

3rd August 2016

Submission to The Review of Pharmacy Remuneration and Regulation

To whom it may concern,

I am a young pharmacist who has primarily worked as a clinical pharmacist in large tertiary hospitals in South Australia. Based on my experiences, I believe if patients were properly educated on their medications and conditions, and their diseases were better managed, a considerable number of hospital admissions could be avoided.

For this reason I am currently transitioning to focus my work in the community as this is an area I feel would benefit greatly from professional pharmacy services. Some of these services include ongoing medication reviews and follow up, education and advice, ongoing management of chronic diseases and monitoring for compliance, adverse events and efficacy. Unfortunately these services are not fully recognised and I face the dilemma of “who will pay me?”

As you are well aware, Australia has an aging population, a rise in chronic diseases and consequently we are seeing more complex patients with polypharmacy. General practitioners (GPs) are doing the best they can to manage these complex patients but unfortunately are frequently time poor. As pharmacist we have the unique opportunity to help support these GPs to better manage their patients by conducting medication reviews and providing ongoing education and advice.

There is evidence to show Home Medicine Reviews (HMRs) and pharmacist reconciliation reduce medication errors and improve patient safety however, this is often a fragmented service and consequently we still frequently see medication errors during the transition of patient care. I believe pharmacists can play a vital role in the community to regularly review patient medications, ensure GP records stay up to date and the patients health care providers are all on the same page to improve the continuity of care.

As my role is a non-dispensing pharmacist, and I have no affiliation to a retail pharmacy, there is no conflict of interest and I can focus my efforts on clinical services to promote the quality use of medicines, getting the best outcomes for my patients. Unfortunately I am currently restricted as to the number of HMRs I can do and there is little to no remuneration for the other services I am able to provide, such as ongoing reviews, monitoring and check ups, education sessions, chronic disease management and other pharmaceutical or health advice. This makes it difficult and frustrating for myself and other like-minded pharmacists as we are left out of pocket when we provide these quality and valuable services. Unfortunately, some pharmacists simply cannot afford to offer them.

Currently being explored and supported by large professional associations such as the Pharmaceutical Society of Australia (PSA), the Society of Hospital Pharmacists Australia (SHPA) and the Australian Medical Association (AMA)

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is the role of pharmacists in GP practices where I also see great potential but why limit these clinical services to the GP practice? Medicine reviews are most effective when conducted in the patients home as the pharmacist gets a greater insight into the patient's living arrangement and the way their medications are stored etc.

Where possible, healthcare services should be proactive rather than reactive. Supporting the role of a mobile pharmacist in the community would enable this. The pharmacist would be able to visit patients in their home to assess and review such things as compliance, device technique, blood sugar control as well as monitoring for adverse events and efficacy to identify and address issues before they become clinically significant or cause harm to the patient.

I propose that funds from the 6CPA go in to further support the role of non-dispensing pharmacists in the community who can educate patients on their disease(s) and medications, help them manage their conditions with regular follow up and provide ongoing advice and support. This would help empower patients to take control of their health and ultimately improve their outcomes. The ongoing nature of this service is conducive to pharmacists being able to pick up errors and identify issues earlier to report back to their GP. It would also dramatically improve patient care, safety and potentially reduce hospital admissions.

I would recommend that the pharmacist is paid a wage similar to the Pharmacist in a General Practice model but are not limited to the confines of the Practice and may work with multiple GP clinics in a specified area. Alternatively the cap on HMRs should be altered to 40 so the non-dispensing clinical pharmacist is able to make an adequate living. I appreciate that there may be some pharmacists that try to abuse this, producing rushed and poor quality reviews to receive maximum remuneration. However, I don't believe this would work in their favour as GPs receiving these inadequate reviews would look elsewhere for the service, leaving these pharmacists struggling to find work.

In conclusion, pharmacists' skills are being underutilised in the community and this is primarily due to a lack of remuneration. The healthcare system needs to establish ways to better managing patients in the community to keep them out of hospital and pharmacists can play a key role in this. Having non-dispensing pharmacists in the community means they are able to visit patients in their home environment, focus solely on optimising patient care, reporting important information back to the GP when it is most critical and helping to educate and empower patients to take responsibility for their health.

King Regards,

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