INTRODUCTION

Health promotion can mean working with individuals, groups or communities to change the determinants of health and disease in order to improve health and well-being of people. It is the process of enabling people to increase control over, and improve their health. Different practices such as legislation, policy development, organisational change community development and education are methods to promote health. Whatever the type of practice, the rural pharmacist’s role is to help others to learn more and encourage change. It is a pharmacist’s role to advocate, enable and mediate as important steps in helping to address the common issue. A rural pharmacist is a resource for others as one with expertise and a level of influence in the community.

Rural pharmacists have a wide role but they are usually restricted in their participation of many health promotion activities by the physical constraints of the pharmacy. By law, a pharmacist must be present when a pharmacy is open thus impacting on participation in outside activities during opening hours. However, the profession is changing. Not only do rural pharmacists face consumers when working in community and hospital pharmacies but they now work as consultants in areas such as home medication reviews. Our current research study, Pharmacist Involvement in Health Promotion Activities: Facilitators and Barriers examines the level of professional participation by rural pharmacists outside the pharmacy. Registered pharmacists in rural Tasmania were surveyed as to their involvement in community talks, newsletter contributions and media productions. Participation in community development Quality Use of Medicines opportunities such as campaigns to collect out of date medication or more general activities such as Falls Prevention programs, osteoporosis seminars or school health projects were also investigated. Respondents were asked to nominate perceived barriers to health promotion activities as well as facilitators. Pharmacy students were also surveyed as to their expectation of future participation in these activities.

This paper examines both the scope of health promotion for rural pharmacists and looks at various health promotion models before discussing preliminary findings emerging from our current study. These findings suggest that the reason why many rural pharmacists are not involved in health promotion is related to lack of time, lack of remuneration and lack of confidence as a health promoter. We think that professional satisfaction will be an important factor in retaining the next generation of rural pharmacists in the workforce and that the days of only dispensing prescriptions
are over. This study attempts to show that rural pharmacists can contribute to the health and well-being of communities through health promotion activities.

HEALTH AND HEALTH PROMOTION

In 1947, the World Health Organisation defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease, or infirmity”. It is a resource for life, not the object of living (WHO, 1984). Health should be approached from a holistic perspective and all aspects considered when encouraging change.

The Ottawa Charter (1986) defined health promotion as “the process of enabling people to increase control over, and to improve, their health”. The Charter has five components — development of personal skills, creation of supportive environments, strengthening of community action, building of health public policy and re-orientation of health services. The Jakarta Declaration declared that health is a basic social right and essential for social and economic development. Health promotion can now be defined as “the combination of educational and environmental supports for actions and conditions of living conducive to health”.

HEALTH PROMOTION AND RURAL PHARMACISTS

Health promotion is the initial standard of the Professional Practice Standards of The Pharmaceutical Society of Australia. The Society is the organisation which sets standards for the profession. This standard for health promotion states: “the pharmacist actively promotes health in the community and provides information on health conditions and their management”.

The scope of this standard states:

- “For the purpose of this document, the term “health education” refers to the provision of information intended to improve health or prevent ill health
- Health Promotion may occur (i) independent from the supply of a medicine, or (ii) at the time of counselling a patient on a dispensed medicine or when recommending a non-prescription medicine.”

The wording of this standard limits pharmacists by equating health education with health promotion. Referring to the definition by Green and Kreuter, health education is one part of the field of health promotion.

Pharmacists do “do” health promotion but usually only certain aspects of those segments as defined by the Ottawa Charter. The health promotion standard perpetuates this by equating health education with health promotion in many of the criteria, which make up the standard. For example, “Criterion 2: The pharmacist provides health education to consumers at individual and community level”. Indicators are health education to the patient or carer, health education relevant to the patient when counselling on medicines, written information on health education to patients and actively that the pharmacists participates in health education to the community. The wording is medical with the use of the word “patient” and tied into

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provision of information in individual or group settings. It can be argued this is health promotion, but it is a small part of what could take place. This is inherently tied to medication provision with no explanation of broader opportunities.

This standard on health promotion should underpin all other standards but it is separated and stands alone. Examples of other standards that should have health promotion as a base include those on dispensing (acknowledged), methadone provision and medication reviews. In the health promotion standard, health promotion is consistently referred to in the context of information supply. However health promotion, in the true sense, is not restricted to the provision of information alone. Pharmacists have a wider role. Provision of health information for pharmacists is part of day-to-day business. The public associate pharmacists with overcoming illness. We are asked, “What are the side effects of these tablets? How do they interact?” The rural pharmacist has the ability to suggest additional health options for improved outcomes.

In the 2002 revision of the standards there are indicators for health promotion as defined by the Ottawa Charter. The new standards do allow for participation in activities outside a pharmacy and acknowledge the role of pharmacists.

Rural pharmacists have opportunities to involve themselves in health promotion in both the community pharmacy setting or outside the pharmacy. An understanding of the scope of health promotion may then allow an active contribution to community health and well-being while also acknowledging factors outside the control of individuals.

Health promotion is not just health education. Different practices and methods may be used to promote health. Whatever the type of practice, the rural pharmacist’s role is to help others to learn more and encourage change. Some factors are personal or psychological in nature and can be influenced by the individual’s own effort or by professional support from a variety of health professionals. However many social and environmental factors are beyond the control of individuals. In these cases the rural pharmacist’s role is to assist the individual to work with others to address those factors, as a group, or as a community, rather than alone. Thus, it is a rural pharmacist’s role to advocate, enable and mediate. The rural pharmacist is a resource for others as one with expertise and a level of influence in their community.

HEALTH PROMOTION MODELS USED IN RURAL PHARMACY

There are several models for health promotion. These are medically, socially or behaviourally based. The Prochaska DiClemente Stages of Change model is the one often chosen for pharmacy care. Thinking about change, preparing for change, making changes and maintaining change with the opportunities to break this cycle or regress are simple individual approaches understandable in a pharmacy setting.

In 1986 in Great Britain health education leaflets were provided with a monthly rotation of topics. Health promotion is more than giving out information or leaflets.

The Barnett High Street Health Scheme, was the first health authority in Great Britain to train pharmacists in health promotion. It concluded that the barriers to pharmacists involvement in health promotion were time, money, space and lack of training. Other
studies concluded space, finance and conflict between the professional and commercial roles of pharmacy.8

The Royal Pharmaceutical Society of Great Britain (RPSGB) has two levels of pharmacist as defined in the 1998 paper “Guidance for the development of health promotion by community pharmacists”. Level 1 (generalist) uses passive health promotion techniques and will respond to requests for advice. Level 2 (specialist and pro-active) seeks opportunities to promote health. These activities do not specify the location of these programs but the inference is within a community pharmacy. Participation in local, state and national health campaigns can still take place within a pharmacy.

Pharmacists have a wide role but they are usually restricted in participation of many health promotion activities by the physical constraints of the pharmacy such as being required to remain on the premises during opening hours and the paucity of relief staff. However, the profession is changing. Not only do pharmacists face consumers when working in community and hospital pharmacies but they now work as consultants in areas such as home medication reviews.

**STUDY BACKGROUND**

Tasmania, an island to the south of the Australian mainland is a rural state renowned for a stable population. The population in 2001 was 470,272 people.9,10 Approximately half live in the south where the capital Hobart is situated. Hobart, which includes the neighbouring urban population centres of Glenorchy and Clarence, has a population of 138,667 equalling 29.49% of the total population of the state. It is classified as highly accessible within the Accessibility/Remoteness Index of Australia (ARIA) system. The rest of the population in the south consists of smaller rural towns. In the central north Launceston, has population of 62,682 people and along the north west coast the cities of Burnie (19,261) and Devonport (24,334) are the main population bases. Launceston and Devonport are classified as highly accessible while Burnie is classed as accessible.

Pharmacy classifications are slightly different.11 As is the case with Darwin, Hobart is funded under the Rural Pharmacy Maintenance Allowance and is not regarded as a capital city. Hobart, Launceston and Devonport pharmacies are regarded as Pharmacy Accessibility/Remote Index of Australia (PhARIA) 1, and Burnie PhARIA 2 and others cover the range up to PhARIA 7.

Thus it could be argued, Tasmania’s population as far as pharmacy classifications are concerned is 100% rural.

**METHODOLOGY**

The initial research for our study *Pharmacist Involvement in Health Promotion Activities: Facilitators and Barriers* was conducted before the professional standards were documented. Additional research taken in 2002 and 2003 of the study should indicate whether pharmacists have embraced health promotion as compared to health education and show any change over time.
Our current study *Pharmacist Involvement in Health Promotion Activities: Facilitators and Barriers* examines the level of participation by pharmacists outside the pharmacy itself.

All registered pharmacists resident in Tasmania in 1999 were surveyed by written questionnaire as to their involvement in community talks, newsletter contributions and media productions. Community development opportunities such as Wise Use of Medicines activities, Falls Prevention seminars or school health projects were also investigated. Contribution to national campaigns was also explored. Respondents were asked to nominate perceived barriers as well as facilitators.

Of those pharmacists registered, 80% practice in a community pharmacy setting, 17% in hospital and 3% in other aspects such as legislative, regulatory, or varying forms of consultancy.12

**PRELIMINARY RESULTS**

Of the 423 registered and giving their address as pharmacists in Tasmania there was a 26% response rate to the written questionnaire. The spread of the responses was even geographically over the north and south of the state. Some of the questions and responses are as follows.

**Question:** Have you ever given community talks in the past two years?

Yes ☐ No ☐

If yes, describe to whom and content

For example:

<table>
<thead>
<tr>
<th>Title and context</th>
<th>Audience and number attended</th>
<th>Length of talk</th>
<th>Preparation time</th>
<th>Aids and handouts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs Implicated in Falls (Falls Injury Prevention Workshop)</td>
<td>Health Professionals (80)</td>
<td>1 hour</td>
<td>4 hours</td>
<td>Own overheads, Self Care Falls Card, Self Care Osteoporosis Card, Medi-Lists.</td>
</tr>
<tr>
<td>How Our Bodies Fight Infections (Be Wise with Medicines Week)</td>
<td>6–7 year old, school class (2 classes 40 in total)</td>
<td>20 min.</td>
<td>2 hours</td>
<td>Colouring in — Germs, word puzzle (self made), some mixtures from a pharmacy, cotton wool white blood cells and TicTac germs</td>
</tr>
<tr>
<td>Wise Use of Medicines (Single Talk)</td>
<td>Senior Citizens (25)</td>
<td>30 min.</td>
<td>10 min. (done before)</td>
<td>Pamphlets — general health, Be Wise with Medicines Kit and some own overheads.</td>
</tr>
</tbody>
</table>

In the past two years 44 pharmacists presented 122 community talks. Sixty-eight per cent of pharmacists gave only 1 or 2 talks in this time. Based on these results, of those registered by the Pharmacy Board only 10.40% are involved in this activity.
Question: What do you think contributes to pharmacists not being approached to be involved in a range of health promotion projects?

- Lack of understanding of the skills a pharmacist can offer
- Pharmacy has poor links with other organisations and services
- Unmanageable time of requests
- Other

Responses were as follows:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of understanding of the skills a pharmacist can offer</td>
<td>78</td>
</tr>
<tr>
<td>Pharmacy has poor links with other organisations and services</td>
<td>49</td>
</tr>
<tr>
<td>Unmanageable time of requests</td>
<td>31</td>
</tr>
</tbody>
</table>

Some of the comments offered by pharmacists included:

- We have not promoted ourselves
- Expectation of receiving medication in “5 minutes” limits the influence of pharmacists
- Great way for pharmacy promotion, BUT it takes time (and money) and we need resources (and some pharmacists do not have the confidence to do this type of work)
- In this information age pharmacists must be pro-active in promoting their knowledge and expertise as this role is being usurped by nurses and quasi-health “professionals” such as complementary/alternative therapy
- The only thing that would prevent me is time, but it is ESSENTIAL to find time

Question: Are you aware of any activities of organisations where pharmacists are not represented but their input would be beneficial?

Rural pharmacists also commented on a range of organisations where pharmacy is not represented, such as nursing home boards, hospital affiliated organisations and self-help and community groups. Since the time of initial study some of these do now have pharmacist involvement. Organisations, such as the Nursing Mothers Association of Australia (now know as Australian Breastfeeding Association), was noted as not having pharmacist involvement. This appeared to be a regional comment as pharmacists are prominent in other areas. Thus some rural pharmacists are not involved with organisations which impact on their profession. Opportunities of participation in areas of community development, potential legislation, policy development, and organisational change may be unrecognised or not acted upon.

CONCLUSION

Additional research is now required and rural pharmacists will be surveyed again and comparisons made with pharmacists in Victoria in an area with a similar population spread and mix. Since the initial study was undertaken, comparison of potential change with Quality Use of Medicine promotion and the advent of medication reviews
in nursing homes and home medication reviews may have started to change the image of rural pharmacy.

The rural pharmacy profession is in crisis with a consistent lack of qualified pharmacists despite the opening of several new pharmacy schools around the country. The average pharmacist in rural areas is male, over 50 years, who may plan to retire in 10 years. Since 1999, Tasmania has only had an increase of 9 pharmacists on the register. Professional satisfaction is something of value to pharmacists and gone are the days of a satisfying career constantly dispensing prescriptions. With other options available for practice, pharmacy is changing.

Rural pharmacists are highly respected members of the community, but reliance on the potentially automated processes of dispensing can threaten this profession. Rural pharmacists must show they can contribute to health in other ways for future viability and professional satisfaction.

REFERENCES

PRESENTER

Helen Howarth has had past experience in community and hospital pharmacy as well as a support and educative role for pharmacists in the Tasmanian community methadone program. In her last position she was a consultant pharmacist with the Tasmanian Health Department where she worked in the areas of health promotion and as an educative resource for health professionals including rural practitioners, thereby enhancing their role in the community. She is a councillor and Chairperson of the Professional Development Committee of the Pharmaceutical Society of Australia (Tasmanian Branch). Combining family commitments with masters hockey and rowing there is also some time for cross-stitch.

In Tasmania, the UDRH’s responsibility covers the whole island except metropolitan Hobart, although it is recognised that there are important rural outreach services from the capital city. Consequently there are many areas of pharmacy practice for students including King and Flinders islands. All students have a rural placement and some community and hospital placements are in rural areas. In addition, an interdisciplinary program is in its second year with students of medicine, nursing and pharmacy working together at rural health teaching sites.

Helen is enjoying the challenge of her new role of enhancing the rural experiences of pharmacy students and supporting of their mentors thanks to the support of Mark Dunn and the School of Pharmacy and UDRH.