

Review of Pharmacy Remuneration and Regulation Submission

1st September 2016 by Sue Scott

Submission to The Review of Pharmacy Remuneration and Regulation.

I write as an accredited pharmacist who has been performing HMRs and RMMRs since 2002. It is interesting that these services were originally funded according to available evidence of benefit and subsequent to that many Australian trials have shown the benefit of these medication reviews to health outcomes. However a further review is currently underway to show their benefit.

With respect to Home Medicines Reviews, the types of information I routinely provide to GPs are:-

- Medication reconciliation- the HMR referral provides the list of medications the doctor has on record for the patient. Very rarely do I find this list accurate, and need to provide an updated list of medications. This includes specialist- prescribed medications, other GPs prescribed medications, OTC medications and complementary medicines. Often the doctor has not included their own changes to medicines prescribed.
- Adverse drug reactions not identified by the doctor – often leading to a cascade of other medicines e.g. drug causing tremor and nausea, leading to prescribing of anti-nauseants and drugs to stop tremor.
- Drugs doses not suitable for age leading to risk of toxicity or current actual symptoms. E.g. diabetes medication in the elderly causing diarrhoea (which really affects QOL).
- Drug interactions potential leading to hospitalisations

Information provided to the patient e.g.

- Explaining indications for all medicines – can improve compliance, or if no longer needed may lead to drug cessation.
- Reviewing inhaler technique – currently most Australians are not using their inhalers optimally, explaining correct use and ensuring regular use reduces hospitalisations.
- Advising of unnecessary (and often expensive) supplements with little evidence of benefit.
- Recommending dose administration aids to assist compliance (either weekly pill boxes- patient prepared or DAAs that are pharmacy prepared).

With the current poorly funded medication management programmes, an accredited pharmacist doing HMRs alone can earn a maximum of circa \$48,000pa. While the Review is not specifically concerned with a pharmacist earnings, it should be aware that there are considerable costs involved in earning an income doing HMRs (which I was doing full time prior to the changes in 2013)...

If the Review sees these services of value in reducing the health burden in Australia, then :-

- removing the cap on HMRs or increasing it to a reasonable level (e.g. 80-100/month),
- ensuring rural and remote patients have equal access (so HMRs can be done in town) – under the current rules a pharmacist may have to drive 200kms to see a rural patient or have to get on a ferry to visit a patient living on an island e.g. in SE Qld (and Pharia 1) – all of which make the exercise not financially viable.

- ensure indigenous patients, mental health patients and DVA patients are regularly assessed and follow-ups are part of the programme.
- Fund the HMR and RMMR programmes under the MBS, not via the CPA (note the Pharmacy Guild does not represent accredited pharmacist unless they are also pharmacy owners, and their financial interests may be at odds with those of accredited pharmacists)

These measures will ensure that a pool of full-time accredited pharmacists is available to provide these services to the Australian community. Currently this is a part-time job and costly enough for pharmacists that it does not represent a viable career option.

My own experience is that members of the community greatly value this service, GPs appreciate the input (just as they do from other specialists and health providers) and as part of the health care team, accredited pharmacists have a valuable role in improving health outcomes and reducing hospitalisations.

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