They must strive to connect with their consumers through social media, retool supply chains to react promptly to changes in demand and become increasingly sophisticated in capturing, aggregating and analysing collective and individual point-of-sale data. As with their counterparts in other industries, they too will be transformed or superseded by the power given to consumers by ubiquitous mobile technology and hyper-connectivity.

The end point of the evolution of a person-centred health system is hard to predict, but the acceleration of that process is inevitable. The only certainty of a fast-changing, competitively driven, increasingly globalised yet intensely individualised health sector is that it will be far richer and innovative than any planner can currently dream.

## The policy response

There appears to be limited recognition among policy makers of the scope and implications of a more person-centric health care system. Health literate consumers willing and able to manage their own conditions should be seen as a valuable resource and their numbers and abilities cultivated accordingly; however, the policy focus remains fixated on the system as it is currently structured and ways to reduce the growth in health expenditure.

Change is possible. In an interview with ABC News, the Treasurer stressed that the Budget should deal with the structural issues. He acknowledged that the Budget is about *“whether we can sustain our current quality of life with an ageing population and with significant competition for our markets”*.<sup>30</sup> He also foreshadowed the need to end the age of entitlement by expecting individuals to assume greater self-responsibility, and this could logically be extended to the medical realm through self care.

Peter Dutton, the former Minister for Health, repeatedly argued that the existing health care system is unsustainable in the face of an ageing population and rising chronic disease. In an address to the Australian Pharmacy Professional Conference, he observed that *“over the last decade, the cost of the MBS has increased 124%, hospital costs are up 83%, and are projected to go up another 50% over the next four years”*.<sup>31</sup>

One option is for consumers to pay more of their own costs to reduce demand and increase revenue. In an interview with the Australian Financial Review, Mr Dutton argued that *“picking up nearly 100% of the cost in the public setting makes no sense for the taxpayer when the consumer is prepared to contribute to their own costs. Therefore, I believe one important job of the Abbott Government is to grow the opportunity for Australians to contribute to their own healthcare”*.<sup>32</sup>

The 2014 Budget therefore included increased means testing for Medicare services, proposed co-payments for GP visits, increased co-payments for PBS medicines, as well as changes to Medicare Locals. These initiatives inevitably provoked outspoken opposition and raised fears the Abbott administration favours an ‘Americanised’ health system, in which the ability to pay determines access to many services. Australians who have typically enjoyed a health system balanced between public and private expenditure are unlikely to accept such a system, and so more politically expedient, as well as financially prudent and health-promoting, alternatives must be found.

Announcing the examination of possible reforms to the Medicare system at a press conference on 22 April 2015, Australian Minister for Health the Hon. Sussan Ley commented on the importance of keeping *“Australia’s world-class health system well and trully functioning into the future”* and making it *“better reflect what it is supposed to do, which is to support patients, to support health”*.<sup>33</sup>

The Productivity Commission in its research paper *Efficiency in Health* released in April 2015 considered a number of options for efficiency gains in the Australia health system. The recommendations focused on reforms that can be “delivered ‘within system’ — that is, without changing existing institutional and funding structures — and without delay.”<sup>34</sup>

A key finding of the Commission was that “Australia needs to invest more in preventive health to reduce the disease burden, improve health outcomes, and get better value from health expenditure”.<sup>35</sup> Good preventive health can also improve long-term participation in the labour force, economy wide productivity and, ultimately, Australians’ quality of life.<sup>36</sup>

Australia’s current spending on preventive health is low by OECD standards — around 1.5% of total health expenditure, or \$2.1 billion, in 2012-13, of which governments paid 95%.<sup>37</sup>

The Productivity Commission 2015 report noted the mixed results from government programs encouraging the populace to take a greater focus on self care - for example, through advertising campaigns designed to modify behaviour. It also acknowledged that “there is no ‘quick fix’ to strengthen the incentives faced by the responsible parties in Australia’s health care system to invest in cost-effective (and efficient) preventive health measures”.<sup>38</sup> The Commission recommended a comprehensive review of the Australian health system to “consider options to strengthen incentives for cost-effective investment in preventive health”, as well as the ongoing trials and evaluation of preventive health programs by Australian, State and Territory governments.<sup>39</sup>

## **Responsible self care and improved health literacy as a solution**

The fractured nature of the Australian health system means its costs are not fully controllable, while political efforts to limit expenditure provokes immediate electoral pain.

However, there are a number of areas where Australians already meet health costs from their own pocket and seem willing to continue to do so. They are willing to buy a wide range of products from pharmacies and retail outlets because of the greater choice, access and convenience. The scope for expanding these options should be investigated and maximised, given the significant savings and benefits involved. Encouraging self care and the responsible use of non-prescription medicines could reduce PBS bills and pressure on GP resources, while improved health literacy should reduce, or at least delay, the incidence of a range of chronic diseases. Several recent research papers have highlighted the scope for a range of non-prescription medicines to treat common ailments and the ways in which primary health costs could be significantly reduced by community pharmacy becoming health consumers' first port of call.



## 2 The Scope of Self Care

### What is self care?

The concept of self care is widely accepted, although its definition and, in particular, its implementation is the source of wider debate. The WHO defines self care as “*personal health maintenance*” to “*improve or restore health or to treat or prevent diseases*”. It is “*what people do for themselves to establish and maintain health, prevent and deal with illness*”<sup>40</sup> and therefore encompasses exercise, relaxation, diet and hygiene, as well as the self-treatment of minor ailments and more specialised regimens to manage chronic conditions or recover from acute events.

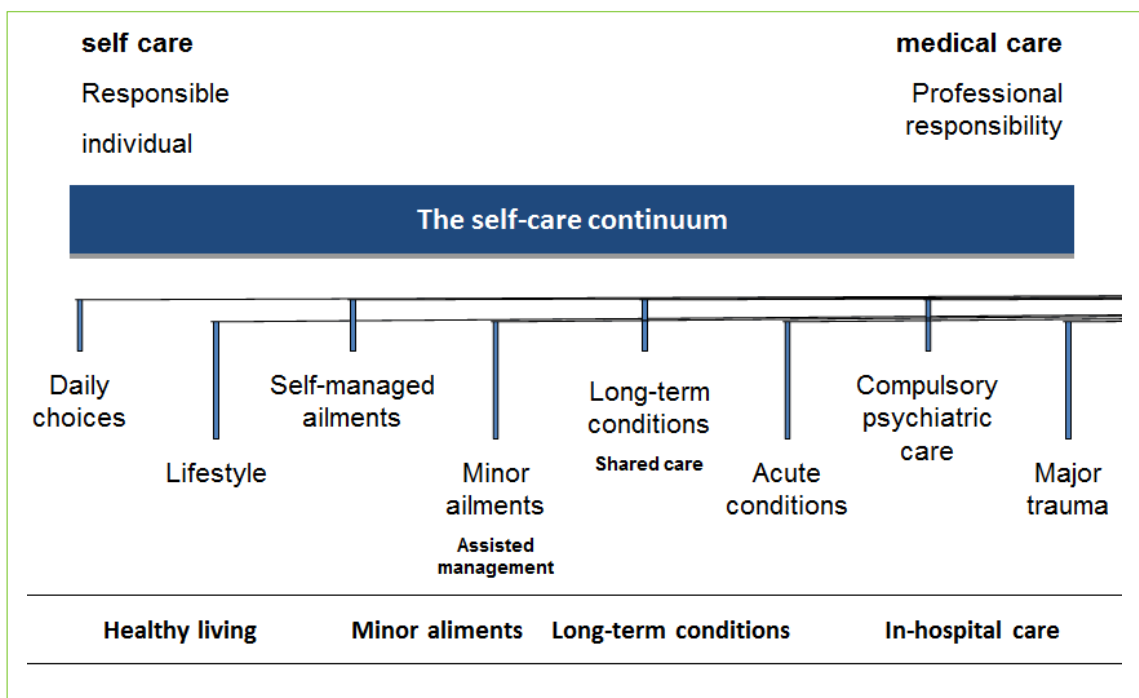
The British Department of Health views self care as “*the actions people take for themselves, their children and their families to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital*”.<sup>41</sup> In emphasising personal agency, it puts individuals in control of their own health and, by expanding earlier concepts based on the self-management of chronic disease, is relevant to all citizens throughout their lives.

Most people practise self care without giving it a name. It is what people do between GP visits, rather than an alternative to them. Many people would like to practise more self care with the assistance of treatments sourced from a range of providers, including a pharmacy where appropriate, but are dissuaded by the need to consult and obtain prescriptions from their doctor despite knowing the nature of their condition and the treatment which works. Regulations designed to protect patients from inappropriate self-diagnosis and self-treatment can, if applied too broadly, prevent responsible people from safely negotiating their own level of managed care.

In addition to its effectiveness in treating specific conditions, self care can ease more general problems of pain, depression, anxiety and fatigue. It can boost self-reported wellbeing and quality of life and improve a patient’s independence, thus reducing the burden on formal and family carers as well as improving self-esteem. Good nutrition and exercise can also reduce the incidence of serious chronic disease. In 2008, the WHO argued that “*non-communicable diseases (are) the major killer of this century. If*

responsible self care is well practised, about 75% of the cases of heart disease, stroke and type-2 diabetes, and 40% of cancers can be prevented".<sup>42</sup>

**Figure 3. The Self Care Continuum (Self Care Forum)<sup>43</sup>**



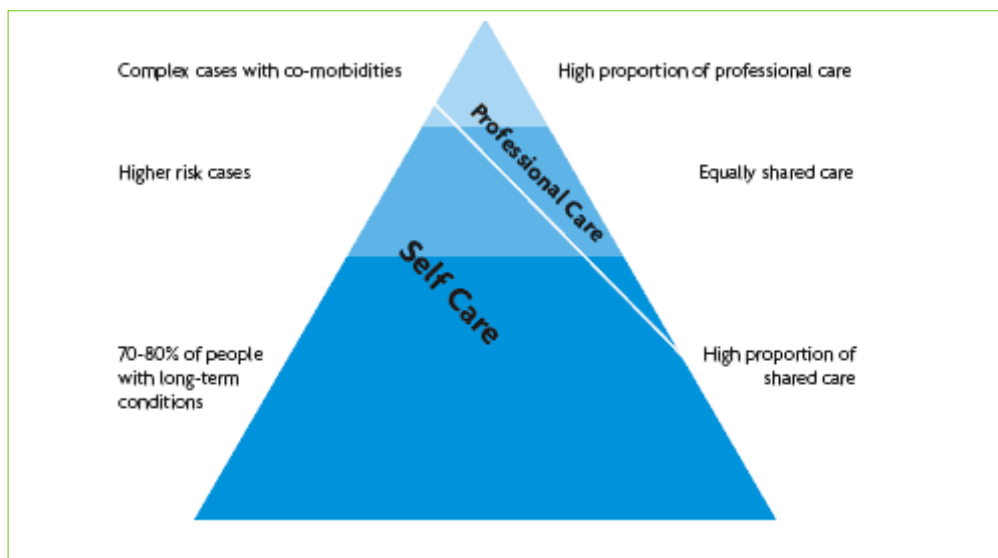
Effective and responsible self care relies on a good standard of health literacy and support from health professionals to inform rational decision making. Responsible pharmaceutical industry and retail advertising and practices should also support consumers' health needs. Healthy lifestyles play a vital part in preventive medicine – the most cost effective way to improve public health.

Self care therefore encompasses a broad range of everyday personal behaviours, in which non-prescription medicines play only a small, if at times significant, part. Brushing one's teeth, eating a balanced diet and exercising regularly have a much greater impact on individual and public health than the occasional purchase of products to ease minor and self-limiting ailments which will usually clear up, with or without treatment, in a matter of days. However, the purchase of such products can prove beneficial. Although no item can cure the common cold, for example, some can help moderate its symptoms, allowing people to go about their lives and stay out of GP consultation rooms.

The simple act of taking positive action, such as imbibing a non-prescription medicine, also fosters the positive mindset associated with better recovery and health. More importantly, a drive to improve health literacy will help individuals maintain health-positive behaviour, identify minor symptoms more effectively and choose self care where appropriate, rather than automatically visit their GP. As more educated and wealthier members of society tend to have higher levels of health literacy, health education efforts should be targeted at vulnerable and excluded groups to have the greatest impact. Good habits must also start young, and health literacy should begin in schools and continue through life as family responsibilities develop and circumstances change.

Self care boosts an individual's self-confidence as well as personal control and tends to reduce unnecessary visits to GPs and emergency departments, freeing highly trained professionals to concentrate their resources on more serious cases. While it implies a degree of self-assessment, self care does not preclude visits to the pharmacist for advice or the GP for serious, unexplained or vexatious symptoms. Indeed, by reducing the number of trivial visits, it could mean shorter waiting times and perhaps longer consultations when required.

**Figure 4. Chronic-care pyramid (UK Department of Health, 2005)<sup>44</sup>**



## Factors driving self care

The drive for expanded self care is propelled by the pull of consumer demand, as well as the push to reduce costs for service providers. Growing patient empowerment, rooted in broader access to education and fertilised by information and interactivity online, encourages an increasing percentage of patients to seek active participation in decisions affecting their health and medical treatment.

Consumers inevitably opt for convenience in every aspect of their lives and purchasing decisions, and health is no exception. Many consumers already prefer the convenience of readily available products at pharmacies to treat known conditions to long waits at a busy doctor's surgery. These advantages could be further emphasised to encourage more people to see the pharmacy as their initial resort for minor complaints. The management of chronic and recurrent illness and post-acute rehabilitation is also shifting to community and home solutions to reduce health costs, free hospital beds and improve patient convenience. Many chronic conditions can be appropriately managed through more effective self-monitoring, appropriate self-administered medicine and lifestyle improvement as part of care plans produced in partnership with health professionals.

Treatments for cold sores, hay fever, irritable bowel syndrome, high cholesterol, benign prostatic hyperplasia related urinary symptoms, migraine, heartburn, asthma, eczema and even emergency contraception, which once required a GP consultation and prescription, are all now available without prescription in many countries, and a range of common products could be safely 'switched' to increase their availability and improve health outcomes. Australia still lags behind comparable nations in some cases, and a more liberal scheduling policy and supporting regulatory framework should encourage the rescheduling of medicines from prescription to non-prescription status where medical evidence shows the benefits of greater access clearly outweighing any medical risk.

Media coverage and public health campaigns on the dangers of smoking, poor diet, a sedentary lifestyle and the benefits of exercise also encourage good intentions, although, as previously noted, while smoking continues its long decline, Australia's obesity rates are stubbornly increasing.<sup>45</sup> It is particularly prevalent in communities suffering from deprivation. It disproportionately affects people with other social difficulties such as the poorest socio-economic groups, people in regional and remote areas, Aboriginal citizens and Torres Strait Islanders and those born overseas.<sup>46</sup> Data from the Australian Diabetes, Obesity and Lifestyle study estimates the total direct cost for overweight and obesity in 2005 was \$21 billion with additional indirect costs of \$35.6 billion per annum.<sup>47</sup>

## International comparisons

Although the internal organisation of national health systems varies greatly across the developed world, they all face the same problems of spiralling costs, ageing populations and increasing demand and expectations. The use of OTC medicines is also common around the world, not least because people tend to suffer from the same minor conditions and treat them in similar ways regardless of where they reside.

A review of consumer surveys by the World Self-Medication Industry<sup>48</sup> shows that non-prescription medicines are used widely and responsibly by health consumers in a host of very different countries in remarkably similar ways.

90% of people around the world report some degree of ill health every month, with 50% of maladies running their course untreated or tended with the simplest of home remedies. Another quarter of problems prompt a visit to the doctor or the use of a previous prescription, while the remainder are treated with OTC products. From Singapore to Spain<sup>49</sup>, people suffer the same common ailments with similar frequency. Colds and headaches, digestive problems and aches and pains do not discriminate by nationality, culture or climate. The survey shows that most people use OTC products cautiously, appropriately and are satisfied with their results, believing them as effective as prescription medicines. Most products are used for much shorter periods than ten-day period typically indicated as the maximum. Consumer satisfaction with such products was actually lowest in Australia at 75%, compared to a high of 94% in Mexico. Many consumers wish to see more information about potential side effects on packaging, for example, and the prices paid by Australian consumers – as for many other goods – remain much higher than comparable nations.

The successful use of non-prescription medicines to treat minor problems increases people's confidence in their ability to manage their own health, which in turn can encourage the adoption of healthy lifestyles to maintain long-term wellbeing.

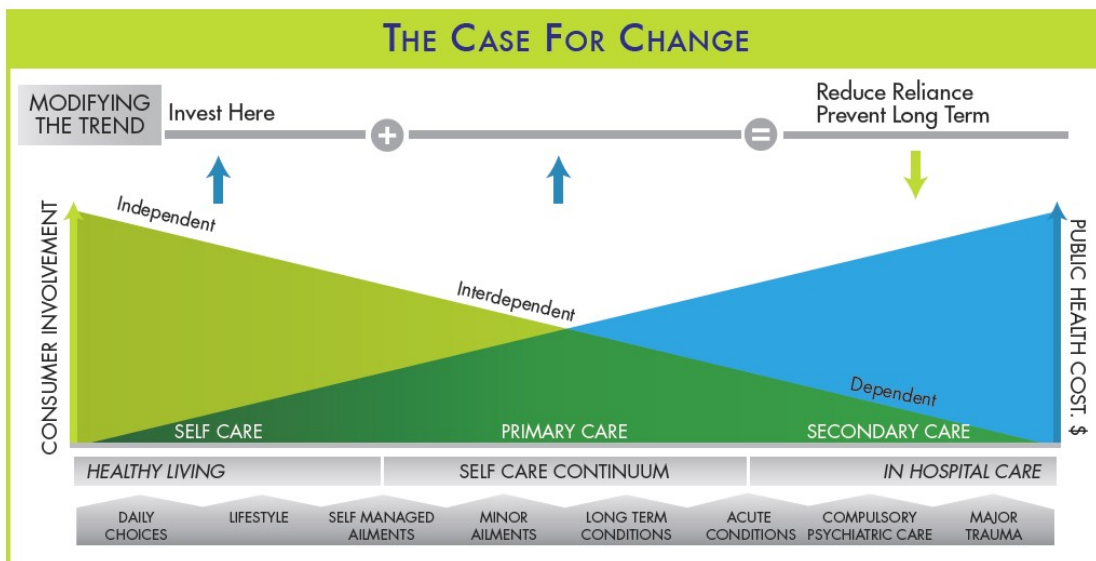
## Health reform and self care in Australia

Structural reform and improvement of services in Australian health care are hampered by its plethora of providers and splintered lines of payment, responsibility and control. Self care is one of the few available strategies which could offer benefits for all stakeholders, and so secure widespread support, rather than promote one interest group at the expense of another.

**Self care can play an important role in the health system, but its encouragement must only be a part of comprehensive health reform.** Although useful and productive in itself, it does not preclude the consideration and adoption of other options to improve the efficiency of Australian health care. Reducing the duplication of services between the Commonwealth and States, structuring insurance rebates to encourage preferred outcomes, prioritising preventive care<sup>50</sup> and identifying and eliminating ineffective procedures<sup>51</sup> must also be vigorously pursued. Non-prescription medicines offer a cost-effective solution to many common minor ailments, but self care should increase the capacity of the health system to deal with more serious conditions, rather than become a convenient excuse to reduce service provision overall, if it is to gain the broad public support it will rely on.

The following diagram published by ASMI in its annual 2012-2013 report summarises the case for change by outlining the self care continuum.

**Figure 5. The Case for Change (ASMI, 2012)<sup>52</sup>**

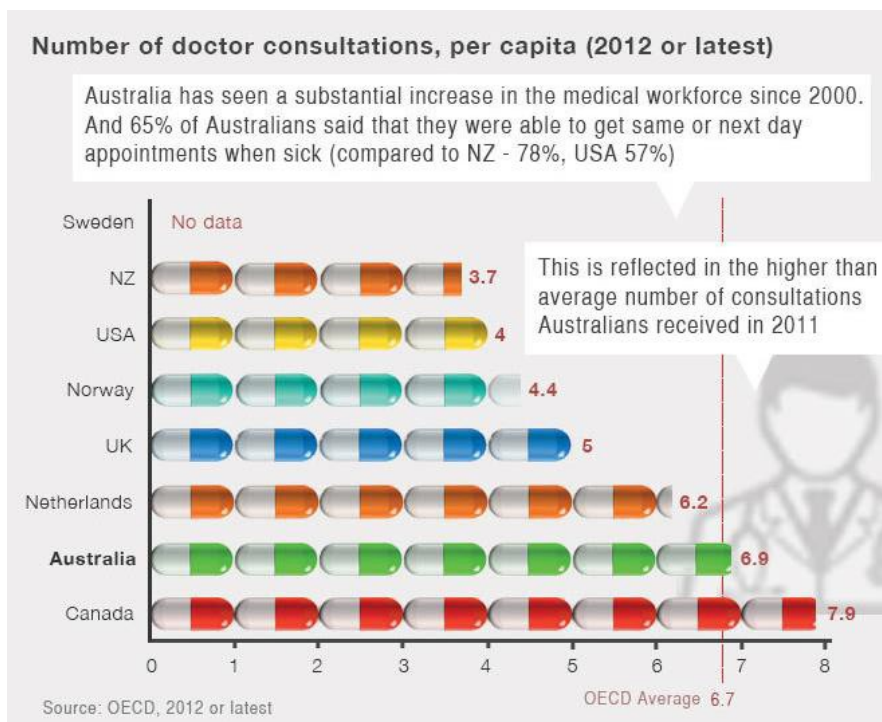


Calls for an expanded role for self care in Australia are not new. The National Health and Hospitals Reform Commission urged the creation of an independent national health promotion and prevention agency to encourage individual and collective responsibility for wellbeing and health in 2009<sup>53</sup>. However, rather than becoming the responsibility of a single agency, self care would best be encouraged by active support from all stakeholders and the general public. The Coalition signaled its acceptance of this argument by disbanding several preventive health bodies created by the previous government and must continue to back its stance with real action. The dissolution of preventive health bodies in the name of cutting costs and red tape can only be justified in health terms if preventive health becomes a central part of every health agency’s remit.

### Economic benefits of increased self care

Australians visit their GPs more often than many comparable nationalities. As a diagram from a recent Grattan Institute article<sup>54</sup> shows, while patients in the Netherlands visited their GP 6.2 times a year in 2012, the British 5 times, the Norwegians 4.4 times, the Americans 4 times and New Zealanders just 3.7 times a year, Australians made an average of 6.9 visits to the consulting rooms.

**Figure 6. Number of doctor consultations per capita (OECD 2012)<sup>55</sup>**



Although the Australian figure is only slightly above the OECD average of 6.7 appointments a year, lower figures in New Zealand and elsewhere demonstrate considerable scope for reducing the number and its associated costs. Norwegians enjoy exemplary health standards, despite visiting their doctor a third less than Australians, and it is New Zealand's health policies, rather than a different set of demographic circumstances, which drives their figure so low. As argued throughout this paper, a greater emphasis on responsible self care and the promotion of the pharmacy as the first port of call for minor conditions would reduce the number of unnecessary GP visits, freeing time and resources to treat more serious conditions and reducing costs and inconvenience for health consumers.

No matter how minor their physical complaint, the habitual entry point for people into the health system is a general practitioner with seven years of rigorous training and possibly decades of practical experience. This inevitably creates bottlenecks in GP surgeries forced to deal with large numbers of minor cases which could more usefully be handled elsewhere or by other health practitioners. Patients and professionals alike would benefit from a modification of this model to allow people with minor complaints to access the system at a simpler level and only escalate to a GP consultation if required after appropriate triage and (ideally) a documented referral. Such a system would be more efficient for both customers and service providers than always entering at the GP's surgery and being filtered up or down as required.

Such a cultural shift would improve consumer convenience and resource efficiency. However, it would also require a fundamental shift in how both consumers and professionals have traditionally viewed the health system. Providers will have to embrace a model in which authority is delegated, and patients accept a situation where a GP consultation is the exception rather than the rule. Both of these cultural shifts are undoubtedly easier to advocate than achieve and would require incentives for both groups to accept.

Improving the health literacy of Australia's population to encourage their use of appropriate self care opportunities and reduce unnecessary visits to health professionals is likely to remain the most efficacious way of delivering substantial change in the immediate future.

Evidence from consumer health studies, including the authoritative Menzies-Nous Australian Health Survey<sup>56</sup>, demonstrates that Australians enjoy accessing pharmacies and trust them to offer appropriate products and advice. The Pharmacy Board of Australia has already taken steps to train pharmacists to undertake a greater role in self care.<sup>57</sup> It



has allowed the Pharmacy Council of Australia to accredit courses training pharmacists to carry out vaccinations, for example, and a certified Advanced Practice Pharmacists' qualification currently under development will acknowledge the shift to self care. The undergraduate curriculum for pharmacists already emphasises the importance of improved communication with customers, and this aspect of the pharmacists role should be further expanded in the future.

A 2008 ASMI report<sup>58</sup> examining the impact of switching the treatment of the ten most frequently encountered minor ailments in general practice to enhanced primary care found it would save \$260 million in Medicare benefits every year and increase Australia's effective GP workforce by 500 to 1,000 full-time equivalent posts - 3% to 7% of the current total.

Several international studies suggest that as many as 25% to 40% of visits to hospital emergency departments are for conditions such as minor pain, gastrointestinal upset, upper respiratory infections and skin problems that could be better managed by the patient's GP, local pharmacy or self care.<sup>59</sup> Younger people and foreign residents unfamiliar with the local health system are particularly prone to presenting with relatively minor problems which should be handled elsewhere, further highlighting the need for improved health literacy and information. People with low levels of health literacy generate above average costs for the health system because they are more likely to use emergency services and be admitted to hospital and less likely to use preventive services and comply with medicines and medical advice.

## Risks of self care

All aspects of medicine incur risks as well as deliver benefits. Although recognising the advantages of consumer empowerment and self care for minor ailments, some doctors fear it might delay people from seeking advice for potentially serious problems. Measures which appear to dissuade people from visiting their GP might further alienate those who feel disconnected from the health service or dishearten people who might use a minor ailment as a catalyst to raise a more serious concern.

While the self-assessment and treatment of many common ailments is comparatively simple, in some cases the symptoms of serious illnesses might be obscured by their treatment by non-prescription medicines, delaying and complicating later care. Incompetent self-medication risks adverse reactions or unforeseen interactions with other medicines, and medicines of any sort are never trivial consumables and should only be used to treat known and specific conditions. 2-3% of hospital admissions already result from problems caused by the side effects or misuse of prescribed medicines, for example, and 10% of consumers have visited their GP with such a problem over a six months period in 2012 (Australian Commission on Safety and Quality in Health Care)<sup>60</sup>. **The importance of partnership and communication between consumers and health professionals must therefore be underlined and emphasised in any drive for self care.**

Pharmacists and other health groups, including GPs and consumer groups, have raised concerns about non-prescription medicines being available from non-pharmacy outlets where limited or no counselling in their use is available. While medicines may be exempt from scheduling and available in small pack sizes from a supermarket, there are no controls regarding how many packs a consumer may purchase, or risk management beyond the information printed on the pack. By comparison, the majority of community pharmacists are accredited under the Pharmacy Guild of Australia's Quality Care Pharmacy Program which mandates pharmacy assistant training for S2 and S3 medicines and reflects other requirements expected of the profession through professional standards developed by the Pharmaceutical Society of Australia.

The valuable role pharmacists could play in identifying potentially serious health issues and risks among their customers should be emphasised. As more medicines are released from prescription status, the performance of pharmacies should be critically appraised and the sector must continually improve its performance in supplying these medicines and supporting self care. There are many examples of the pharmaceutical industry working with the pharmacy sector on protocols for Schedule 3 Medicines and

providing training and information resources, and these links should continue to strengthen. It is important that sponsors of medicines work closely with the pharmacy profession when a medicine is switched from Schedule 4 to Schedule 3 status to ensure the pharmacy sector is prepared and resourced for the appropriate use of the newly switched medicine.

Pharmacists have both legal and professional responsibilities they must exercise when supplying any medicine, particularly in regards to Schedule 3. However, according to consumer surveys<sup>61</sup>, many customers resent being questioned about their use or circumstances by a pharmacist when asking for a product by name, so there are risks in balancing the pharmacist's professional and legal responsibilities with consumer expectations when requesting non-prescription medicines. This problem could be ameliorated by ensuring regulations are practical, supporting pharmacists with decision-making platforms such as GuildCare<sup>62</sup>, and raising consumer awareness of the pharmacist's responsibilities and their importance for consumer safety. The latter can in part be achieved by improving consumer awareness of the nature of Schedule 3 medicines and the reasons behind their control.

There is also a risk that more vulnerable population groups may not know where else to seek assistance for their health problems and so attend GPs or even emergency departments as the first port of call for any minor conditions. Clinicians may also need access to interpreter services so they can assist people from culturally and linguistically diverse (CALD) backgrounds. Pharmacists can access free interpreter services for PBS-related matters<sup>63</sup>, but not for other primary care activities. This should be ameliorated by extending this service for any primary health care matter.

Schedule 2 and unscheduled medicines can be advertised, but the promotion of most Schedule 3 medicines is prohibited. Advertising can be useful in promoting consumer awareness that treatments are available for certain health conditions, but there are genuine concerns that it can also promote inappropriate use or overconsumption. Information about the advertising of medicines can be found on the TGA website<sup>64</sup>, while Consumers Health Forum of Australia has produced fact sheets to help raise awareness regarding health advertising online<sup>65</sup>.

# 3 The Importance of Health Literacy

## What is health literacy?

The WHO defines health literacy as “the cognitive and social skills and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health”.<sup>66</sup> The Organization values it as “an essential life skill” which “helps people take control of their lives”. Health literacy helps individuals and families adopt healthy lifestyles, avoid disease and injury, make appropriate health decisions and navigate the health system successfully. Building health literacy improves public as well as individual health outcomes, as peer pressure encourages healthy habits and mass vaccination creates herd immunity for the small minority of people unable to be immunised. By building social capital and maintaining capacity and activity, it allows more people to work, providing important social and economic benefits as well.

Governments can take decisive and effective action on public health, and health literacy plays a vital role in supporting and winning public acceptance of such measures.

Australia’s health system is highly complex, with a plethora of service options, and the range of medical and complementary treatments offered to consumers continues to expand. Improvements in general health literacy, in combination with specific advice from health professionals, are therefore required to reduce the risk of consumers making the wrong decisions about their care. While there can never be absolute certainty of outcomes in health, health literacy improves an individual’s prospects of success and their ability to understand and act upon the expert advice they receive.

As the WHO definition acknowledges, health literacy also empowers citizens to navigate their country’s health system, as well as maintain their own long-term wellbeing and self-treat minor conditions. The ability to understand and use the system is particularly important in Australia, given its complex systems of care.

As well as improving the ability of consumers with more serious conditions to access the specialised care they require, better health literacy will encourage the public to recognise and successfully treat a host of common and essentially minor and self-limiting

complaints themselves. Many of these require little or no formal medical intervention, but are often the source of time consuming and expensive visits to GPs and even hospital emergency departments. Most cases of recurrent allergies, athlete's foot, bites and stings, cold and flu-like symptoms, conjunctivitis, constipation, cystitis, diarrhoea, head lice, indigestion/heartburn, mouth ulcers, warts and verrucae can be treated at home with products supplied by pharmacies or, in the case of listed medicines, supermarkets and other retail outlets.

Health literacy also encourages the adoption of healthy lifestyles and habits including regular exercise, balanced nutrition and the relief of stress. These are important for children as well as adults as norms and habits secured in childhood tend to be maintained in later life. A major Europe-wide survey<sup>67</sup> found people reporting a range of benefits from lifestyle improvements, including better health outcomes, a strengthened immune system and reduced stress and weight. Other perceived benefits include a reduction in metabolic risk factors, better sleeping habits and fewer minor aches and pains.

Greater consumer engagement should be supported by professionals and replace outdated assumptions of passivity and deference as self care is accepted as an integral part of the health system. Information should flow freely between consumers and health professionals to maximise health outcomes, and between health bodies and government to encourage ongoing systemic change.

Furthermore, health professionals need the skills to detect when consumers are struggling to understand and act on health information, and the ability to better address their specific needs. A study undertaken as part of the Fifth Community Pharmacy Agreement to investigate the capacity of community pharmacies to manage consumers' health literacy needs promoted the use of 'universal precautions', whereby limited health literacy is assumed until (or unless) the pharmacy staff member detects cues or clues of higher-level engagement.<sup>68</sup>

Health literacy is not achieved by the mere presentation of accurate information, necessary though that is. Many consumers struggle to understand important technical information about doses, drug interactions or side effects if it is not presented in a user-friendly manner. More fundamentally, many people lack the critical skills required to differentiate between trustworthy and unsubstantiated or actively dangerous advice gleaned from friends, fringe practitioners or the internet. Other consumers feel swamped with information when they search for it, with the flood of data overwhelming their ability to comprehend it. Any number of traditional and alternative remedies compete with evidence-based medical science for their attention, and doctors and

pharmacists must help people navigate through the dense and confusing jungle of claim and counter-claim to find the solution which best suits their needs.

If pharmacists are to play a greater role as the initial health professional a consumer may see in a system of extended self care, they must become more proactive in providing advice on treatment options, possible medicine interactions and other aspects of care. The Pharmacy Guild of Australia has already called for community pharmacies to offer standardised, accredited health literacy programmes and underlines the importance of the QUM (Quality Use of Medicines) in regard to prescription, as well as non-prescription medicines.

Encouraging greater self care should not require extra expenditure if improved health literacy motivates individuals from within. Every Australian practises some form of self care every day to a greater or less extent. The question is how to improve their access to the knowledge and skills they require to do so most effectively.

Knowledge itself is not a guarantee of changed behaviour. Everyone knows the dangers of tobacco, but around 20% of men and 15% of women still smoke regularly and young people exposed to anti-smoking information all their lives still start smoking every day. Although the imposition or increase of price signals through taxes on harmful goods or co-payments for subsequent treatment always have an effect, people might be given a greater sense of control over their own actions, and therefore motivation to change and succeed, through more imaginative strategies, including gamification, prompts and self-documentation by mobile apps and devices, scheduling services or the ability to use their health care record as a tool.

More research has been conducted on relatively small cohorts of consumers self-managing a specific and serious disease, than into the much broader, if less easy to quantify, economic, social and medical effects of everyday self care. However, people who do not take care of their own general health are not only more likely to suffer a range of serious acute and chronic conditions in later life, but might be less likely to stick to restrictive management plans after a lifetime of bad habits.

The Department of Health worked with the Consumers Health Forum of Australia and Arthritis Victoria to agree to pursue a self-management model developed at Stanford by Professor Kate Lorig<sup>69</sup> for people with chronic illnesses. This programme aims to identify and train appropriate disseminators of health literacy in the community and could be usefully expanded.

## Factors affecting health literacy and self care

While public health campaigns have long targeted traditional public health issues such as smoking, there have been fewer such efforts to encourage self care around the world. The Epposi Self Care Barometer<sup>70</sup>, a biannual survey of consumer attitudes to self care in Europe, finds that while most people clearly understand the need to maintain health through diet, exercise and hygiene, they are less likely to embrace self-medication. Fewer still see self care as a partnership with health professionals, and the lowest proportion of all accept it as learned behaviour conducive to improvement, particularly in cultures where family traditions are strong. While the overwhelming majority of people accept a responsibility to care for their own health, less than one in five surveyed feel 'very confident' about their ability to do so. Better health literacy tends to boost the confidence required to make such decisions, and therefore the ability to self care, although higher levels of knowledge do not in themselves reduce the number of visits to GPs. Health literacy requires not only the provision of information, but also the development of people's functional, interactive and critical skills to allow them to understand, assess and act on that information effectively.<sup>71</sup>

A 2006 study of Australian health literacy by the Australian Bureau of Statistics<sup>72</sup> found that only 41% of Australian adults demonstrate adequate or better than adequate health skills - including the ability to combine information in text and a graph to calculate a product's safety.<sup>73</sup> These levels were lower than for other forms of literacy – which were also worryingly limited – perhaps because health literacy requires a combination of prose, document and numeracy skills. Almost a fifth of adults exhibited Level 1 skills – the lowest level – with just 40% reaching level 2. These people would struggle to find information on a medicine container regarding the maximum duration of treatment, or correct dose for a child. Surveys in Canada, the USA and the UK reveal a similar paucity of abilities.

People with limited health literacy are more prone to missing appointments with GPs or recommended medical tests. They are less able to maintain a long-term medicine regimen for chronic conditions, such as high blood pressure or diabetes, and less inclined to act on health advice. They also make more errors with their intake of medicines and practise self care less effectively.<sup>74</sup> Limited health literacy can therefore demonstrably degrade people's whole lives, as well as their immediate health status, and the consequences can weigh heavy on those around them. Limited e-health literacy can also compromise one's health care, and many consumers would require assistance to effectively navigate and apply online health information.<sup>75</sup>

A person's ability to care for themselves and their loved ones, maintain a healthy lifestyle, self-treat minor conditions and actively engage in the management of chronic complaints is influenced by their cultural, economic and social background as well as their individual choices. Specific factors include gender, age, self-reported health, education, working status, income, first language and place of birth.

Health information must therefore be culturally and linguistically appropriate to improve patient knowledge and challenge misconceptions effectively. Pharmacies are again playing an active role in this area and steps to improve Australian pharmacy training and practice are already underway. As part of the Fifth Community Pharmacy Agreement Research and Development Program, for example, the Health Literacy Research Project (HeLP)<sup>76</sup> will design an innovative, accessible, manageable and evidence-based education package in health literacy for community pharmacies.

## **Demographic and social factors**

A range of demographic and social factors influence health literacy and must be acknowledged and addressed in the promotion of health literacy and self care to the general public. There are no 'one size fits all' solutions, and public health campaigns may prove more effective when targeted at specific groups.

### **Gender**

Women tend to assume greater responsibility for the health of their children and relatives and are therefore the main conduit for health promotion within communities. Their focus on caring for others can come at the price of the attention they pay to their own health, however, with females less likely to appreciate their risk of cardiac disease, for example, despite several female-centric public heart health campaigns. Indeed most high-profile health campaigns are aimed at women – breast cancer has a far higher public profile than prostate cancer, for example – even for problems where men are more likely to suffer ill health. More men than women are overweight, but diet and wellbeing messages are predominantly aimed at women, particularly if commercial in nature, as women are much more likely to make purchasing decisions of relevant goods.



## **Age**

Health literacy improves with maturity for young men and women before declining again in old age.<sup>77</sup> Only a third of teenagers between 15 and 19 are adequately health literate, while around half of 20 to 49 year olds reach an acceptable standard. The ebbing of health literacy in older age groups may be associated with a decline in mental acuity, less exposure to or interest in new medical developments, the length of time since leaving school and the fewer years of formal education commonly completed by older generations. The impact of this decline is exacerbated by the much higher rates of long-term health complaints among older people requiring combined medicine. The 2007–2008 National Health Survey found that 83% of people over 65 lived with three or more long-term health conditions.

## **Self-reported health**

Reported self-assessment of health tends to mirror actual health standards. 8.3 million Australian adults considered their health very good or excellent in 2006<sup>78</sup>, while 4.4 million described it as good and 2.4 million thought it fair or poor. Self-reported health is also positively associated with objectively measured levels of health literacy. Almost half (48%) of those who felt in excellent or very good health exhibited adequate or better health skills, compared to just a quarter of those who felt their health poor. People with limited health literacy are more likely to suffer from chronic conditions and less likely to manage them effectively.

## **Education**

People with higher levels of education tend to enjoy better standards of health, not least because academic qualifications tend to secure more highly paid and less physically arduous employment which in turn pays for better housing and food. More educated people tend to be more willing to seek out and use health information, while higher incomes allow the purchase of more health services, particularly dentistry, to successfully treat problems at an early stage. Three quarters of people holding Bachelor or further degrees have adequate or better health literacy, compared to half of those who finished education in year 12 and just 16% of those who left in year 10 or earlier. People with degrees but low income had near average levels of health literacy (48%), but just 39% of low-income earners who had left school in year 12 and 12% who left in year 10 or before demonstrated adequate health skills.<sup>79</sup>

### ***Working status***

People in employment tend to exhibit higher health literacy than the unemployed or those outside the labour market. 47% had adequate or better health literacy compared to a quarter of those without work, although workers also tend to have higher educational attainment and income than non-working people. 71% of professionals displayed higher levels of health literacy, compared to less than a quarter of labourers.<sup>80</sup>

### ***Income***

63% of high-income Australian earners enjoyed adequate or better health literacy in 2006, compared to 43% on middle incomes and just a quarter of the low-income group. A National Consumer Council survey in the UK in 2005 found that poorer people were less likely to ask their GPs questions or seek out information for themselves. 45% of people in the highest social groups questioned their GP, compared to 35% of people in lower socioeconomic groups while 39% of wealthier people searched the internet for health information compared to 16% in lower socioeconomic groups.<sup>81</sup>

### ***First language and overseas birth***

People with a first language other than English can struggle to understand health and drug information in Australia. Almost 3 million Australians used English as a second language in 2006, and figures from the 2011 census show that almost a quarter of Australian households speak another language at times during the day. Only a quarter of people with English as a second language demonstrated adequate health literacy in 2006, compared to 44% for whom English was their mother tongue. Just 5% of those with adequate or better health literacy needed help to read information in English, compared with 19% of people with poorer health skills. Only a third of people born overseas had adequate or better health literacy when tested in English, compared to 43% of native born Australians.<sup>82</sup>

Efforts to improve the health of recent migrants from diverse cultural backgrounds demand the understanding of cultural contexts and the building of two-way communication, reciprocal learning and trust. The engagement of whole families and entire migrant communities, rather than individuals alone, is important, as language barriers are not the sole issue to overcome. There is little point in teaching children about better nutrition at school if their families are not engaged at home, and maternity services for migrant women must involve their partners and families where traditional practices and peer pressure remain strong.

### ***Regional variations***

While Australian states exhibit relatively similar levels of health literacy, 56% of people living in the ACT have adequate or higher levels, compared to just 40% in the Northern Territory. These figures closely correlate with post-school educational attainment.<sup>83</sup>

### ***Medical conditions amenable to self care***

Even though many treatments for common ailments are available without a prescription or guidance from a health care professional, their use should remain consistent with the principles of QUM. These guidelines underline the need for effective communication between consumers and health professionals such as pharmacists and GPs, to ensure that people are fully informed about the medicines they are taking. QUM dictates that a medicine should only be used after consideration of all other options and after appraisal of its risks and benefits, length of treatment and cost. Medicines must be used safely and offer quantifiable benefit to health and quality of life. QUM, like self care, is person-centred, and its tenets are all the more important when consumers are acting independently or with the minimum of supervision from qualified professionals.

Many common ailments are amenable to self care and can benefit from the use of non-prescription medicines. These include occasional back pain, sprains, strains, colds, coldsores, conjunctivitis, constipation, coughs, diarrhoea, mild earache, haemorrhoids, hay fever, head lice, headache, heartburn and indigestion, infantile colic and insect bites and stings. Other suitable minor conditions include eczema and dermatitis, athlete's foot, fungal nail infections, mouth ulcers, nappy rash, sore throat, teething, threadworm, thrush, warts, flu, cradle cap, period pain, migraine, muscular pain, dandruff, psoriasis, gingivitis, travel sickness, acne, nasal congestion and cystitis. Evidence-based treatments can help reduce symptoms or eradicate the problem entirely, although many minor ailments are self-limiting and would heal without medical intervention of any kind.

Evidence-based OTC treatments for a range of common ailments are available and, in most instances, people could use these options rather than visit their GP. Whatever the ailment, if symptoms persist, deteriorate or threaten vulnerable people such as the very old, the very young or those suffering from other serious conditions, a GP's advice should be sought without delay.

## Initiatives to improve health literacy

Limited health literacy is a global, as well as Australian, problem. The Agency for Healthcare Research and Quality Report estimates that only 12% of Americans have proficient health literacy, for example, costing the US economy US\$200 billion a year. Recent Australian figures suggest that 56% of Australian adults have limited health literacy, with this figure increasing to 80% of the over 65s and 96% of adults from diverse cultural and language backgrounds.<sup>84</sup>

Many factors affect health literacy, as noted above, and low levels exhibited by any individual can be a transient as well as permanent experience. Language literacy itself is important, but other factors such as illness, stress, pressure and anxiety can also affect it. Education is positively correlated with health literacy, but even highly educated people may experience a lack of situational literacy when faced with a professional – be they a doctor, mechanic, accountant or lawyer – in a field they are not conversant with and find themselves entirely reliant on that person's judgement of their affairs.

The consequences of poor health literacy can be serious and acute as well as long-term and debilitating. People with limited health literacy may take potent medicines incorrectly, misinterpret labels and health messages and fail to provide relevant information when relating their clinical history to health professionals. They may miss out on entitlements and tend not to participate in decision making about their own health care. They are not able to navigate the health system effectively and may suffer shame and embarrassment in doing so. All these factors can degrade health outcomes and their ability to contribute to the economy, society and their families.

The positive results of the emerging health literacy initiatives such as the Murrumbidgee Medicare Local health literacy action plan<sup>85</sup> show how incorporating health literacy principles in the day-to-day practice of primary healthcare professionals and their ongoing engagement with consumers can make a difference to the health outcomes of Australians.

# 4 Consumer Decision Making

## How consumers view their health

Given that the symptoms and minor ailments suffered by consumers vary little around the developed world and their use of non-prescription medicines tends to be the same, a summary by the Proprietary Association of Great Britain<sup>86</sup> of consumer attitudes and OTC consumption can usefully be applied to the Australian experience. In line with other research, it notes that while most consumers consider themselves in good health (71% in the survey), and expect to remain healthy in the future (65%), wealthier people report better health and outlook than those in lower socioeconomic groups. Poorer people are less healthy, have lower health expectations and tend to feel their health is beyond their control. People overwhelmingly believe they are responsible for their own health (88%), and half agree they should do more to improve their health, but almost a third claim to be too busy to look after themselves better.

The most common problems people incurred include colds and headaches (each suffered by 66% of people in the previous year), tiredness (61%), muscular aches and pains (58%), minor cuts and grazes (51%), bruises (49%), upset stomach (45%), indigestion (43%), joint stiffness and back problems (38%), while sleep problems and anxiety are growing concerns. Many of these issues, and others such as cold sores, are not treated by any purchased medicine, although OTC products are available to at least alleviate their symptoms.

Many problems of a seemingly vague or intractable nature are left to their own devices. 90% of men with thinning hair took no action about it, while 88% cases of bruises, 79% of tiredness, 69% of times when people felt low and depressed, 66% incidences of stress and anxiety and 61% of sleeping problems also went untreated. By contrast, only 19% of cases of heartburn or allergies, 16% of eczema and headache, 12% of flu, 11% of migraine and 9% of asthma cases passed without medicine. Such maladies tend to have more severe and immediate symptoms, demanding attempts at relief, and have popular and well known non-prescription treatments.

More people use a 'home remedy' than buy a new OTC product, and seldom consult a pharmacist for advice, although most adults agree that pharmacists are a good source of information. 70% of people decide for themselves how serious or trivial their problem may be, with 12% going to the doctor, 11% consulted friends or family and just 6% asked their pharmacist for their opinion. Despite this lower figure, pharmacists are seen as a trusted source of medical information by over 90% of health consumers, although pharmacy assistants are trusted by only slightly over half the population. Significantly, over 70% of customer conversations in a pharmacy are dealt with solely by assistants, with only a third involving a fully qualified pharmacist. Only 2.5% of people ask to speak to a pharmacist directly, with 67% of consumers asking for a product instead. Just 7% of minor eye problems, 6% of flu and mouth ulcers, 5% of cold sores and 4% of cold, sinus or catarrh problems prompted consumers to seek advice from pharmacy staff.<sup>87</sup>

A mere 11% of people reported seeking advice from a pharmacist about any problem at all, and just 2% had sought advice about available tests. Despite this, 60% of people would like to receive more advice from pharmacists, although almost a quarter of consumers express irritation when questioned about their purchase if they have asked for a product by name. Two thirds of pharmacy consumers are female, emphasising the responsibility women often shoulder for family health.

The more serious and long-lasting a condition, the more likely a doctor's help will be sought, but even OTC purchases are typically made in a state of relative distress in the hope of immediate relief from pain or irritation. The single exception to this is the purchase of analgesic pain relievers, which are typically planned purchases after stocks run low at home, rather than purchased to eliminate a specific pain immediately.

The 'top 20' ailments most often treated with non-prescription medicines are, in descending order of incidence from around 90% to 50%, dry or chapped lips, dandruff, athlete's foot, headache, period pain, cold sores, colds, coughs, mouth ulcers, hangovers, sore throats, indigestion, flu, diarrhoea, haemorrhoids, migraine, stomach ache, wind, nasal congestion and muscle pain. Over 80% of consumers report using painkillers for headaches, almost 60% use cold and flu symptom relievers, just over 40% take vitamins, 40% use indigestion remedies, 36% use cough mixtures, just over 20% use muscle or rheumatism remedies and 10% take laxatives and various salts.

Approaching 90% of consumers bought pain killers and cold remedies in the previous year, with nearly 60% purchasing vitamins and just over 50% buying skin products. Other OTC products were bought by less than a third of consumers, with most products bought by less than 10%. Around 10% of the population also use alternative therapies on a regular basis. Nine in ten OTC products are seen as being somewhat or very effective, with over 90% being bought again to solve the same problem when it reoccurs.

Factors motivating consumer buying decisions include their own experience with the specific product (46%), a relative's advice (19%), a doctor's or dentist's suggestion (14%), the well-known nature of the brand (11%), a pharmacist's recommendation (10%) and advertising (6%). Printed information on packaging, in-store displays, media coverage and previous experience with a prescription account for just 1% to 3% of a consumer's purchasing decisions. Given that most OTC purchases are made in distress to cure an immediate problem, consumers tend to stick to habitual brands<sup>88</sup>; building a small 'portfolio' of remedies they know will work for them and which are bought or asked for automatically. The most commonly purchased products – pain killers and cold relievers – are also those for which least advice is sought. Nearly two thirds of purchases are repeat purchases<sup>89</sup> – mirroring the incidence of self-selection. However, a recommendation from a pharmacist is seen as more important when buying a product for the first time.

Parents report that children suffer from more ailments than adults, with 32% of children suffering minor cuts, grazes or bruises, 24% catching a cold, 15% suffering a headache, 13% an upset stomach, 11% tiredness, 10% sickness, cough or skin problems and 15% having other problems in a week. While most of these issues were left to clear up without treatment, 22% were treated with an OTC medicine already in the house. Childhood ailments were slightly less likely to provoke a trip to the pharmacy, doctor or home remedy shelf than adult illnesses.

Around 80% of people agree with the importance of having access to treatments for minor problems, although fewer than 60% think it useful to have access to 'stronger' medicines without a prescription. This may be because 60% of people do not feel confident in using such products without medical advice, and only 70% of people feel confident about choosing the right product to treat minor maladies. While almost 70% of people agree that for some health problems non-prescription medicines are just as effective as those prescribed by a doctor, only 38% see them as good value for money. Reasons for buying from a particular pharmacy range from its convenience, a relationship of trust with the pharmacist, particularly in rural areas, low prices, discounts, range of goods and the nature of impulse buys when filling a prescription.

## Consumer decision making

Proposals to reform health care all too often concentrate on improving productivity, cutting costs or reducing absenteeism, rather than actually improving health outcomes, and so fail to generate the public support they ultimately depend upon for success. The impact of self care and OTC medicines is harder to quantify than a single procedure in a small and controlled setting, but its broader nature speaks to its importance to general health reform. The problem to be solved is not the long-established system of local GPs serving their local population, but rather the use the public makes of them. Generations have been raised to regard the family doctor as the first contact with the health system, and the need in most minor cases, as previously outlined, is to turn that focus to the pharmacy.

To ensure that people gain the greatest benefit from non-prescription medicines through appropriate choice, purchase and consumption, consumer decision making inside the pharmacy must be better understood. As personalised medicine makes inroads into 'one size fits all' systems, understanding the motivations and catalysts of purchase decisions will not only affect marketing, but also help consumers buy a safe and affordable product they actually need. The public's enthusiasm for self care will quickly wane if they find themselves pressured into purchasing expensive treatments with little or no demonstrable benefit to their general health or specific condition.

## New research into consumer segmentation

ASMI and Macquarie University are collaborating on research into the current and future impact of self care on the Australian health care system.<sup>90</sup> Initial work by Professor Scott Koslow and his team is examining consumer decision making and the management of conflicting consumer segment needs.<sup>91</sup> Further work may employ everything from eye tracking technology to analyse how consumers scan a range of products on a shelf before making their choice, to the detailed analysis of advertising, information and distractions in the retail environment. This behavioural approach relies on the observation of real-world activity in the belief that environmental factors are key determinants of human choices and outcomes. Such research should lead to the development of more effective health literacy campaigns and self care decisions, as well as commercial marketing campaigns.



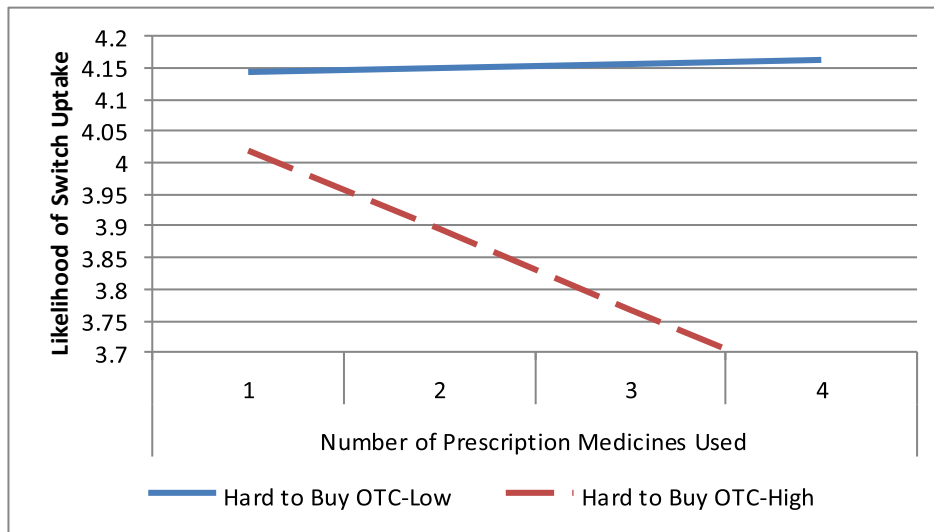
The TGA regulates therapeutic goods (medicines and medical devices) to ensure public health and safety. However, different groups of people, segmented by their attitudes, knowledge and behavior, rather than broad demographic or social categories, use products in very different ways. Some will misuse commonly available products, while others would use currently restricted medicines safely and responsibly. The needs of diverse consumer groups inevitably conflict as a result and will respond differently to policy proposals.

Professor Koslow analysed a representative sample of 1,146 Australian consumers and their use of OTC products in December 2013 to assess the potential impact of expanding consumer access to a number of currently restricted scheduled medicines. His survey recorded the cohort's use of existing OTC products, their prescription only alternatives, their use of 11 common prescription medicines and, finally their consumption of vitamins and attitudes to OTC products in general. The results were factor analysed and subjected to cluster analysis to produce coherent consumer segments, which were then profiled and named. **The research identified nine different consumer groupings, which are outlined in the Attachments.**

Segmenting consumers by use and attitude, rather than broad demographics, allows for a more realistic modelling of the impact of changes to medicine policy. The identification of these consumer segments highlights the need for health education to recognise and account for the different needs and attitudes of groups defined by their behavior, as well as gender, age, income or culture.

The respondents were also asked to estimate how many GP visits they would save if the 11 commonly prescribed medicines under consideration were rescheduled to Schedule 3. The more likely they were to use such medicines, the more visits to the GP they would save.

**Figure 7**



When respondents consider OTC medicines relatively simply to purchase, the likelihood of switch uptake is consistently high; however, when respondents find purchasing OTC medicines more difficult, the likelihood of switching falls.

**Figure 8**

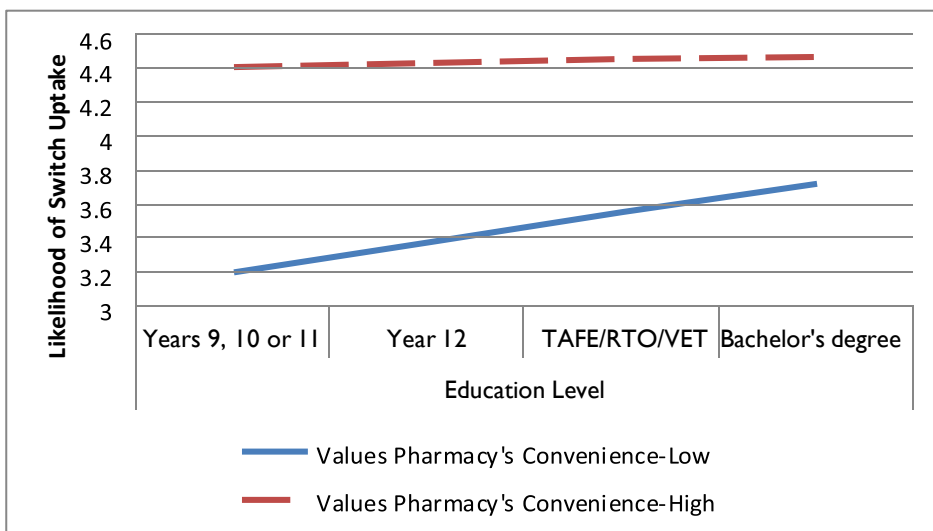


Figure 8 outlines the relationship between a consumer’s valuation of the convenience of pharmacy-only availability and their education. When the respondent values convenience, their switch uptake is reasonably high regardless of their schooling, but if respondents do not value convenience, then higher education leads to a greater anticipated switch uptake.

**Figure 9**

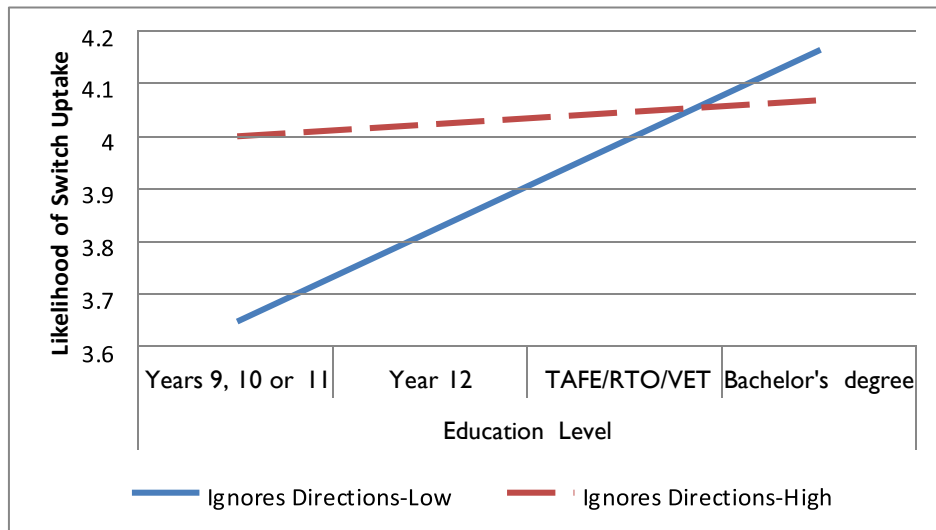


Figure 9 delineates the relationship between levels of education, the likelihood of ignoring medicinal instructions and the willingness of the consumer to buy switched medicines from the pharmacy.

Given the overriding importance of public safety, drug scheduling is often set to cater for the lowest common denominator of health literacy and personal responsibility. If a small proportion of the public might ignore dosage warnings to a dangerous degree, then policy is forced to restrict access for all, despite the inconvenience that causes the majority. Unfortunately, consumers who knowingly misuse medicines can display great ingenuity in circumventing measures put in place to protect people acting in good faith from harm. Restrictive policies may therefore inconvenience the majority without limiting abuse by that small minority. Although apparently minor, the costs of reduced availability can become significant when aggregated across the whole system and assessed for their full social, economic and medical impact. The ancient ethos of *Primum non nocere* is more complicated than it may first appear.

# 5 Towards Responsible Self Care in Australia

## Encouraging supported self care and health literacy

'Taking responsibility' was a major theme of the 2009 National Health and Hospitals Reform Commission Report<sup>92</sup>. The Commission called for action to improve Australian health literacy, which in turn should encourage greater self-care.

Personal confidence and capability in health matters can be strengthened through a range of strategies, including the provision of appropriate and accessible information on general health and specific issues, the development of individual care plans for chronic problems with health professionals, and the encouragement of supportive peer networks and local health programmes. It can range from the teaching of first aid and hygiene to children in schools to the creation of websites and the provision of sophisticated physical and online self-diagnostic tools and monitoring devices.

Supported self care can also reduce the incidence of acute problems for vulnerable people, such as falls and strokes in the elderly. Information on self care should also be given to patients discharged from hospital as part of their care plan to maximise recovery and minimise rates of re-admission. Above all, improved health literacy demands a change of attitudes from the public and health professionals alike. Rather than dispensing health advice to passive recipients, health professionals must accept the importance of partnership and two-way communication to ensure understanding and long-term improvement for their clients, while patients must assume a greater responsibility in maintaining good health and positive lifestyles.

The importance of improving Australian health literacy is acknowledged in the Australian Safety and Quality Framework for Health Care, the Australian Safety and Quality Goals for Health Care, and the National Safety and Quality Health Service Standards. The Framework argues that health care be consumer-centred, organised for safety and driven by information and therefore target the improvement of health literacy. The Safety and Quality Goals encourage partnership between consumers and professionals and the reduction of barriers to good health.

The Australian Commission on Safety and Quality in Health Care acknowledges that health literacy is a product of complex interplay between individuals, communities, health professionals, the media and the wider health system. In 2011-2012, it produced a Health Literacy Stocktake<sup>93</sup> to document initiatives by health services and organisations. These included a wide range of professional bodies and member groups, consumer groups, government agencies, safety and quality advisories, local government departments, educational bodies, research groups and universities. It received 66 submissions detailing 229 projects, mostly at the health service level. These projects targeted health workers as well as the general public and specific population groups, with a particular focus on producing health material for Australia's increasingly diverse cultural and linguistic populations. While traditional efforts have focused on increasing health literacy through the provision of information for individuals, more focus is now placed on examining and reducing the level of health literacy customers require to navigate the health system successfully.

The stocktake identified six broad types of initiatives – broad policy or framework approaches (4% of the total), the development of tailored health information (47%), the improvement of individual skills (14%), the reduction of health service barriers (7%), workforce training (7%) and research and knowledge sharing (21%) – although many of the projects touched on several of these.

The media produced by these initiatives varied, from fact sheets, DVDs and web-based resources to health promotion campaigns using the radio, internet and other forms. Many of these took a multicultural, multilingual approach to reach communities which previous health information campaigns had failed to service, or tailored material for people with intellectual or other disabilities. Individual projects noted the importance of focus-testing material with target audiences, ensuring that content was culturally relevant and checking with native speakers that translations were accurate. The training of community spokespeople to speak to the media was also emphasised. Education programmes included the inclusion of health literacy into school curricula, self-management programs for people with chronic disease and the creation of telephone and other support services. The projects spanned a wide range of issues. One local council, for example, ran a heatwave awareness programme to reduce the health risks of hot weather.

The stocktake highlighted the scope and variety of activity currently underway to improve Australian health literacy, and lessons should be learned from specific projects to improve its delivery overall. Acknowledging the importance of children of all backgrounds adopting healthy habits at an early stage, for example, the Department of

Health provides a 'Get Set 4 Life – Habits for Healthy Kids Guide'<sup>94</sup> which offers practical information on children's health and offers tips and techniques for teaching healthy habits which should last a lifetime. It covers healthy eating, regular exercise, speech and language, dental health and other issues and has been translated into six community languages - Arabic, Traditional Chinese, Greek, Italian, Spanish, and Vietnamese.

Life Education<sup>95</sup> is an Australian health and drug education provider for school children aged 5-13 years and offers another example of practice which could be more widely engaged. Life Education rolled out the Medicine Matters program to students aged 8 to 11 to develop the social skills and knowledge required for effective decision-making, communication, negotiation, peer resistance and refusal in illicit drug related situations.

The development of health literacy must begin in childhood, at home and in school, and continue to evolve through old age. It is dynamic, rather than static, as its components and purposes are constantly in flux. It is therefore the responsibility of government at all levels, public health agencies, the health system and health professionals, the media, insurers, and civic and voluntary groups as well as the individual. Such bodies can at least ensure that necessary information is presented in an intelligible manner. Health information should use simple language and terms, break complex information into comprehensible pieces and emphasise the most important points first. Information must not 'preach to the choir', but reach out to those estranged from the system and offer relevant incentives for improved behaviour.

#### *International activity to improve health literacy*

Steps to measure and improve health literacy are well underway in most western countries, including the USA<sup>96</sup>, Great Britain and Canada, as well as Australia.

Given the plethora of dubious health advice on the internet, for example, the British National Health System (NHS) encourages health literacy through its NHS Choices program. This online service includes advice and interactive tools to help people lose weight, get fit, stop smoking, reduce alcohol consumption and eat healthily, as well as tips on common diseases. The NHS direct website and phone line offer clinically approved help and advice 24 hours a day, 7 days a week, while a new 111 service summons non-emergency help in several regions as an alternative to the emergency 999 line. The 'Choose Well' scheme uses a colour coded 'thermometer' to help people assess the

severity of their symptoms when issues arise and the appropriate action or service required. Evaluation of the UK Expert Patient Programme<sup>97</sup> has also demonstrated the effectiveness of improved health literacy and self care in improving health outcomes and reducing reliance on health services for those with chronic conditions. Most reviews inevitably focus on the short-term effects of education programmes, and, although these have demonstrated their effectiveness<sup>98</sup>, more work must be done on the long-term effects of self care and health literacy schemes.

NHS Choices encourages consumer engagement and interactivity, rather than simply posting information on the web. Although such online and mobile media are increasingly important, older people and residents of remote areas should not be forgotten as they are less likely to be online. The value of health information can be assessed by the real and sustained changes in individual behaviour it produces. The Consumers Health Forum of Australia, for example, has long produced guidelines on how to read internet health articles and assess their credibility.

The British initiatives have few Australian corollaries and show that domestic health literacy must attract greater resources, given the high rate of return for preventive health. Partnerships across the private, public and voluntary spheres are required as much as partnerships between consumer, pharmacist and GP. Grassroots schemes must be integrated with state and national initiatives to be sustainable and produce long-term and widespread effect. Health literacy must have its own specialised advocates, counsellors and guides as well as being an adjunct to every health professional's medical responsibilities. It should also take its place in the realm of political debate.

The United States requires better health literacy to compensate for its unwieldy and complex health system and diverse cultural and medical challenges. The 2010 US National Action Plan to Improve Health Literacy<sup>99</sup> calls for:

1. The development and dissemination of health and safety information that is accurate, accessible, and actionable.
2. Changes in the health care system that improve health information, communication, informed decision making, and access to health services.
3. The incorporation of accurate, standards-based, and developmentally appropriate health and science information and curricula in child care and education through the university level.

4. Support for and expansion of local efforts to provide adult education, English language instruction, and culturally and linguistically appropriate health information services in the community.
5. The building of partnerships to develop guidance and change policies.
6. An increase in basic research and the development, implementation, and evaluation of practices and interventions to improve health literacy.
7. The dissemination and use of evidence-based health literacy practices and interventions.

Given that the Australian Health Literacy Stocktake<sup>100</sup> criticised domestic steps to improve health literacy as ‘largely fragmented’ and lacking local collaboration and national leadership, the adoption of a similar plan for Australia to drive change beyond existing pockets of excellence would do much to improve the overall picture.

Limited health literacy is a public health problem as much as measles or diabetes, and depresses the health standards and life potential of a far greater number of people. If self care is to play an enlarged and more positive role in the nation’s health system, all Australians should have access to appropriate data to inform their decision making and self care.

#### *Improving health literacy through community pharmacies*

The HeLP project developed and evaluated a health literacy education package for community pharmacists and pharmacy staff in Australia (see Attachments). The project revealed the importance of encouraging consumers to ask open ended questions and trialled the ‘teach back’ technique to establish consumer understanding. The pilot demonstrated that behavioural change in pharmacy staff can be achieved, but such changes must be maintained over the long term to be effective.

Given the importance of pharmacies to the promotion of self care and health literacy, the Pharmacy Guild of Australia has advocated partnerships between Australia’s 5,000 community pharmacies and local schools.<sup>101</sup> The program would see school visits by pharmacists to educate children about the safe and appropriate use of medicines to reduce the number of ‘medical misadventures’. Individual pharmacies would ‘adopt’ their local schools over the long term, ensuring continuity and ever closer relationships. Greater support should also be given to ensure the correct use of medicines in



residential care homes, with pharmacists educating prescribers and carers about proper use and safety. Standardised presentations and supporting material could be provided for both school and residential care visits through a dedicated website.

The plan also calls for pharmacies to become community health information centres, leveraging the pharmacist's ability to advise consumers on ailments and resolve conflicts in the information which consumers have gleaned from other and perhaps less reliable sources. A fuller employment of pharmacists' skills as part of community health teams aligns with recommendations from the National Health and Hospitals Reform Commission and the Primary Health Care Strategy. It should also enjoy pharmacist support, as it enhances their commercial viability and positions them as an indispensable part of local life.

## **The role of pharmacy in supporting responsible self care**

While most people either allow minor ailments to heal themselves, self-medicate with products already in their medicine cabinet, or visit the pharmacy for appropriate relief, a significant percentage still default to their GP and emergency departments for almost any problem. This squanders both their time and money and the limited resources of the GP. A successful health system relies on citizens taking care of their own health as far as possible, and while habitual surgery visitors may be seeking personal reassurance as much as medical treatment, the drain on GP time remains the same. There is little difference in the actions of people in different socioeconomic groups regarding their reliance on the doctor for minor complaints, although their health literacy can vary greatly.

The pharmacy therefore offers a vital nexus between the public, doctors, broader health care system and the pharmaceutical industry and, given improved levels of health literacy, could potentially become many people's first port of call for minor symptoms and everyday ailments. Pharmacists can triage consumers' symptoms efficiently, given the minor nature of most complaints, and offer advice, remedies or direction to the GP as appropriate. Responsible self-medication requires that treatments are demonstrably safe, efficient and of known and reliable quality. They must be used as indicated for self-recognisable or well understood conditions, and be accompanied by relevant information the user can understand. The pharmacist is in an ideal position to assure these standards are maintained and may be the only health professional in a position to do so. Rather than be regarded as a mere dispenser of prescriptions, the pharmacy could become a central hub for community wellbeing and health positive activity.

Pharmacy will need support to evolve its practice and assume an expanded role as part of the self care team. A greater investment will be required in preparing pharmacies to conduct private discussions with consumers, ensuring adequate staffing levels, training and professional development of staff and continually reviewing and assessing its services for quality improvement. While the sale of non-prescription medicines will contribute to this service, pharmacies will need to be adequately remunerated. International examples of minor ailments services indicate that consultations with pharmacists can take up to 15-20 minutes. Internationally, governments have been investing in supporting pharmacists to take on an expanded role with minor ailments and self care.<sup>102</sup>

Pharmacists would have to initiate conversations, offer unbiased information and undertake continuing training and professional development to meet their increased role. Qualified pharmacists must already ensure their staff and assistants offer the highest standards of care, as most consumer interactions are with retail staff, rather than qualified pharmacists. In addition to their legal duties of product classification, quality assurance and professional performance, pharmacists should deepen their relationships and partnerships with other community health organisations and participate fully in health education, screening and awareness campaigns.

Greater emphasis should therefore be placed on communication and consumer counselling skills in formal pharmacy training, as well as the practice period, and the professional obligation for professional development should be strictly enforced. The use of systemic approaches to standardise interactions with consumers for varying illnesses – guidelines, flow charts and standard operating procedures – should be expanded to help the assistants handling most consumer interactions. Such a scheme has been trialled by Sriram et al. (2014) for community pharmacy clients presenting with lower bowel symptoms for example. Named the 'Jodi Lee Test', the pharmacy staff member applies a checklist of symptoms and clinical judgement to determine the need for referral for further investigation.<sup>103</sup> At the very least, pharmacy staff should remind consumers of the importance of reading instructions for newly reclassified medicines provided.

Although pharmacies are ubiquitous and regarded as trusted sources of information, they remain underused. Consumers seldom ask for advice<sup>104</sup> and can resent a conversation about their choice when asking for a product by name, given the repeat nature of many purchases. Communication skills, sensitivity and physical measures offering privacy in pharmacies are therefore paramount to ensure good customer relationships are strengthened and maintained.

Pharmacies cannot assume this expanded role without support. A joint effort from government, health services, GPs, the pharmaceutical industry and other stakeholders is required to encourage more people to safely care for themselves where medically appropriate. Such a joint front will reinforce the message and allay public fears that any one group is encouraging self care merely to further its own financial interest. The long-term success of 'stop smoking' campaigns, for example, rests in their relentless ubiquity more than specific advice from GPs.

Practice behaviour regarding documentation and record keeping must also evolve. There is no current requirement to record OTC sales or interactions in pharmacies for minor ailments, although some jurisdictions require the recording of S3 product sales. Similarly, many pharmacists already provide consumers with advice or referrals for minor ailments that are not linked to the supply of a product. This data is currently not captured and could be usefully included in PCEHRs.

In the longer term, personally controlled electronic health records could be used to capture the use of all medicines for chronic conditions, including OTC products, and pharmacists are well placed to lead this strategy, given appropriate incentives.

The Pharmaceutical Society of Australia's April 2015 announcement of its new partnership with industry<sup>105</sup> is a significant step towards transforming community pharmacies into healthcare destinations.

### *Collaboration between GPs and the pharmacy*

Pharmacists could work much closer with GPs and bring their expertise and accessibility to broader multidisciplinary teams. The community pharmacist should be part of a newly systematised and standardised team-care model in which the GP plays the leading role. A recent UK inquiry into person-centred care in the 21<sup>st</sup> century<sup>106</sup> also recommends an enhanced range of options to support self care, including greater integration with general practice, pharmacy and other health care services.

Community pharmacists in Britain and Canada work in a collaborative model with GPs and consumers to supply prescription medicines for extended periods without the need for consumers to report back to the GP unless an issue arises. This model encourages responsible self care and is particularly suited to people with stable, chronic conditions or in remote or rural areas.<sup>107</sup>

A new model of 'self care pharmacy' is being commissioned in the UK by the North East London Local Pharmaceutical Committee. The trial allows pharmacists and patients with chronic diseases to collaborate on developing a self care plan which may also involve onward referral of the patient to external health and social care providers. The aim is to empower patients to change their behaviour and improve their health and wellbeing in any of twelve target outcome areas during three follow-up sessions held over a 12-week period.<sup>108</sup>

## The role of non-prescription medicines in self care

### *Increasing access to non-prescription medicines*

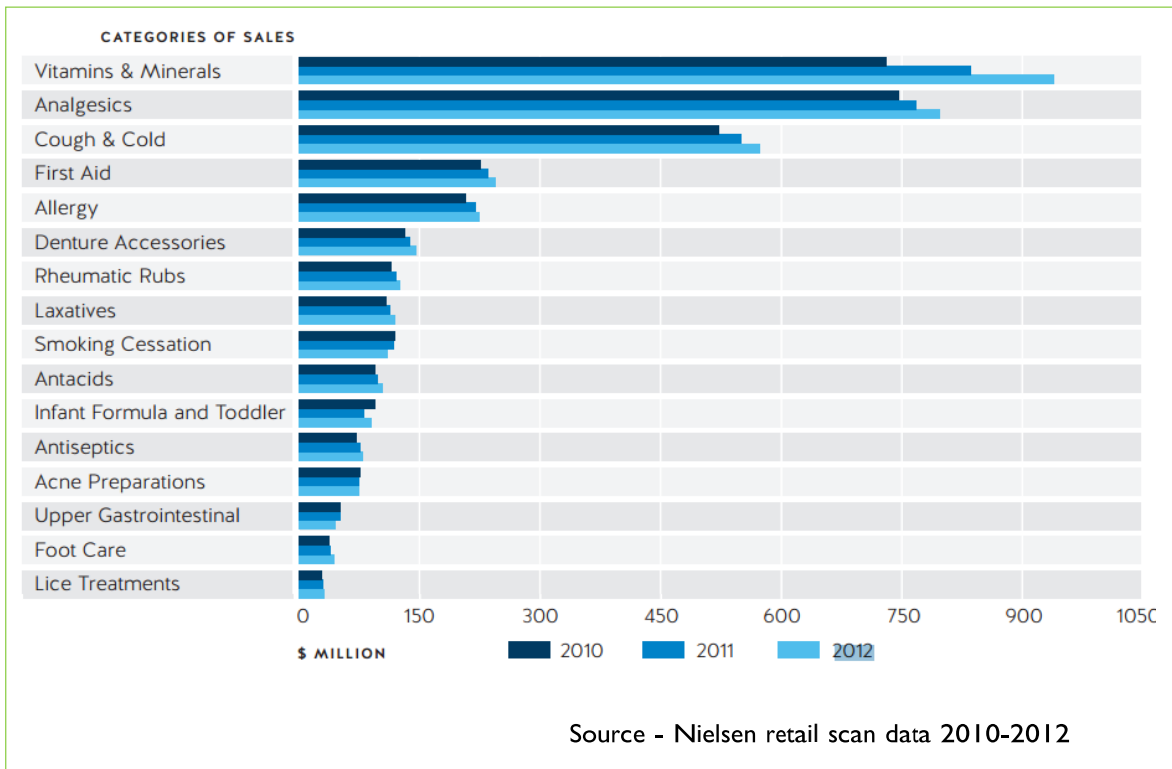
The total market for Australian medicines, prescriptions and OTC was worth \$16.8 billion in 2013-2014. 77% of this formidable sum comprises prescription medicines (worth \$13 billion), with non-prescription medicines accounting for the remaining 23% (\$4 billion).<sup>109</sup> The majority of prescription medicines are supplied under the PBS where the Government subsidises much of the expenditure. Commentary around the sustainability of the Australian health system often refers to the rapid growth in Commonwealth expenditure driven by the Pharmaceutical Benefit Scheme. Although the growth of the PBS has slowed in recent times, a new range of targeted medicines, particularly for oncology, is expected to place the PBS budget under renewed pressure.

Greater access by consumers to OTC and complementary products could provide an opportunity to meet some of the funding challenges facing the health care system in the future. Unlike prescription medicine, consumers meet all the costs associated with OTCs and complementary medicines out of pocket, spending nearly \$4 billion a year on such goods. Australians are already accustomed to paying for a fifth of their medical expenses out of their own pocket. A 2010 survey of eleven high-income countries found that 21% of Australians pay more than US\$1,000 for out-of-pocket costs in a year.<sup>110</sup>

The OTC market in Australia is growing at 5% per annum and supplies over 250,000 different products to consumers.<sup>111</sup> Australia's OTC medicine sector employs 18,000 people and manufactures around 17,000 registered and listed therapeutic products. This domestic manufacturing generates \$2.1 billion per annum and ships exports worth \$1.2 billion.<sup>112</sup>

Figure 10 highlights major product categories and reveals their domination by vitamins, pain relief medicines and cough and cold treatments.

**Figure 10. The value of different product categories bought OTC in Australia**



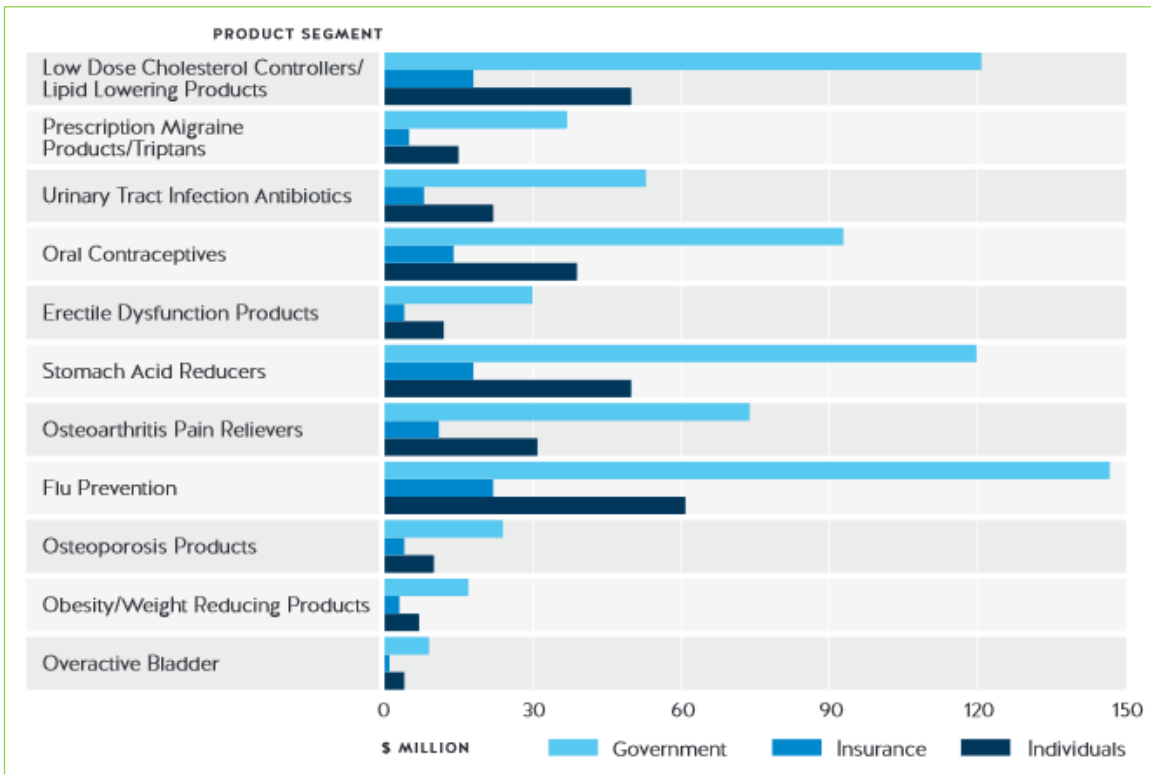
Four in five Australian adults use OTC medicine in any given month, during which they are also given to 40% of Australia’s children.<sup>113</sup>

*Opportunity for non-prescription medicines to deliver improved health outcomes*

Recent research conducted by the Macquarie University Centre for the Health Economy and funded by ASMI<sup>114</sup> reveals that the use of a range of OTC products for minor ailments saves 58 million visits to the GP, worth \$3.86 billion, and preserves \$6.55 billion in productivity that would otherwise be lost through time off work spent travelling, waiting and consulting the doctor. Pharmacists, unlike GPs, do not claim reimbursement through Medicare for consultations with the public.

Further research<sup>115</sup> suggests that the reassessment of 11 widely used prescription-only medicines could save an additional 17 million GP visits<sup>116</sup>, cut \$1.1 billion in direct medical costs and boost productivity by almost \$1 billion. These products treat a wide range of common problems and needs, including overactive bladder, weight reduction, osteoporosis pain relief, flu prevention, stomach acid control, erectile dysfunction and oral contraception.

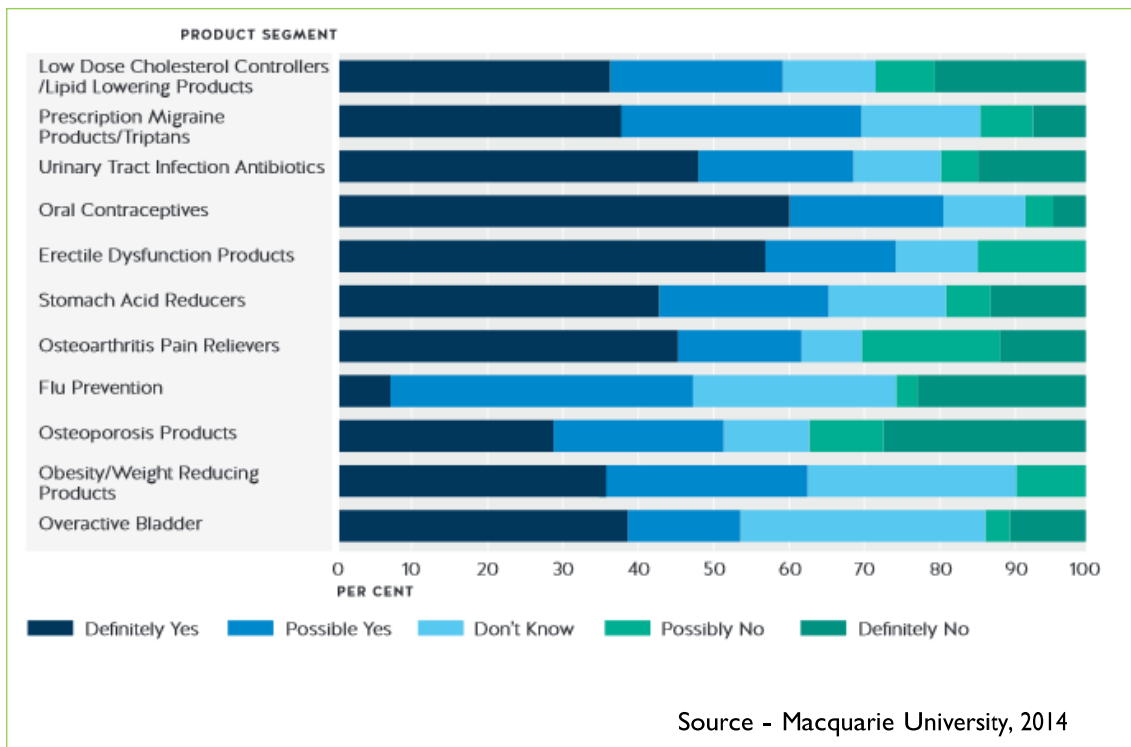
**Figure 11. Cost savings through switching 11 types of Rx product to S3**



Source - Macquarie University, 2014

The same study found that a majority of consumers would be willing to buy these medicines and treatments direct from the pharmacy without prescription, as illustrated by Figure 12.

**Figure 12. Consumer sentiment regarding the purchasing of 11 types of Rx product directly from the pharmacy**



*The 2014 Frost and Sullivan study*

A recent study commissioned by ASMI and conducted by economic research firm Frost and Sullivan has quantified the potential reduction in economy-wide health care costs and productivity losses that could result from the use of specific complementary medicines in targeted populations.<sup>117</sup>

The ‘Targeted Use of Complementary Medicines: Potential Health Outcomes and Cost Savings in Australia,’ study revealed that the use of specific complementary medicines by high-risk target populations could improve the health of individuals and lower costs due to reduced hospitalisation, time of work and reduced productivity.<sup>118</sup>



The study followed a 'health to wealth' methodology, using scientific evidence as a guide to the potential for cost savings and productivity gains to benefit Australian federal and state governments, individuals, employers and private health insurers. 70% of Australians have taken complementary medicines in the last year for general health, and almost half of users take a complementary medicine daily, particularly those aged 65 years or older (67%). Two of the most popular complementary medicines are fish oils and calcium. 29% of fish oil users take it for reasons of heart health and 71% of calcium users take it for bone health. The biggest gains identified in the study are in the area of osteoporosis and osteopenia – conditions which in Australia resulted in approximately 140,822 fractures in 2012 and affect some 1.8 million people at a cost of approximately \$3 billion per annum.<sup>119</sup> Potential health care savings and productivity gains were calculated if all women over 50 with osteoporosis were to take calcium and vitamin D at a preventive dose to reduce the risk of osteoporosis-attributed bone fractures.<sup>120</sup>

Frost and Sullivan found the relative risk of an individual in the target population experiencing an osteoporosis-attributed fracture would be reduced by 19.7%, given the use of calcium and vitamin D at preventive intake levels. This translates to a potential of 36,783 avoidable osteoporosis-attributed fractures in 2015, given uniform utilisation of calcium and vitamin D by the high-risk population.<sup>121</sup> The report estimated that average annual hospitalisation costs of \$922 million could be saved between 2015 and 2020, with an additional average annual productivity gain of \$900 million.<sup>122</sup>

More than half of the potential total benefits would accrue to the individuals involved, while over 42% of potential total benefits would be realised by federal and state governments. The average annual benefit/cost ratio between 2015 and 2020 would amount to \$22.34 for every dollar spent on this complementary medicine regimen.<sup>123</sup>

The report also explored the burden of cardiovascular disease (CVD) on Australians and the potential health and economic benefits that can be realised if an omega-3 fatty acid regimen was used by all Australians aged 55 and over who are diagnosed with CVD. It was estimated that the relative risk of hospitalisation due to a CVD event can be reduced by 4.9% and 6,894 average annual medical events avoided between 2015-2020 if all Australians aged over 55 with CVD were to take omega-3 fatty acids at a preventive level. The average annual benefit cost ratio from 2015 to 2020 would be \$8.49 for every dollar spent on the omega-3 fatty acids.

### *Policy levers to encourage a greater role for non-prescription medicines*

The wider availability of efficacious and affordable OTC medicines has the potential to improve public health by providing consumers with easier, more convenient and faster access to therapeutic products to treat conditions and maintain good health.<sup>124</sup> The studies cited earlier by Macquarie University and Frost and Sullivan also highlight the scope for cost savings and productivity benefits from a greater uptake of OTC and complementary products.

With the exception of a small number of Schedule 3 medicines, OTCs are intended for the relief of symptoms of simple self-limiting conditions, e.g. headache, itch, coughs and colds, stomach aches and hay fever. However, while their risk is low, most non-prescription medicines are regulated as ‘registered’ medicines under the same TGA legislation as prescription medicines. This reflects an increasing tendency to apply similar regulatory standards to non-prescription and prescription medicines, despite their very different risk profiles.

Non-prescription medicines differ from prescription medicines<sup>125</sup> in that the safety of the active ingredients has already been assessed by the TGA and determined to be suitable for supply to consumers without the intervention of a medical practitioner. The majority of OTC medicines may be advertised and offered for sale directly to consumers. Labelling is therefore of key importance in ensuring that consumers know what the product is used for, how it should be consumed, when it should not be considered and when to seek professional advice.

### *The role of the Therapeutic Goods Administration*

The policy lever most relevant to the issue of self care and greater access to non-prescription medicines is the TGA’s responsibility to determine the scheduling of medicines. As referenced throughout this paper, the major schedules applying to non-prescription medicines are Schedules 2 and 3.

The TGA manages the publication of the Standard for the Uniform Scheduling of Medicines and Poisons, which lists the medicines and their schedules and is adopted or referenced by the States and Territories. States and Territories regulate the supply of medicines through legislation. While it is largely similar, there can be variations

regarding the storage and supply of these medicines. Western Australia and Queensland, for example, require Schedule 2 medicines to be stored behind the counter, i.e. these medicines are not available for self-selection by consumers.

The TGA also administers the scheduling committee which makes recommendations to the delegate of the Secretary to the Department of Health in the TGA.

Regulators around the world increasingly support a 'lifecycle approach' to medicine oversight, with continuous evaluation of safety and efficacy over time. Such analysis should balance social benefits, including the value of access and convenience against medical and other risks.

Around 60 active ingredients have switched to OTC status in developed nations over the last decade<sup>126</sup>, although relatively similar countries have markedly different attitudes to their availability. Greece and Spain retain a highly regulated pharmacy sector, for example, while Italy allows the sale of OTC products from other retail outlets with supervision and while a pharmacist is on the premises. Portugal allows their sale from retail outlets with much fewer restrictions. Statins to treat cholesterol are available without prescription in the UK while they remain restricted in Australia. Triptans to treat migraine are available without prescription in Britain, New Zealand, Germany and Sweden, while antibiotics to treat urinary tract infections are offered OTC in New Zealand as well.

Medsafe, the New Zealand medicines regulator, and the TGA published the outcomes of a joint consultation on the reform of medicines classification in March 2013, and a staged roll-out of a new risk categorisation framework began in April of that year.<sup>127</sup> These reforms should improve the efficiency, cost effectiveness, transparency and predictability of the regulatory process and harmonise arrangements between New Zealand and Australia. They promise the application of an appropriate risk/benefit analysis to assess medicine switch applications, allowing the public timely access to safe and effective OTC products where possible.

Changes in scheduling are driven by wider trends towards greater individual autonomy, government deregulation and cost-containment efforts by health care organisations. Improved access can result from a review of the scheduling framework and a liberalising of the advertising environment for these products.

### *Elements for successful medicine switches*

Although different countries vary somewhat in their speed of change, thousands of products containing agents which were once prescription only are now available OTC at pharmacies around the world. Most changes favour liberalisation in the light of greater use, data and familiarity; however, on occasion medicines are subjected to tighter conditions after evidence emerges of abuse or safety concerns.

Medicine switches must occur as part of a broad and coherent self care policy and be supported by effective education and advice from health professionals. The vulnerabilities of certain groups – from teenagers and the elderly to known medicine abusers – should not restrict availability to the vast majority of responsible consumers, but must always be borne in mind. Laxatives are overused by people with eating disorders, and codeine can lead to addiction, for example, but overall their availability is a public health gain.

As part of improved health literacy, if consumers are to be empowered to buy, they must be empowered to understand what they are buying and how to use such products properly. Support and information should be tailored to the needs of differing groups and provided in a variety of user-friendly ways. Information on packaging should be clear and to the point, for example, and advertising material should be clearly differentiated and respect industry guidelines regarding the honesty and scientific credibility of their claims.

Successful switches involve medicines with a good safety record and which deliver a demonstrable and clear public health benefit. Controversy in itself should not necessarily preclude change. The non-prescription status of nicotine replacement therapy and, in particular, emergency hormonal contraception was hotly debated at the time, but is now widely accepted. The concerns of doctors and pharmacists should be addressed at an early stage, and the self-reported outcomes of consumers should also be considered as the public is the group most affected by such change.

Sales of the product must also offer returns for manufacturers and retailers to be economically viable, but competition between them should be encouraged to prevent cost becoming a barrier to use and penalising lower-income consumers. Branding is a wider issue as it both encourages recognition and the confidence to self-medicate, but may also confuse consumers about active ingredients when different medicines share the same brand. Delineation between impartial information to inform consumers and advertising to promote a particular brand must be maintained to retain consumer trust and confidence.

# 6 Developing a Self Care Policy

## **Recommendations for Australia**

Maximising the opportunities for expanded self care to lighten the load on Australia's hard-pressed health services and constrained health budget should become a priority for all stakeholders, as all stakeholders will benefit from it. Developing and implementing targeted and effective policies to this end can only be achieved through collaboration and coordination over the long term to maintain strong partnerships which leverage self-interest to further the public good.

### ***The major stakeholders in self care***

Fundamental to the success of self care is the formation of strong partnerships between stakeholders. Self care does not mean consumers are left on their own; nor does it translate into "no care". To succeed, it requires informed consumers, the expertise and support of pharmacists, GPs and other practitioners, the provision by industry of evidence-based products and remedies, the creation by government of a favourable policy and regulatory environment, and innovative approaches from private health insurers.

### **Consumers**

Consumers need encouragement to take more responsibility for their health and wellbeing, but they also need the knowledge, skills and tools required to succeed. The community is generally better educated and informed about health alternatives than ever before, but lack of information and knowledge remains a barrier to safe and efficacious self care. Better health literacy is therefore a critical element that will not only help urban consumers make the correct health purchases, but reduce inequalities in health outcomes, particularly in remote and Indigenous communities.

## **Government**

Government must create a policy environment in which self care forms an integral part of a national health policy and to work with all stakeholders to make it a reality. Health investment should prioritise health promotion and disease prevention to treatment costs for preventable and chronic disease in the future.

Regulatory authorities should encourage an environment that supports evidence-based non-prescription and complementary medicines. There is a strong case for wider access to prescription medicines with an extended and safe record of use by switching these to non-prescription status, particularly those targeting the treatment and prevention of preventable conditions identified in the National Health Priority areas.

Improved partnerships between government and other stakeholders, including the pharmaceutical industry, will generate positive outcomes through sharing of resources, personnel and data.

## ***Health care professionals***

The move towards greater self care will necessitate a cultural change in the relationships between health care professionals and patients and between the different health care professions - GPs and pharmacists in particular - towards sharing the clinical management of patients more appropriately according to the patient's needs.

GPs must remain the first option for more serious ailments, but many minor ailments are suited to responsible self care, consultation with a pharmacist or another health care provider or treatment by a nurse practitioner. Self care opens up the choice of a range of health professionals including GPs, pharmacists, naturopaths, nurses, psychologists, physiotherapists, dieticians and others, and the long-established diversity of Australian health provision leaves it well placed to make the most of these opportunities.

If professionals are to play a more active role in supporting self care, their roles should be better defined. Renewed professional and skills training is critical, because self care involves a cultural shift from professionals being the principal providers of care and patients being passive recipients, towards more emphasis on shared care, preventive care, healthy lifestyles and patient involvement in their own care of minor, acute and long-term conditions.

## **Industry**

The four arms of the National Medicines Policy and any new policies underpinning self care will dictate industry's role and responsibilities in the shift towards its utilisation. Industry will have to provide timely access to medicines that are safe, efficacious and of high quality at affordable prices. The expansion of self care will increase the demand for a broader range of solutions - demand that should be met through product innovation and wider access to safe, effective treatments.

Industry will need to work with health care professionals, relevant professional bodies and patient groups to ensure consistency of message and information. As patients become more involved in the management of their conditions, there will be a need for new and different types of consumer information. Responsible advertising and communication will be central to the goal of raising disease awareness and encouraging self-management.

Training for health professionals will become a significantly bigger issue for industry. Product-specific treatment guidelines will need to be proactively developed in cooperation with professional bodies for use by pharmacists and other health care professionals. Industry will also be required to demonstrate that consumers have the necessary information and access to advice to ensure that products can be used appropriately without close medical supervision.

### **Private health insurers**

The private health insurance industry has a key role to play in offering the right mix of incentives to alter behaviour in favour of self care. There are a range of payments and rewards already available for their customers who avoid certain risk-taking behaviour and make positive lifestyle changes.

More evidence is emerging that simple and cheaper prevention strategies can be at least as cost-efficient as more expensive interventions, including the use of calcium and Vitamin D in the prevention of fractures caused by osteoporosis.

As health care costs escalate, there will be an increased focus on innovative ways of encouraging individuals and families to adopt healthy alternatives, in order to prevent longer-term, costly and often traumatic medical interventions.

## The UK Self Care Forum

Britain faced similar challenges in promoting the benefits of self care and in response established a self care forum for key stakeholders, including clinical health professionals, consumer representatives and Department of Health personnel. The forum estimates that self care could save the NHS £2 billion every year – a quarter of a million pounds for every general practice in England. The forum’s six-point action plan advocates:

1. Recognition that supporting self care can create capacity in general practice for longer consultations.
2. The support of self care by all health care professionals in every contact with patients.
3. The adoption of a ‘self care aware’ conversation in all consultations.
4. The implementation of the NHS Constitution at practice level to underpin support for self care.
5. Support for Patient Participation Groups to implement the National Association of Patient Participation programme supporting self care for the practice population.
6. Incentives for health care professionals to enable patients to self care.

The UK Self Care Forum supports a greater role for pharmacies in managing common minor problems and long-term conditions, arguing that a reduction of the 20% of GP time spent on common ailments, such as back pain, headaches and indigestion, would free scarce resources for more serious complaints at no cost to the NHS.

## A Self Care Alliance for Australia

Building on the UK experience, and recognising the need to create multistakeholder partnerships to firmly establish self care as a cornerstone of Australia’s health system, an Australian Self Care Alliance was launched in Canberra in March 2014.

The Self Care Alliance cannot meet the challenge of wider health reform on its own, but it can work collaboratively with its partners and bring expert opinion to bear on some of the critical issues that affect primary health, particularly self-limiting ailments and chronic conditions.



The Self Care Alliance aims to provide an authoritative source of information on the issue of self care and ways in which people can proactively protect and improve their own health.

The Alliance comprises a broad range of stakeholders, including consumer representatives and consumer groups, health care professionals, the pharmaceutical industry, private health insurers and health researchers. Its key strategic priority is to tap into the accumulated knowledge of the relevant stakeholders. Consumers and patient group representatives will be central to identifying further opportunities for self care, for example, as well as its obstacles and challenges, and offer improved means of effectively communicating with target audiences.

Following its launch, the Alliance has held several meetings with an initial focus on immediate measures to support the embedding of self care in the Australian health care system. It is developing a schedule of activities, research projects and studies to be progressed by its working groups to establish a robust evidence base for self care in Australia and a platform upon which further work can be undertaken.

The work streams of the Self Care Alliance will evolve over time and may include:

- Lifestyle
- Diet and exercise
- Health literacy
- Use and safety of medicines
- Use of e-health and related technology
- Consumer attitudes to self care
- HCP<sup>128</sup> approaches to self care
- Integration of prevention and self care into the workforce
- Developing community-based approaches to key health issues such as obesity, smoking and alcohol
- Contributing to programs that target Indigenous, remote and rural health
- Commissioning and publishing articles; a self care journal

Consistent with the Government's stated support for greater personal responsibility in regard to individual health, the GAP Taskforce on Self Care recommends that government support the work of the Self Care Alliance. Whilst the organisation does not require any public funding, the involvement of key federal and state health agencies in

its work program will be essential to establish the Alliance as the umbrella body responsible for self care initiatives and policies.

As well as serving as a repository of expert advice for stakeholders, media and the wider Australian community, the Alliance will offer innovative thinking on key issues in primary health care, formulate policies to advance consumer health, facilitate research and enable the dissemination of evidence-based information to the community, the media and key target audiences.

# 7 Conclusion

## A consumer-driven future

Although they may not use the term explicitly, people increasingly act as health consumers rather than traditional patients. They compile a basket of purchasing choices from a wide range of options to suit their individual and evolving needs. The Australian Centre for Health Research advocates a new focus on 'person-centred', rather than 'patient-centred', care to remove the connotations that 'patient' has created. The health market, like any number of others, will be transformed as information supplants infrastructure in importance and consumer empowerment dismantles long-entrenched producer interests with unprecedented speed.

Powered by new apps, devices and virtual services, the future of health care will increasingly be shaped by the myriad decisions of innumerable consumers, rather than trail the interests of a small number of powerful producers.

Millions of people already scour the internet to research their symptoms, use Twitter and Facebook to share health tips and make medical appointments, buy diet and fitness apps for their smart phone and check out a burgeoning range of smart watches with built-in health monitoring sensors. While the pharmacy may offer itself as a hub of community health information in its locality today, the virtual realm will surely assume that function for the world tomorrow.

Responsible self care and improved health literacy may begin with greater use of OTC medicines and better information leaflets, but these are but the first steps towards the person-centred health care system of the future.

## Taskforce Membership

**The Hon., Dr Michael Armitage**  
Chief Executive Officer  
Australian Health Insurance Association

**Ms Olga Bodrova**  
COO and Director of Research  
Global Access Partners

**Mr Greg Duncan**  
Senior Research Fellow  
Eastern Health Clinical School  
Faculty of Medicine, Nursing  
and Health Sciences  
Monash University

**Ass. Prof Lynne Emmerton**  
School of Pharmacy  
Curtin University

**Mr Chris Flood**  
National Manager  
Agreement Policy and Planning  
Pharmacy Guild of Australia

**Mr Peter Fritz AM**  
Group Managing Director  
TCG Group  
Chairman, Global Access Partners

**Ms Catherine Fritz-Kalish**  
Co-founder & Managing Director  
Global Access Partners

**Mr Alex Gosman** (*Chair*)  
Principal  
Alex Gosman Consulting

**Ms Tricia Greenway**  
Independent Community Advisor

**Mr Grant Kardachi**  
President  
Pharmaceutical Society of Australia

**Prof Scott Koslow**  
Department of Marketing and Management  
Business and Economics  
Macquarie University

**Mr Robert Lippiatt**  
Executive Director  
SPC Consulting Group  
Chair, Australian National Consultative  
Committee on Health

**Mr Damian Mitsch FAICD**  
Chief Executive Officer  
Australasian Podiatry Council

**Dr Adrian Nowitzke**  
General Manager  
Health Informatics  
Telstra Health

**Mr David Quilty**  
Executive Director  
Pharmacy Guild of Australia

**Mr Patrick Reid**  
Chief Executive Officer  
Leading Age Services Australia

**Dr Deon Schoombie**  
Executive Director  
Australian Self-Medication Industry

**Dr Tamati Shepherd**  
eHealth Consultant

**Ms Edyta Wiatr**  
Assistant Project Manager  
Global Access Partners

## Attachments

### The growth and potential of OTC medicines in international markets

Health systems in other developed nations face the issues similar to Australia, and their moves towards greater self care and expanded access to OTC products may offer clues to improving the situation here.

#### *Austria*

Austria's two-tier health care system offers its citizens comprehensive publicly funded care with an option to purchase supplementary private health insurance. A 2012 study of the potential of OTC medicines<sup>129</sup> in the country found OTC medicines cost just a fifth as much as an equivalent prescription and doctor's consultation. In addition to the financial expense, an hour and a half of travelling, waiting and seeing the doctor was saved by their purchase as an alternative, reducing time off work. If just a tenth of current acts of Austrian self-medicine required an additional doctor's visit, it would consume another 417 hours of every GP's time per annum – well over an hour a day.<sup>130</sup>

#### *Great Britain*

Britain's National Health System pays doctors a set amount to manage a potential pool of patients in their area, regardless of the care actually provided.

The UK OTC market is already huge, with sales of £2.5 billion.<sup>131</sup> British health consumers bought 990 million packs of OTC medicines in 2009, compared with 1,015 million prescriptions.<sup>132</sup> Nine out of ten common illnesses are treated by people themselves, with consumers purchasing the same trusted products on a consistent basis. However, this could be expanded further, as 57 million British GP consultations a year - 200,000 per day - involve discussion of minor ailments.<sup>133</sup> 90% of these (51.4 million) are for minor ailments alone, equating to over an hour a day for every GP.<sup>134</sup> 91% of minor ailment consultations end with the issue of a prescription (52 million prescriptions per annum) at a cost of £370 million.

The ten most common minor ailments are responsible for 75% of consultation costs and 85% of prescription costs, amounting to £1.62 billion every year.<sup>135</sup>

British OTC medicines cost an average of £3.50, with the average household spending less than £3 a week on medicines and health products, compared to nearly £80 a week on leisure activities. Self care could reduce outpatient visits by 17% and decrease days off work, visits to emergency departments, hospital admissions and the length of hospital stays by up to half.<sup>136</sup> Even a relatively small increase in the self care of long-term conditions would help reduce the demand for Britain's health services.

### *Portugal*

The liberalisation of the Portuguese medicine market in the middle of the last decade offers an interesting case study for the debate about greater flexibility in Australia. Until 2005, prescription and non-prescription pharmaceuticals were only sold through high street and hospital pharmacies, but new retail outlets termed 'Parapharmacies' were introduced in September 2005 to sell OTC products, although sales of reimbursable OTC lines continued to be confined to pharmacies. After the liberalisation, a single qualified pharmacy technician could be responsible for the sale of OTCs in up to five retail outlets within a 50km range.<sup>137</sup>

During 2006, the first full year under the new system, non-reimbursable OTC products were placed under no pricing restrictions, but studies demonstrated that prices, beyond some supermarket discounts, showed little change.

The number of such outlets increased from 186 in 2006 to 613 in 2007. As part of the new government's cost cutting measures, a 6% cut in retail prices on all reimbursed medicines was imposed from January 1<sup>st</sup> 2007. From November 2007, new legislation allowed non-pharmacists to own up to four pharmacies, although doctors, wholesalers, manufacturers and healthcare providers were precluded from ownership. Mail order and online medicine sales were also allowed, although specific regulations had not been developed to ensure patient safety. Minimum distances between pharmacies were reduced from 500m to 350m to serve a reduced 3,500 citizens per pharmacy, while opening hours were expanded to a minimum of 55 hours per week. Publicly owned pharmacies within hospitals were allowed to be open 24 hours a day all year round. Pharmacy discounts and flexible pharmacy pricing were approved in March 2007.<sup>138</sup>

This rapid rate of change allowed Portugal to become one of the leading countries in the relaxation of medicine restrictions in Europe, a position it still retains.

### *Singapore*

Although a small city state such as Singapore may appear to have little relevance to an enormous landmass such as Australia, the vast bulk of Australia's population is concentrated in a handful of cities isolated from each other by geography and different state systems. Seen in that light, Singapore can usefully be compared to Australia's major conurbations. It has a population of 5.4 million<sup>139</sup>, larger than the 4.7 million of Sydney and the 4.3 million of Melbourne.

Singapore spent just 4.7% of its gross GDP on health in 2012, compared to 9.1% in Australia.<sup>140</sup> Despite this, its health outcomes are broadly similar, with a slightly lower life expectancy offset by marginally lower infant mortality. Singaporeans pay for 62% of their health expenditure from private insurance and their own pocket, compared to just 32% in Australia where 68% of health spending is funded by government.<sup>141</sup>

A strong tradition of family care persists, and the government blends public and household responsibility through a system of subsidies and an individual Medisave account. Citizens, government and employers all contribute to these accounts, which Singaporeans can use to pay for family medical and hospital expenses. Despite the onus on individuals paying for care, medical expenditure is increasing quickly in Singapore, growing by 8.1% in the first decade of the 21<sup>st</sup> century, compared to just 2% in Australia.<sup>142</sup>

### *South Korea*

South Korea has a universal health insurance system, and its services tend to concentrate on treatment, rather than prevention.<sup>143</sup> There are 12 hospital beds per 1,000 people in the country<sup>144</sup>, double the OECD average of five.<sup>145</sup> Although its life expectancy has increased greatly since World War Two, its affluence, urbanisation and growing number of elderly has seen significant growth in chronic disease, now suffered by almost a quarter of the population.<sup>146</sup> Exacerbating these problems, a third of Korean adults still smoke<sup>147</sup> - a much higher rate than in Australia. In contrast to Portugal, the liberalisation of South Korea's OTC medicines sector has been sluggish, as the government struggled to find consensus among the interests of consumers, medical and pharmaceutical stakeholders, health policy experts and civil society.<sup>148</sup> South Korea's



Ministry of Health and Welfare recently announced that convenience stores will be allowed to sell an additional 13 medicines, but it is unlikely these will contribute significantly to overall OTC sales.<sup>149</sup>

### *United States*

The United States has traditionally combined remarkably high levels of health spending with some of the worst health outcomes in the western world. Despite spending more in absolute terms, more as a percentage of GDP and more per head of population than other developed nations, its infant mortality, the number of disability free years per citizen and life expectancy have lagged well behind other OECD nations.

Despite ongoing political controversy and administrative hiccups, the Affordable Care Act ('Obamacare') is beginning to limit administrative and out-of-pocket costs as it requires health funds to deliver 85% of benefit for every dollar collected.<sup>150</sup> However, the underlying failure to create a truly efficient market remains. The marketplace has not produced the efficiency required to overcome the waste, duplication and redundancy created by the vast range of private health providers and purchasers. Although public systems such as Britain's NHS are regularly – and justifiably – criticised for their administrative lethargy and bloat, the myriad array of private health actors in the USA creates an administrative quagmire which is far more difficult for patients to navigate. High fees are charged for comparatively simple tests and operations, while little attention has been paid to national health literacy and coordinated preventive care.

Services given to patients have too often been driven by their level of insurance cover, rather than medical need, with wealthy patients subjected to a number of expensive and sometimes unnecessary tests – often to defend against the perceived threat of legal action for negligence if they are not performed – while large numbers of uninsured people have suffered from a dearth of affordable services.<sup>151</sup>

The high costs of the American health system, its large numbers of uninsured people and its long-standing failure to deliver acceptable levels of care must be remembered when considering the enormous size of its OTC market.<sup>152</sup> Americans spend a vast amount on OTC medicines, just as they do on prescription medicines, but part of this reliance is a product of the failure and expense of its broader health system over many decades, rather than a successful strategy to prioritise self care.

US consumers spent \$23 billion<sup>153</sup> on OTC medicines in 2010<sup>154</sup>, with around half that amount covered by employer insurance schemes and a quarter by government programs such as Medicare and Medicaid. 240 million people bought or used at least one OTC product out of the 250,000 items on its market. Vitamins, minerals and supplements are the largest and fastest growing sector in American consumer health care, just as they are in Australia. There remains scope for further development of the market, one study<sup>155</sup> calculating that the use of OTC medicine to treat common upper respiratory infections could save the USA \$4.75 billion a year in direct medical costs, with further savings from reducing time off work and the resulting loss of productivity.

Total sales in the US pharmaceutical market grew to a staggering \$347.2 billion in 2013 - more than three times the size of the next largest market in Japan.<sup>156</sup> Sales of patented, generic and over-the-counter medicines in the US are larger than anywhere else in the world, and many individual American states have larger medicine markets than entire countries.

Combined sales of prescription medicines and OTC medicines were forecast to increase to \$352.8 billion in 2014. While this increase represents just 1.6% of the total, its value in absolute terms is more than \$5 billion. The US pharmaceutical market is forecast to achieve annual compound growth of 1.7% until 2018.<sup>157</sup>

## HeLP study

A research project titled HeLP (Health Literacy in Pharmacy), “An Evaluation of the Impact of a Health Literacy Educational Package for Community Pharmacists and Pharmacy Staff in Australia”, was led by a consortium of academics from five universities: Monash University, Curtin University, University of Sydney, University of Technology Sydney, University of Queensland, James Cook University, and the Victorian branch of the Pharmaceutical Society of Australia.

HeLP was a tendered project funded by the Australian Government and managed by the Pharmacy Guild under the Fifth Community Pharmacy Agreement.

The project developed and evaluated a health literacy education package for community pharmacists and pharmacy staff in Australia. It comprised five stages, beginning with a comprehensive literature review to understand existing schemes and needs which remain unfulfilled. The second phase looked at other resources available, including ‘grey’ literature, internet sources and health literacy components of pharmacy schools’ curricula. Drawing on the expertise of a range of people within the consortium and beyond, it developed a pilot educational package which was then evaluated in controlled trials with community pharmacists and pharmacy assistants and modified in the light of feedback received.

The HeLP project initially considered opportunities for screening pharmacy consumers to determine their health literacy, but a number of factors saw that approach abandoned. There is no simple screening tool useful in the short encounters seen in the pharmacy setting. More importantly, the sheer size of the problem precludes an individualised approach. The project therefore adopted an approach of ‘**universal precaution**’, with pharmacists encouraged to assume their consumers have limited health literacy until interaction proves otherwise.

The initial literature review found there was limited research about health literacy in the context of community pharmacies. The review confirmed that low health literacy in the elderly is associated with poor health outcomes and high all-cause mortality. Very few interventions address the effects of poor health literacy, and those which exist are limited in their effect. Multiple strategies are therefore needed to tackle the problem, given its diverse nature, rather than any single approach. The readability of information, for example, is another important issue. However, any project which raises awareness of health literacy is useful, and formal health literacy training significantly improves pharmacist’s health literacy practices.

Importantly, the review found that the supposed link between health literacy and adherence to medicine regimes is not well supported by recent research. The assumption had been that people with limited health literacy would be less likely to complete their course of treatment as directed, however, when messages are correctly presented in the right context, people with limited health literacy can take medicine as successfully as others. It is confusion about specific directions, rather than a general lack of health literacy, which must be addressed in such cases.

There are many web-based health literacy resources, and those by the Agency for Healthcare Research and Quality (AHRQ)<sup>158</sup> are particularly well presented.<sup>159</sup>

The review also identified four specific health literacy tools for pharmacies:

1. Pharmacy Health Literacy Assessment Tool & User Guide
2. Training Program for Pharmacy Staff on Communication
3. Guide on How to Create a Pill Card
4. Telephone Reminder Tool to Help Refill Medicines on Time

The program sought to ‘train the trainer’ to maximise its impact and ensure the widest possible delivery. While the initial plan was to train a pharmacist from each pharmacy, the advisory panel suggested that pharmacy assistants be involved in the initial training as well. One member of staff, either a pharmacist or pharmacy assistant, was therefore trained from each pharmacy and given material to train their colleagues in turn. Two versions of initial training delivery – face-to-face all-day instruction and training using media such as DVDs – were assessed. Both used a modular, step-by-step approach, building and consolidating understanding before moving to the next step.

The course began with a definition of health literacy and the costs and consequences of poor standards. The next module examined strategies for improving health literacy, with the following three modules looking at health literacy in culturally and linguistically diverse communities, aged care facilities and schools.

The key to separating people with functional health literacy from those who lack it was taken to be their **capacity to ask questions**. People who did not engage with the pharmacy staff therefore received simple factual information to help them adhere to medicine regimens and reduce their risk. The universal precautions approach was put into practice in a ‘three by three’ approach, with three broad strategy areas and three key activities for each.

Pharmacy assistants themselves exhibit a wide range of health literacy, as staff may be school children working on a Saturday morning or highly experienced, educated and motivated full-time staff. Training information was therefore kept simple to allow all participating staff to engage and deliver the interventions effectively.

The behavioural outcomes revealed the importance of encouraging consumers to ask questions. This can be accomplished with simple turns of phrase – while asking ‘*do you have any questions?*’ tends to elicit no positive response, pharmacists should ask ‘*what questions do you have for me?*’ to encourage a reply. ‘*What questions do you have?*’ implies that questions are normal and the health professional expects them to be asked, and it is easier for the consumer to ask a question than not. This subtle distinction provoked a major change. Consumers who had not asked a question in twenty years in one rural pharmacy started to ask questions straight away.

The project also attempted to use the ‘**teach back**’ technique to establish consumer understanding. Teach back involves asking the consumer to explain what they know or understand of a situation as the basis for further counselling; however, this proved less productive. Although teach back is an intrinsic part of communication training for all health professionals and most people think they do it well, the evidence suggests it is employed sporadically and is often poorly done. Professionals must become more aware of how they employ it and ensure consumer understand the information they are given.

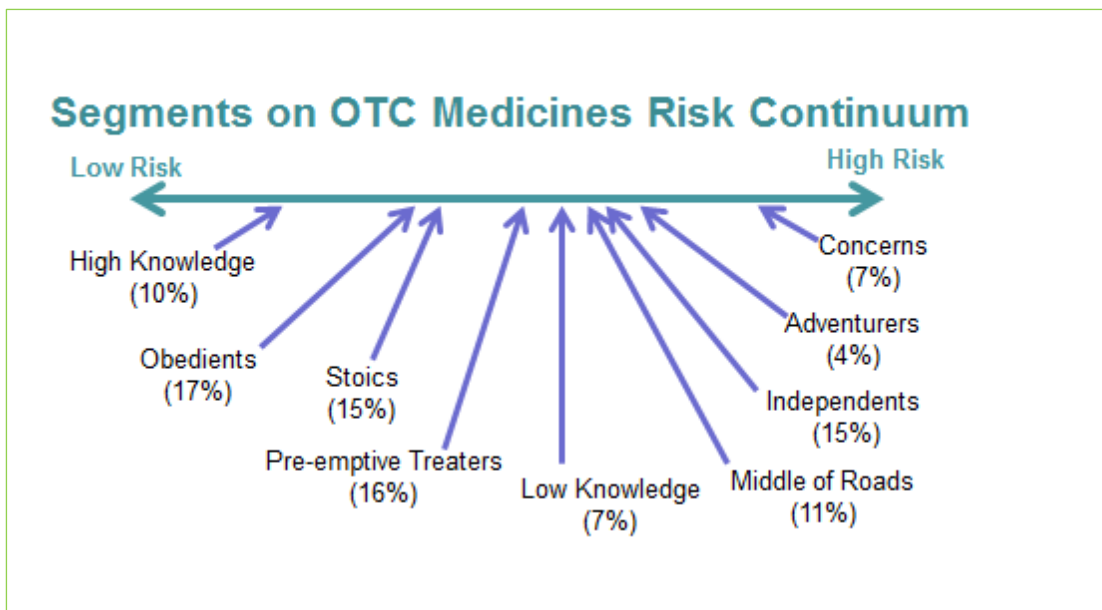
There were increased outcomes from face-to-face training, as people preferred it to the electronic version. The face-to-face training ensured that the entire group completed the training appropriately, while not everyone completed the e-training on their own.

Surveys of attitudes before and after training showed positive changes in attitudes towards health literacy training. Positive changes were also made in pharmacy environments with more informative materials provided. Pharmacy assistants enjoyed doing training with the pharmacists and being treated as equals. They liked being trained by someone they knew and trusted in house, and discussing the program with their colleagues helped build a constructive work culture. The flexible nature of the program allowed it to be delivered in a concentrated couple of sessions or over a longer period of time, and this has been further enhanced in the final version, with the final version condensed to four modules.

The pilot demonstrated that behavioural change in staff can be achieved, but such changes must be maintained over the long term to be effective.

# Consumer Segments

Nine groups of consumers identified by Professor Scott Koslow in his 2014 study:<sup>160</sup>



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- <sup>98</sup> Patient-focused interventions - A review of the evidence. Angela Coulter and Jo Ellins. Picker Institute Europe. August 2006
- <sup>99</sup> [http://www.health.gov/communication/hlactionplan/pdf/Health\\_Literacy\\_Action\\_Plan.pdf](http://www.health.gov/communication/hlactionplan/pdf/Health_Literacy_Action_Plan.pdf)
- <sup>100</sup> <http://www.oehcsa.org.au/library-resources/community/health-literacy/health-literacy-stocktake>
- <sup>101</sup> <https://www.guild.org.au/docs/default-source/public-documents/tab---the-guild/Strategic-Direction/health-literacy-promotion-.pdf?sfvrsn=0>
- <sup>102</sup> A Canadian evaluation of a pharmacy service for minor ailments showed that the minor ailment assessment took approximately 15 minutes to complete (range of 3-45 mins); see the final report of the Pharmacy Association of Nova Scotia “*Evaluation of the Provision of Minor Ailment Services in the Pharmacy Setting Pilot Study*”, October 2013, [https://pans.ns.ca/wp-content/uploads/2013/11/2013-10-17-PANS-report\\_FINAL.pdf](https://pans.ns.ca/wp-content/uploads/2013/11/2013-10-17-PANS-report_FINAL.pdf). This was reproduced in another Canadian evaluation which indicated that the consultation and documentation took a pharmacist ~15-20 minutes; see ‘*British Columbia Pharmacy Association (BCPhA) Clinical Service Proposal Treatment of Minor Ailments*’, March 2013; [http://www.bcpharmacy.ca/uploads/Treatment\\_of\\_Minor\\_Ailments.pdf](http://www.bcpharmacy.ca/uploads/Treatment_of_Minor_Ailments.pdf). Internationally, pharmacists are remunerated for providing a minor ailments service; see, for example, Community Pharmacy Scotland’s “*Minor Ailment Service - Remuneration*” at <http://www.communitypharmacyscotland.org.uk/nhs-care-services/services/minor-ailment-service/mas-remuneration/>; and the NHS Minor Ailments Scheme 2013/2014 at <http://psnc.org.uk/avon-lpc/wp-content/uploads/sites/23/2013/07/Br-CCG-MAS-Service-Contract.pdf>.
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