

5. Phase Three: Public Call for Submissions

This chapter presents the key issues that emerged out of the public Call for Submission process. The objective of this third phase of the project was to expand on the views identified in the Literature Review and Stakeholder Consultations, to facilitate detailed and considered input by other interested parties. (A List of Submitters is attached at Appendix 3. The advertisement for the Call for Submissions is shown as Figure 2 in this report.)

5.1 Key findings from the Call for Submissions

The following section presents the key findings from the submissions. This section has been grouped according to the recurring themes that emerged.

5.1.1 Awareness, engagement and participation

A number of professional issues were reported to be inherent in the current HMR process, including a lack of engagement of GPs and pharmacists.

Many of the barriers to the uptake of HMRs were attributed to a lack of interest by pharmacy owners in facilitating HMRs. Some MMR Facilitators and consultant accredited pharmacists viewed community pharmacy owners as, not only disinterested in HMRs, but at times neglectful of their role in the process. (MMR Facilitator VIC; and consultant accredited pharmacist, VIC)

... if I wasn't providing this service, then probably nobody would - the local pharmacy has shown no interest in doing HMRs since the Program started many years ago, and even now, barely manages to acknowledge my presence. They even asked me to stop emailing copies of the HMRs to them because they never read them anyway! (Consultant accredited pharmacist, VIC)

Submitters claimed that the lack of interest shown by community pharmacy business owners or managers in facilitating HMRs was due to two reasons. Firstly, there is a perceived lack of immediate financial reward for the community pharmacy business owner/manager. Secondly, it is a time-consuming and costly process for the community pharmacy business owner/manager to either personally undergo accreditation training or have a staff member do so.

A number of accredited pharmacists and consultant accredited pharmacists reported that while they were willing and able to conduct HMRs, their efforts to promote the HMR service to GPs were not successful. Attempts to engage GPs in the process did not result in HMR referrals. However, the requirement for a community pharmacy to be involved in the process was reported to be a factor for consultant accredited pharmacists who perceived that pharmacy owner/managers may be unwilling to facilitate HMRs, thus rendering the promotion of HMRs to GPs a fruitless exercise. (University submitter, QLD)

Many submitters reported that a general lack of understanding between the parties involved in the HMR process impeded the successful and timely completion of HMRs. GPs were reported to lack an understanding of the needs of community pharmacies and accredited pharmacists and vice versa. This lack of understanding was reported to be particularly severe in relation to the level and type of information required by each party. Overall, these factors were seen to contribute to the low value of some HMRs.

Strategies to increase GP engagement

A number of submitters thought that visits to GPs by facilitators to promote HMRs were not productive, however the use of real-world case studies was thought to enhance the value of the MMR



Facilitator's role, and to be an effective tool in demonstrating the value of HMRs to promote participation.

The provision of case studies was supported by both MMR Facilitators and Divisions. These submitters believed that real case studies would provide evidence to GPs of benefits to the patient. (MMR Facilitator, NSW)

The lack of measurement of aspects of the HMR Program was reported to affect the uptake of the Program by GPs, as they were not convinced of the benefits of the Program. Therefore, submitters recommended an assessment of the Program be conducted to boost Program credibility. To address this issue, some submitters recommended that the Program be reviewed annually - with clearly defined measures of effectiveness and uptake – so that the results can be communicated to GPs and pharmacists.

Promote Program evaluation: a collective, transparent, evaluation of the service describing how and why it works would provide an evidence base and broader support for the initiative among health professionals. Hard clinical data and an assessment of the findings with recommendations will add further credibility.
(National authority)

Linking HMRs in with National Prescribing Service (NPS) facilitation program for GPs was considered a valuable strategy to raise the status of the HMR Program with GPs.

Strategies to increase community pharmacy engagement

There were some suggestions of a need to increase promotion of the HMR Program to community pharmacies with the aim of improving the slow uptake of HMRs, however there was little supporting information to indicate that this would be any more successful than previous attempts. The Guild was expected to play a vital role in this promotion, and both GP and pharmacy-based submitters called for greater action by the Guild.

Some submitters criticised the current strategy and communications campaign employed by the Guild (in some parts of Australia). These submitters suggested that the campaign (based around Margaret Fulton) is outdated, and misses the target audience of HMRs. Submitters suggested that the Guild revise its advertising and reconsider its target audience. (Regional DGP, WA)

Strategies to increase consumer engagement

Nearly half of the submissions received mentioned the need for an enhanced consumer awareness campaign in order to drive uptake of HMRs, however few submissions addressed the question of whether such an approach was appropriate or whether the consumers reached would be those in greatest need of a HMR.

Many submitters reported that the great majority of consumers who would benefit from a HMR were not aware of the Program, so would be most unlikely to ask for a referral from their GP. This lack of awareness was demonstrated from both personal experience and from research conducted in the area. (QUM Officer, Regional DGP, SA)

... Four out of six patients interviewed had no prior awareness of the HMR service. (MMR Facilitator, Regional DGP, Qld)

Further, it was reported by one submitter that awareness of HMRs appeared to be decreasing rather than increasing, despite the promotional efforts to date.

NPS' annual survey shows that 29% of consumers were aware of HMRs in 2005 compared with 32% in 2004 and 31% in 2003. The question was not asked in 2006 and NPS is currently examining 2007 results. (National authority)



One submitter who supported the need for additional efforts by The Guild to generate demand for the HMR service by consumers quoted the Urbis Keys Young report of 2005 to back up their suggestion.

Some submitters were critical of the consumer education and awareness campaigns that had been implemented to date by The Guild.

I believe the HMR Program needs to be marketed to the public much better than it has been. After close to a decade of operation, very few people are aware of it, and that shows that the marketing to date has been woeful. (Consultant accredited pharmacist, VIC)

Mixed feedback was received about the consumer campaign which featured Margaret Fulton. One submitter indicated that the campaign sent many wrong messages about HMRs to consumers, while another suggested that the entire campaign was outdated.

A revised national advertising campaign for consumers was suggested by almost half of submission respondents. The campaign was thought to require two key components: raising awareness of the Program; and prompting a call to action for consumers to ask their GP about a HMR.

Many submitters felt that messages for a national campaign should focus on a self-empowering model for the patient, so they do not feel that a HMR is ‘checking up on them’ but will be empowered to self-manage their medications. The benefits of the Program and absence of out-of-pocket expense for consumers were considered to be important messages to convey.

While support for a mass media campaign was strong, other submitters (Consultant accredited pharmacists, VIC) advocated a more targeted approach, and suggested promotion through specific consumer support groups.

NPS, in partnership with Council of the Ageing, runs a peer education Program which has delivered 1,000 sessions to approx 23,000 senior Australians per year. Seniors attend a community education session for 1 hour, which promotes HMR and provides written information for participants to take away. There is scope for an integrated approach to promoting the service through some of the Programs that NPS or other organisations currently run. (National authority)

Strategies to boost numbers of HMRs

The submissions contained arguments for and against the introduction of universal screeners and automatic triggers for HMRs. Those who argued in favour of such screeners and triggers saw them as a clear means of increasing uptake of HMRs, while those against this approach felt they would encompass many consumers who did not necessarily need a HMR – that is, boosting numbers of HMRs regardless of the level of risk of medication misadventure would be inefficient and inappropriate.

Many submitters supported the introduction of blanket screenings or universal triggers for HMRs, although these appeared to be predominantly submitters related to pharmacy peak bodies.

A pharmacy peak body suggested that a HMR request should be automatically generated for patients who are aged over 65, who are taking four or more medications, who have been discharged from hospital or who have reached the Pharmaceutical Benefits Scheme Safety Net limit.

A pharmacy peak body also suggested that for chronic disease patients, automatic referral for HMR could be categorised into four categories - with four triggers for the initiation of a review. (Note, further discussion about HMR linkages, with reference to Indigenous consumers with chronic disease, is included at Section 5.1.4)

I believe that the HMR Program should be integrated into the numerous chronic disease management and preventative health Programs being rolled out by the Department of Health & Ageing ... HMRs are seen as yet another MBS item number with its own unique qualifying criteria...

HMR as part of an over 75 year old Health Assessment



HMR as part of annual cycle of care in Diabetes management or in COPD/ Asthma management

HMR prior to a patient commencing a D.A.A.(dose administration aid)

HMR as a part of the development of a GP management plan for a patient with a chronic or terminal medical condition

HMR for a patient with an intellectual disability.

(Consultant accredited pharmacist, VIC)

A consultant pharmacist suggested that the HMR trigger and administration process could be amended for patients with chronic diseases. Rather than an annual review, this stakeholder suggests that the trigger for a HMR could be integrated into existing diagnostic and screening procedures.

For chronic diseases such as COPD asthma, heart failure and chronic pain, consideration could be given to <allow>ing a 2-3 staged review instead of restricting HMRs to an annual intervention. This would allow identification of issues, collaboration with the GP and follow-up where outcomes could be measured to determine effectiveness (Consultant accredited pharmacist, WA and GP, WA)

Provisions which exist within the detail of the current business rules allow for more than one HMR per year under certain rules, including a new referral from the GP and following assessments of continuing clinical need. The comments by submitters indicate however that there is very little awareness of this provision and it is clear that it is not how HMRs are being delivered at present.

To establish which risk factors are being used by GPs to identify HMR candidates, one academic (VIC) suggested accessing some of the GP networks such as the Health Communication Network.

5.1.2 Gaps in access for potential service recipients

A large number of submitters identified that **post-hospital discharge** should act as a vital trigger point for a HMR but noted that at present this is not occurring. The weeks immediately following hospital discharge were seen as the most crucial for patients in learning to manage their medications. Often patients discharged from hospital may not see their GP for some time, or the GP may not be aware they have recently been hospitalised, so they may not be given a HMR referral for some time.

...currently, I feel the system fails in this area, as hospital discharge protocols should include post-discharge review by a pharmacist (MMR Facilitator, WA)

When a patient comes out of hospital, the referral pathway is even longer than the usual HMR referral pathway, precisely when it needs to be the most streamlined and occur most urgently. (DGP, VIC and Regional Health Service, VIC)

The referral pathway is complex: Referral to GP, then community pharmacy, then accredited pharmacist, then review and proposal for consideration/ action undertaken. . (Peak body)

A number of accredited pharmacists reported in their submissions that they had often arrived to conduct a HMR without being advised that the patient had a limited grasp of English, causing difficulties in the conduct of the review. At present, in some states and territories, accredited pharmacists are unable to directly arrange free interpreting services, but instead must make this arrangement through the GP's office. Submitters indicated that such an arrangement is rarely made, or is cumbersome to arrange and the problem is compounded by the lack of pre-notification that the patient had limited English. (Consultant accredited pharmacists, VIC and NSW)

Both pharmacy and GP-based submitters recommended that the community pharmacist should be able to arrange interpreter services for a HMR, free of charge, just as the GP can. Both parties viewed the effective provision of interpreter services to be a matter of equity in access to the HMR Program. (Pharmacy peak body)

5.1.3 Reaching those at highest risk of medication misadventure

Concerns that many people who are most in need of a HMR are currently missing out on the service, were prevalent throughout the submissions. Many submitters provided recommendations on how best to reach these high risk consumers.

Access for residents of Supported Residential Services

Residents of Supported Residential Services are automatically considered suitable candidates for HMRs, however it appears that some GPs may not be aware of this. One stakeholder suggested that an educational campaign could focus on this area to raise GPs' awareness.

Many residents in Supported Residential Services and Community Residential Units are eligible for HMRs; however there is confusion among GPs about this. This has arisen because of the distinction between RMMR and HMR for residents in Commonwealth-funded beds in aged care facilities. (DGP, VIC)

One stakeholder described a pilot project that promotes medication reviews in Special Residential Services. The liaison with management and the conduct of HMRs at these facilities was thought to be of great value.

These centres are the homes of many people with serious health problems, disabilities etc, and are staffed by people with generally minimum medication management skills. Assistance with administration of medicine is greatly valued using a HMR with the resident and the carer. In federally funded Aged Care Homes, an annual Residential Medication Review can be initiated by the pharmacist or a collaborative one by the GP. This should occur in <Supported Residential Services> and <Community Residential Units>.

5.1.4 Access for Indigenous consumers

There has been very little use of HMRs among Australia's Indigenous population, where the incidence of medication non-compliance and misuse is known to be significant. (Consultant accredited pharmacist, NSW)

In addition to the remote location issues related to many Indigenous communities, accredited pharmacists described a range of specific challenges associated with conducting HMRs with these consumers, where they had very little exposure to western medicine.

A very different model of care is needed. There is an assumption that they understand the western biochemical health model, but many do not. In other words, many do not even understand what it really means when you say 'Take this white tablet three times a day', so you have to start at such a basic level ... and it takes a lot of time and many visits to ensure the basic information is given and understood. ... Even the concept of 'Home' in Home Medicines Reviews is mostly irrelevant. I'm just as likely to be talking to patients under a tree in the dust out the back of somewhere, surrounded by lots of others, who will also listen to what you're saying, which means you are also educating a number of people at once, so there is that flow-on benefit as well. In this setting, the Aboriginal Health Worker acts as a cultural broker really, and will translate as well for health professionals who do not know the local languages, but then the pharmacist can do their job. (Locum pharmacist, very remote area, WA)

Access to a GP for remote Indigenous patients is extremely difficult, and secondly, health workers in these areas were reported to be occupied with acute or high priority health matters rather than referring to, or taking part in HMRs.

I visit some remote communities in the region, none of which have a resident full-time GP. The communities range in size between 80 and 400 people and have a health clinic staffed by nurses or Aboriginal Health Workers. The GP operates mainly by telephone communication with these staff and make regular visits. On the regular visits, they are usually flat out with urgent things that relegate things such as HMRs to the bottom of the pile. (Academic submitter, NT)



All respondents who tabled issues regarding remote communities agreed that the current HMR model is largely unworkable for remote areas. Workforce shortages in very remote areas severely limit consumers' access to HMRs, and most consumers are Indigenous and are typically facing multiple healthcare challenges. Importantly, many communities in very remote areas do not have a community pharmacy to dispense medications let alone undertake HMRs.

Referrals to a 'community retail pharmacy' via a GP are so impossible for this population. Indigenous clients who use an Aboriginal Health Service (AHS) generally do not ever set foot into a community pharmacy. They receive all of their medications directly from the AHS. (Consultant accredited pharmacist, NT)

A submitter (Locum pharmacist, WA) with extensive experience with remote desert communities, stressed the need to build rapport and continuous engagement with Indigenous consumers in order to gradually make a difference on medication compliance. He emphasised that a HMR process with this population ideally would involve up to three medication discussions a year, with the first visit solely related to building rapport and basic education about medicine and tablets. This would be followed up several months later with a little more information and again later, each time gradually adding to the knowledge and reconfirming the important messages. He claimed that a one-off visit by a pharmacist they'd never met, and without any follow-up, would be ineffective.

I have heard of some pharmacists who have gone into Indigenous communities in the northwest and just done as many HMRs as they possibly can in one day (as that was the only way they could get them done under the current funding model) and this means they can spend very little time with each individual. The patient would have no idea what they were talking about most of the time and so it would all be a complete waste of time. (Locum pharmacist, WA)

In order to target more Indigenous Australians for a HMR, a number of submitters recommended that all Indigenous patients on the chronic disease register be automatically referred for a HMR. Automatic referral for a HMR for those on the chronic disease register would enable easier access for a visiting pharmacist, as they would know that a certain pool of reviews could be conducted in any one visit, avoiding problems dealing with a transient population who might move from community to community every few months. Using the register in this way was also seen to reduce complexities associated with the referral process.

Anyone on a chronic disease register <in an Aboriginal community> should be <referred>, because the doctor has put them on there in the first place with a diagnosis, so they should be <considered to be referred for a HMR> simply because of that.

All Aboriginal health services are dealing with extremely high rates of chronic disease, and most adults in the community will be on the chronic disease register, so this provides a means to manage a model of the HMR Program which could work for these communities. (Locum pharmacist, WA)

The inclusion of the AHS in the HMR process was thought to address two significant barriers to uptake in remote areas: the lack of GPs and the absence of community pharmacies.

There is a need for special arrangements with accredited pharmacists that are doing HMRs, so they can work directly with the doctors in charge of AHSs and not have to go through a retail pharmacy ... The need for AHSs to have available the pathology results that are needed for the HMR pharmacist and make these available to the AHW <to forward> to the HMR pharmacist. The case for direct contact between an accredited pharmacist and an AHS will be greater as AHSs move more towards having their own pharmacist employed by the AHS – an ideal that many aspire to, especially the regionally based 'health boards' and the larger urban-based health services. (Consultant accredited pharmacist, NT)

One submitter recommended that Aboriginal Health Services be empowered to make HMR referrals, and also suggested the use of telemedicine to further expedite the process.



...modifications to the business rules for undertaking HMRs need to be made to encourage greater usage of the HMR service amongst Indigenous people. For example, the business rules should be changed to allow referrals for a HMR for an Indigenous person to be made by an Aboriginal Health Worker (AHW)/nurse employed by an Aboriginal Medical Service (AMS) or over the phone by a medical practitioner working for/in AMSs. (Peak body)

Some suggested that the parties involved in the HMR process need to include medical practitioners who are in remote locations, including those from the Royal Flying Doctor Service (RFDS) and registered nurses, as opposed to relying on practitioners, like GPs or community pharmacies, which are not located in these areas. The authors note that the Department advises that in fact RFDS medical practitioners would already be able to refer for HMRs but they are not eligible for any rebate. It appears that the options for RFDS involvement are either not known or poorly understood by many of those who work in remote health, including, as demonstrated in the quote below, some MMR Facilitators.

I have several towns in this situation ... Why <can't] there be provision for a registered nurse, such as those practicing in rural nursing posts ... to apply to Medicare for permission to refer for a HMR? If a patient living in a <remote] town ... requires a doctor, they will generally see a doctor from the Royal Flying Doctor Service (RFDS) in a clinic. However, RFDS doctors are unable to claim MBS item numbers (such as Item #900 for HMR) due to the service's funding structure; therefore, they are reluctant to refer as the process does require time and labour without further remuneration for the organisation. The result of this is no usage of HMRs in these towns. (MMR Facilitator, Regional WA)

Access for rural/remote consumers

A number of submitters reported that in some rural areas a cluster of issues combine to make HMR work less attractive to consultant accredited pharmacists. In turn, the shortage of practitioners limits consumers' access to HMRs in those areas.

Submitters pointed out that some small towns do not have their own community pharmacy. Under the current HMR model, this prevents access to HMRs for consumers living in those areas.

Many rural areas do not have a pharmacy, but have dispensing nurses and GPs, therefore there is no way an accredited pharmacist can be contracted in this situation. (Consultant accredited pharmacist and academic, Qld)

Submitters also reported a chronic shortage of accredited pharmacists in some rural and regional areas. This shortage meant that consultant accredited pharmacists travel long distances to reach patients. (Consultant accredited pharmacists, QLD and VIC; pharmacy peak body; and the CEO of a Regional DGP, VIC were among the submitters who discussed this issue.).

In a number of submissions, supporting information was presented to describe strong relationships between health professionals leading to an effective HMR Program in those rural areas. The approach succeeds through the rapport established between hospital discharge staff, GPs and community pharmacy business owner/managers in these areas.

Access for CALD consumers

Submissions regarding CALD consumers tended to correspond with the findings of the literature review and indicate a desire for accredited pharmacists conducting HMRs to be authorised to arrange free interpreting services for patients directly, rather than via the GP's office. The issue of access to free interpreters arose repeatedly in the study, at different phases of the research. While such services may be available, they are either not widely known or cannot be easily accessed or to do so requires time-consuming arrangements involving the GP (in some states/territories). It is clear that there is variation among states and that this is an issue of concern for consultant accredited pharmacists. The current arrangements often lead to no interpreter being used at all, an approach widely acknowledged as sub-optimum. As some submissions described CALD patients as being among those at high risk of

medication misadventure, this interpreting issue is of particular concern. Often the lack of language skills is seen to contribute to low levels of understanding of medications.

5.1.5 The HMR process

The following section looks at submitters' views on procedural and practical aspects of the HMR Program, including referral pathways, conducting HMRs and reporting.

Referral pathways

Submitters reported a number of issues in relation to the HMR pathway that exists between GPs, community pharmacies and accredited pharmacists. The delays associated with the required pathway between these submitters were also raised as an issue.

Numerous submitters expressed the view that some GPs are uncomfortable with referring to an unknown pharmacy or pharmacist to conduct the HMR review.

In response to this, submitters recommended that there should be an option for GPs to refer directly to the accredited pharmacist rather than going through the community pharmacy business owner. This approach was advocated by a wide range of respondents including GPs, community pharmacy business owners, government and peak bodies, Divisions, academics and MMR Facilitators. However, it should be noted that even with this direct model, most submitters advocated for the community pharmacy maintaining some level of involvement, for example the GP should supply a copy of the HMR report to the patient's nominated community pharmacy or the community pharmacy business owner/manager could charge a fee for providing information and acting on reports if nominated by a consumer as their regular pharmacy.

On the other hand, not all submitters advocated changes to the referral pathway for HMRs. One, in particular, advocated for the HMR service delivery model to remain unchanged as they saw the current model as the one to provide the greatest value and best clinical outcomes for consumers. This view- that the model should remain unchanged- was strongly contested within the submissions. In particular, the assumption that continuity of care is embedded in the current model, where the GP refers the patient to the community pharmacy of their choice, was disputed by a number of submitters. However, there was support for retention of the community pharmacy's role in the HMR referral pathway because they have the patient's dispensing history, know the patient's background and can offer advice the next time the patient orders medication.

As already noted, several submitting organisations felt that nurses should be able to make referrals for HMRs in certain circumstances, in order to relieve the burden on GPs and thereby improve access for some patients. While many Practice Nurses are understood to already actively identify patients in need of a HMR and make a recommendation to the GP for a referral, several submitters believed that the Practice Nurse should have the ability to undertake a great deal of the referral and recall process unaided. However, the majority support the use of a Practice Nurse to initiate the referral system under the supervision of a GP.

One submission from a nursing organisation indicated the use of nurse practitioners in the HMR referral process is supported given their role in relation to medications is now somewhat closer to that of medical practitioners. The submission stated that, in their ability to provide patients with additional services known as 'extended practice', nurse practitioners are ideally placed to identify issues of medication mismanagement and recommend patients for HMR referrals.

Nurse Practitioners are often faced with issues of poly pharmacy, misuse and mismanagement of medication particularly in the community setting ... <they> are ideally placed to identify elements contributing to mismanagement and/or misuse of medicines.

Some submitters considered medical specialists should also be able to initiate HMR referral. It was suggested that for some people with highly complex conditions, the relevant specialist is the medical practitioner who has overall say on any and all aspects of their medical treatment. In these cases, a GP was seen to be highly unlikely to be involved or to feel comfortable recommending a HMR. However, there is no consistency in the submissions on the question of whether specialists should be able to refer for HMRs. While some submissions proposed that medical specialists should be able to initiate HMRs, others recommended that specialists only be able to recommend a referral, not actually refer.

Patient self-referral was seen by a number of pharmacy based submitters as providing a direct way to increase the numbers of HMR referrals. The appropriateness of such an option however was a matter of debate. While a small number of submitters recommended investing certain patients with the ability to self-refer for a HMR, there is little overall support for this approach.

Conducting HMRs

Government legislation in many parts of Australia requires that at least one community pharmacist be present in pharmacies during opening hours. However, the HMR process necessitates that accredited pharmacists work off-site, thus depriving some pharmacies of one staff member. Submissions indicated that in situations where the community pharmacy business owner/manager is the only available accredited pharmacist, many felt forced to either conduct reviews after pharmacy hours (a personal burden) or employ another pharmacist to undertake reviews (a burden on the pharmacy as a business). Even where the community pharmacy owner/manager undertook the interviews, this led to the same dilemma of absence from the pharmacy and resulting need to work on this outside normal hours.

A range of submitters expressed concern about the length of time between each step in the HMR process. Throughout the phases of this study, significant concerns were raised at the excessive delays in HMRs being undertaken. Regardless of the range of reasons for this, the effect was one of HMRs frequently being conducted in a timeframe which was far from ideal for the consumer. Submitters reported that logistical issues contributed to prolonged and variable time frames at all stages of the HMR process, from initiation through to follow-up. HMR guidelines recommend that the review process be completed within 2–3 weeks. However, respondents reported that significantly longer timeframes are the norm. For example, a small study undertaken by one submitter (Ph.D candidate (Qld) concluded that the whole HMR process commonly takes 11 weeks or longer to complete. This timeline was consistent with findings of the qualitative phases of the fieldwork but was in contrast to the apparent lack of awareness or possible underestimation by many of the stakeholders, about the extent of delays.

Submitters recounted a range of factors that contribute to delays, including the complexity of the referral process and the potential for the process to ‘break down’ if one of the parties to the HMR did not complete the required actions (GP, patient, community pharmacy etc).

Both GP and pharmacy-based submitters identified that ‘blockages’ and delays associated with the referral process were often due to a lack of action by pharmacies. (CEO, Regional DGP, VIC; Consultant accredited pharmacists, VIC). Concerns of this kind were certainly borne out in the qualitative fieldwork with health professionals. These substantial delays were reported to have a flow-on effect that limited uptake of the HMR Program. Some pharmacy and GP-based submitters questioned the clinical effectiveness of HMRs due to the delay in implementing medication regime changes as a result of the HMR. Further, one Division Representative(Qld) reported that delays and systemic blockages caused some GPs to cease using HMRs altogether.

GP frustration with time lag between referral to receipt of report from pharmacy discourages continued use of the item number. (Peak body; Statewide DGP, NSW and Regional DGP, Qld)



Referrals and Reporting

Submitters reported considerable variation in the quality and overall usefulness of referrals from GPs. From an accredited pharmacist's point of view, submitters reported that GPs did not always provide sufficient detail about *why* a HMR is required, or the medical history of patients. Further, it was often reported that the referral to the pharmacist provided insufficient information, or large amounts of irrelevant information. These factors were reported to impact on the pharmacist's ability to effectively conduct the HMR, or provide a useful and meaningful report back to the GP.

Communication of reasons for referral by doctor e.g. 'symptoms of adverse drug reaction' but often no information is provided in the referral as to what symptoms may suggest adverse reaction or if there is any idea which drug may be involved. What made the doctor think there was an adverse drug reaction?
(Consultant accredited pharmacist, WA)

The use of an electronic system was also proposed to generate standard referrals that could be filled in and sent to the community pharmacy electronically. The same software could generate a standard reporting format that could be sent electronically back to the GP. Such a system was suggested as a means to simplify the referral required by the GP. (MMR Facilitator, Regional DGP, Qld)

Conversely, both GP and pharmacy-based submitters expressed dissatisfaction with the quality of the pharmacist's report back to the GP. (CEO, Regional DGP, VIC). One submitter reported that GPs are at times dissatisfied with the standard and style of the reports they receive from accredited pharmacists. The report was described to be in a format incompatible with their software, and may not have effectively addressed the issues that were outlined in the referral.

5.1.6 Payment and Remuneration

Issues around inadequate remuneration for HMRs related almost entirely to the 'pharmacy' side of the HMR equation, rather than the GP side. There were substantial concerns at what numerous submitters described as the inadequacy of payment for both the community pharmacy component as well as the accredited pharmacist component. This study did not include a financial assessment of the figures involved as such, because that was not within the project scope, however many submitters did provide justification for their concerns and these were supported in other phases of this research. Submitters (and later, pharmacists interviewed for the qualitative research) noted that typically they would take about three hours to undertake a HMR. Submitters noted that community pharmacies tended to retain around \$40 of the HMR fee. This leaves a payment of close to \$150 for the accredited pharmacist, which equates to around \$50 an hour. Submitters considered this to be below a reasonable hourly rate for a qualified pharmacist.

Note, while the time taken to conduct a HMR clearly varies depending on circumstances, many submitters cited a period of up to three hours. This was justified on the basis of factors including: scheduling, travel to and from the consumer's home, and the fact that often there were no economies of scale as other HMRs were not necessarily required in nearby locations. In order to achieve economies of scale, many submitters noted that some HMRs are deliberately postponed, so there can be an accumulation of HMRs in the one area, further adding to the lack of timeliness.

While one element of the literature referred to the rates being reasonable based on the consideration of the Accreditation Incentive Scheme, submitters (and later health professionals at the grassroots level) clearly did not include consideration of these incentives in assessing the adequacy or otherwise of the HMR payments. Some community pharmacy business owners or managers and accredited pharmacists, did however comment favourably on the Incentive Scheme and were appreciative of its introduction.

The perceived inadequacy of the payments appears to be a major factor contributing to the low retention rate of accredited pharmacists



Pharmacists were, on average, taking more than 3 hours to complete each review. For \$150 I collect the referral and dispensing history, arrange the appointment, write letters, prepare and research the material, drive to the patient's residence, spend up to an hour with the patient, write the report and communicate it to both the pharmacy and GP, prepare invoices and receive feedback from the GP. This typically takes more than 3 hours. This is probably about half what I pay a plumber to change a leaking tap washer. (Consultant accredited pharmacist, Qld and former peak body Board member)

Submissions consistently called for an increase in the remuneration rate. Most suggested an amount between \$220 and \$250 per review for the combined community pharmacy and the accredited pharmacist components. Many submitters believed that this amount would cover the costs associated with HMRs (including time for administration, conducting the review, on-costs etc) and represented a more realistic hourly rate for accredited pharmacists. One consultant accredited pharmacist (WA) cited research conducted for the Third Community Pharmacy Agreement that supported an increase of this magnitude. Another submitter (Pharmacy peak body, TAS) advocated a far higher (in fact, the highest) increase to a payment of \$260 per HMR, while the general consensus was for an increase to a minimum of \$220.

... unless a fee of at least \$220 (indexed) per service delivered in the home is available, there will continue to be insufficient justification from a business case perspective to achieve large scale participation by community pharmacies in the provision of HMRs. (Pharmacy peak body)

Consultant accredited pharmacist submitters reported that the issue of inadequate payment is exacerbated by slow payment from the contracting community pharmacy. One consultant accredited pharmacist (VIC) reported *it is not unusual for consultant pharmacists to wait months for payment from the community pharmacy*. Delays and erratic payment by community pharmacies were seen as a significant disincentive and led a large number of accredited pharmacists to call for payment to be made directly to them. Indeed, this was one of the strongest arguments presented across many submissions, including from some peak bodies. The administrative burden of sending reminders and 'chasing up' community pharmacies was also highlighted. A compromise payment scheme was also proposed, whereby the fee could be split between the community pharmacy business owner/managers and the accredited pharmacist.

I would recommend a set fee paid to pharmacists for HMRs service – paid directly to the accredited pharmacists and another fee paid to the local pharmacy for their part of the HMR service. (Consultant accredited pharmacist, Qld)

Claims process for GPs

Very few submissions made any negative comments about remuneration levels for GPs. Where a small number of submitters did comment, rather than the *level* of remuneration for GPs – which is widely regarded as adequate – GP and Division-based submitters reported that the administrative *process* of claiming is considered complicated for GPs. The primary issue related to the timing of the process: GPs can only bill at the end of the process, so if the HMR is blocked by the patient or the community pharmacy business owner, then the GP does not receive payment. A number of submissions called for the claiming method to be altered so that the GP can claim a part-payment for both parts of the HMR process, rather than one claim at the end of the procedure. The first stage of this recommended payment schedule was typically at the commencement of a HMR, when a patient first provides consent, or at the time of referral. This view was expressed by both GP and pharmacy-related submitters who considered it to introduce additional 'red-tape'.

Lack of critical mass of HMRs

Without a 'critical mass' of HMRs to conduct, some accredited pharmacists - both those in community pharmacies and those who are consultants - suggested that many pharmacists are unwilling to adopt

HMR as part of their practice. This problem also meant many pharmacists were reported to be unwilling to make the investment required to become accredited.

The workload is erratic. Looking at the workload, and hence income, it is not difficult to see why many young pharmacists would not find this a viable full-time career path. (Consultant accredited pharmacist and former pharmacy peak body Board member, Qld)

Pharmacists are taking a gamble that they will get sufficient HMR referrals to make it worth their while to become accredited. This is a vicious circle – GPs don't refer if there aren't accredited pharmacists conveniently located, and pharmacists don't want to become accredited if there aren't the numbers of referrals. (QUM Program Officer, Regional DGP, SA)

5.1.7 Accreditation and training

Submitters reported that, overall, accredited pharmacists view the accreditation training as burdensome, expensive, difficult and time consuming. (MMR Facilitator, Qld) Given these high demands, and the limited rewards for most consultants conducting HMRs, many submitters perceived the accreditation process as a barrier to the recruitment, retention and, ultimately, participation in the HMR Program.

The guidelines for gaining and maintaining accreditation are difficult and expensive to complete. (CEO, Regional DGP, VIC)

The process of accreditation is seen as especially arduous for rural pharmacists, as they also have to travel long distances for training, increasing both the time and financial requirements. In addition to travel, workload and professional support were also reported to hinder participation in accreditation:

Young, clinically interested pharmacists ... find it hard to go through the accreditation process due to long working hours, a lack of peer support and the need to travel to most educational events. (QUM Program Manager, Qld; and CEO, Regional DGP, VIC)

Several submitters (including a pharmacy peak body and an MMR Facilitator) suggested that the concept of medication reviews should be introduced into undergraduate pharmacy degrees. (Note, the authors understand that this may already be occurring in new degree courses).

A number of consultant accredited pharmacists signalled that the feedback on HMR reviews they have conducted is a valuable self-education tool. As noted by one accredited pharmacist, few accredited pharmacists have a mechanism whereby their own performance can be reviewed, and the impact of the HMR can be assessed. Many accredited pharmacists stated a desire to improve their practice through structured feedback from GPs, but they often did not receive this feedback from the GP or community pharmacy business owner/manager.

5.1.8 The roles of the Pharmacy Guild and MMR Facilitators

The role of the Guild

Many submitters expressed strong views that the role of the Guild had led to an over-representation of the interests of pharmacy businesses rather than a balance between the interests of consumers, accredited pharmacists, GPs and community pharmacies.

The role of the Guild in the HMR Program was seen by a number of respondents as presenting a conflict of interest, and an inappropriate monopoly over the process. Both of these factors were thought to negatively impact the ultimate goal of the HMR Program: the appropriate and effective use of medicines in the community.

Currently the Pharmacy Guild is the chief negotiator for HMRs ... <and given> equity of health care access is Government policy, the prime, and indeed only, consideration should be delivery of the service to those most likely to need and benefit. It is not about returning dollars to community pharmacy owners. The

monopoly that has been created does not allow models to meet the needs of individuals. (Consultant accredited pharmacist, Qld and peak body representative)

The point of greatest contention regarding the role of the Guild was their requirement for the involvement of community pharmacies in the HMR referral pathway. Many submitters perceive that the current model which allows no option other than referral through a community pharmacy is thwarting the process, as it appears many community pharmacies do not want this work, and only add to the time delays in the process.

Under the current model, ... the customer should be referred to the community pharmacy of their choice so that their pharmacy can provide appropriate continuity of care. However, the reality is that a significant portion of the HMR-approved providers employ or contract an external accredited pharmacist to conduct the reviews; and that the non-accredited dispensing pharmacists don't even read the final HMR report, and rarely see a management plan come back from the GP! This results in a very small percentage of eligible HMR recipients receiving the 'appropriate continuity of care'; but large numbers of eligible people not even receiving a HMR in the first place because of an archaic, self-serving, restrictive push by the Pharmacy Guild to retain control for their members over HMR payments. (Consultant accredited pharmacist, NSW)

Some respondents believed that while community pharmacy business owner/managers were generally receptive to the idea of direct referral, it was the Guild which continues to strongly lobby for the continuation of current practice (with few exceptions). One academic submitter (Qld) recommended that the Pharmaceutical Society was the appropriate body to take charge of the HMR process to overcome issues of self-interest.

5.1.9 The role of MMR facilitators

While not the focus of this research study, many submitters nevertheless reported mixed views on the functioning and efficacy of MMR Facilitators. Given that many of these submission comments relate directly to impacts upon the effectiveness of the HMR Program, it was considered important to include a range of these comments in this study. (The authors understand that a separate review of the Facilitator program is underway under the auspices of the Department.)

Some pharmacists were sceptical of the usefulness of the MMR Facilitators' role in the HMR Program, suggesting that the role of Facilitators needs to be reviewed.

My recollection of the evaluation of the Community Pharmacist HMR Program was that more funds were spent on the facilitator program than actually paid to accredited pharmacists. The effectiveness of the facilitator program needs to be urgently addressed and either redesigned or funds allocated to more effective enhancers of HMR delivery. (Consultant accredited pharmacist and former pharmacy peak body representative, Qld)

However, some accredited pharmacists perceive that this lack of efficacy is due to inadequate funding, while others felt those recruited for the positions were often not well suited to the task. (Consultant accredited pharmacist, VIC)

In other phases of this research, there has been discussion about the importance of GPs as champions for HMRs, and that they are more important proponents than Facilitators, with some stakeholders commenting that only GPs can effectively be champions to other GPs. Despite this belief however, even where one GP is actively championing the benefits of HMRs, this has not necessarily translated into higher uptake of HMRs among his or her colleagues. (See section 6.10.3 and 6.10.5)

Some MMR Facilitators are employed part-time, and are also self-employed as accredited pharmacists. Some submissions provided information that indicated that this had enhanced uptake of HMRs in the region, while others expressed concern that this posed a potential conflict of interest.

MMR Facilitators are funded and <should> encourage the uptake of HMR by prescribers in their area. It is of concern however, that some MMR Facilitators are actually operating a business as HMR contractors. This presents them with a conflict in that while they are supposed to be helping community pharmacists develop a business of HMR provision, at the same time they are building their own business. (Consultant accredited pharmacist, NSW)

This concern of conflict of interest was echoed in another submission:

In fact, there appears to be <a>conflict of interest if an accredited pharmacist takes the role. (Pharmacy peak body).

In Phase Four of this study, Qualitative Research with Health Professionals, specific examples related to this issue arose and comments are found in Section 6.10.5 of this report.

MMR Facilitators and representatives of Divisions suggested that revised strategies are required for approaching and promoting the HMR Program to GPs. Specifically, these submitters pointed out that repeated practice visits serve little value in the promotion of HMRS.

The function of practice visits to inform GPs on home medicines reviews is wasted after the introductory visit to existing and new practitioners. GPs and pharmacists alike are extremely busy people and do not want repetitive detail. (CEO, Regional DGP, VIC)

To better resonate with GPs, this respondent recommended that the title of ‘MMR Facilitator’ be changed to ‘Quality of Use of Medicines Facilitator’ as it was a title more consistent with the role of facilitator with the NPS Programs. The NPS Program was seen to lend greater credibility for the HMR Program in the minds of GPs.

Divisions work with a number of other Programs with specific targeted and coordinated Programs. For example, the National Prescribing Service runs a predetermined series of clinical updates and audit Programs for GPs that the HMR Program could also target. (Statewide DGP, Vic)

5.2 Conclusions arising from Public Call for Submissions

There were a number of key themes arising from the Call for Submissions phase of research which required exploration during the qualitative phase, for the purpose of assessing their validity, these included the call for a consumer awareness campaign; the call for increased remuneration for the ‘pharmacy side’; the call for alternative referral pathways; and the stated ambivalence of many community pharmacies and GPs (just to name a few, as there were indeed many more issues canvassed as part of the Qualitative Research with Health Professionals).

There were however a number of issues where substantial supporting information was provided within the submissions, even though additional material also emerged during the subsequent qualitative research phase. Substantial supporting information was provided on a range of matters, including, but not limited to, the failure of HMRS to reach and assist high risk consumers; travel allowance inadequacies; issues affecting remotely located Indigenous Australians; issues affecting CALD consumers; payment arrangement inadequacies; and the long delays associated with many HMRS.

Of all the issues that emerged from the Call for Submissions, the following were the most prominent and information to support these issues was provided in the submissions.

High risk consumers least likely to receive HMRS

It emerged from an analysis of the submissions that under the current model, high risk consumers tend to be those least likely to be assisted through the HMR Program, thereby substantially decreasing the potential value of the Program. Material provided in many of the submissions provided substantial detail to confirm these concerns and extrapolate on issues which arose in the literature review and

stakeholder consultation phases of this research. Information contained in submissions elucidated the arguments around lack of provision of HMR to many high-risk consumers.

Given the scale of the problems around failure to reach high risk patients which is so clearly laid out in many submissions and which is supported by some of the literature and stakeholder consultation outcomes, the authors suggest that any studies aimed at revealing the clinical effectiveness of the HMR Program will be highly likely to reveal limited clinical evidence, until such time as the Program can be reconfigured to reach those consumers most at risk and who would benefit most from an ideal HMR process.

Findings on this matter contained within the submissions reflected some of the concerns raised through the previous two phases – Literature Review and Stakeholder Consultations – however it was information provided during the Public Call for Submissions phase which initially and graphically illustrated the concerns about how rarely HMRs were provided for those at high risk of medication misadventure. Later phases of this research, namely the Qualitative Research with Health Professionals and Consumers, provided additional confirmation of the genuine concerns on this issue.

Post-hospital discharge

The majority of submitters felt that the HMR program needed to find solutions for patients immediately after hospital discharge if the HMR Program is to meet one of its key aims of assisting high risk patients and preventing hospital (re)admissions due to medication misadventure.

The submissions received provide clear supporting material to confirm that this is a key point at which the current model fails high risk patients in many regions at present, particularly due to the consistent pattern of considerable delays in the provision of the HMR due to a combination of factors (including examples such as waiting three months for a total of four HMRs to accumulate, before the consumer receives the service).

Formalising of links with hospital pharmacists and hospital-based community health services were among the solutions put forward by submitters. At present, these links appear to be dependent on the goodwill and personal approach taken by individual MMR facilitators or hospital pharmacists. As such, the degree of effectiveness of these links varies enormously from one Division to another.

Formal linkages with chronic disease management clinics in hospitals have been shown to lead to more productive and timely arrangements for HMRs. For example, the Heartlink Program at the Prince of Wales Hospital in Sydney, described by one submitter. This one hospital has 106 such clinics, so these can be a major source of screening for referrals when linkages are fully established, including MMR facilitator education workshops on site at the hospital.

It was strongly suggested that there is an urgent need for a formal system of links, as well as specific referral pathways for high risk patients in the post-hospital discharge period, given the widespread agreement and concern that this is often a period of greatest need for a HMR but a period when the current arrangements are least likely to be effective or timely.

There is no strategic, program-wide concerted effort being made to address the gaps that inevitably allow high risk patients to fall through the cracks in the HMR system when they are likely to be in most danger: that is, in the period following hospital discharge.

Barriers to access for Indigenous consumers

In remote Indigenous communities where medicines are provided through the Aboriginal Health Service and the nearest community pharmacy is perhaps 1,000 kilometres away, the potential HMR patient never sets foot inside a community pharmacy.



Submitters reported that HMRs are so impractical in remote Indigenous communities at present that they are rarely able to be pursued at all. Moreover, submitters felt HMRs are highly unlikely to be effective even when they do occur in these communities, based on the current model.

Specific models for major overhaul of this aspect of the HMR Program were put forward by submitters (and later explored to some extent in the qualitative research with grassroots health professionals in Phase Four). However, further research specifically focusing on Indigenous communities and/or a pilot program would be desirable as an adjunct to this research.

Direct referral

Submissions strongly held that the fact the GP cannot refer to an accredited pharmacist of their choice (a model much closer to their current familiar and longstanding arrangements of referrals to specialists) can be a barrier to GP participation. Reference to this as a barrier emerged throughout each of the first three phases of research conducted for this project, and this was identified as requiring further exploration in the qualitative research amongst health professionals at the coalface of HMRs.

The need for overhaul of the referral pathways was put forward in the submissions, specifically to allow, as an option, for referrals to be made directly to an accredited pharmacist (from the GP) and not necessarily via the community pharmacy. Submissions provided supporting material (not included as a document or article reference in this study due to issues around identification of submitters, unless that material was already fully and publicly available) to confirm that the community pharmacy link does not apply for all patients and is inappropriate and indirect for others, for example:

- where an area does not have a community pharmacy
- where a small town has only two pharmacies and one community pharmacy business would need to refer patients to the other, who has an accredited pharmacist, in order to have a HMR take place – causing concerns about loss of custom to the competition
- in suburban areas where several large local community pharmacies service ‘super-practices’ involving many GPs and servicing thousands of patients (often including a high proportion of older patients). Submissions described the disinterest in HMR by some of these community pharmacies and believed this was believed to contribute to the inaction on HMRs by local GPs, thereby disenfranchising hundreds of patients whose health may have been improved through HMR support.

The HMR business rules appear to be at the core of the concerns for many. There was considerable accumulated supporting information at this point of the research, that the business rules – namely the perceived narrow provisions that allow only a community pharmacy to arrange a HMR – were restricting the potential effectiveness of the Program and may need to be altered in order for uptake to substantially increase and to assist more patients. Many examples were provided in the submissions of how the HMR business rules are having a negative impact on uptake of the Program.

Travel allowances

The submissions provided adequate and clear supporting material to confirm that travel allowances were, in some cases, a genuine and specific barrier to the conduct of HMRs, regardless of the need of the patient.

At present the formula for travel allowance is calculated on the distance of the consumer’s home from the community pharmacy, rather than the actual distance travelled by the accredited pharmacist conducting the HMR. Submissions demonstrated the need for a revision of travel allowances to accurately reflect the time involved and the distance travelled by the accredited pharmacist, rather than the current system of allowances based on PhARIA regions. (Detailed financial calculations were not included in the scope of this research study however numerous submissions do provide examples to support this argument, ie, consultant accredited pharmacists having to travel up to 40kms each way to

conduct a single HMR, yet being unable to secure any travel allowance as the region is metropolitan). The current system appears to provide a major disincentive for the conduct of HMRs in some rural and remote areas, and also within parts of metropolitan areas, under certain circumstances.

The current travel allowance arrangements result in considerable pressure on accredited pharmacists to wait until they have accumulated a larger number of HMR referrals across a geographic area. Invariably this prevents timely HMRs for patients at high risk, as it may for example take 8 weeks or as long as 4 months for sufficient referrals to accumulate. In many other cases, a 'profitable' number may never eventuate.

Payments for accredited pharmacists

Considerable supporting material provided with submissions confirmed that the current indirect payment approach for consultant accredited pharmacists presents an unreasonable burden.

Based on the many detailed examples provided, arguments for payments to be made directly to the consultant accredited pharmacist to enable a fair and reasonable business approach appeared to be valid. The current payment arrangements for consultant accredited pharmacists were shown to be onerous and unwieldy for many providers.

Precedence of community pharmacy business interests over those of consumers

There was considerable concern expressed by a broad range of submitters that the very constitution of the Pharmacy Guild means that they have a conflict of interest in their current 'monopoly' of the HMR system. Submitters argued that the primary driver for the HMR Program arrangements must be solely, **the best interests of the patient** and that this needs to drive a range of changes to current arrangements.

In addition, the submissions clearly showed that the business interests of community pharmacy proprietors are often taking considerable precedence over the interests of consultant accredited pharmacists and GPs. The priority granted to community pharmacy business owners frequently leads to the patient missing out on any chance of a HMR.

The submissions revealed that the precedence given to the community pharmacy's business interests has become a source of widespread resentment by consultant accredited pharmacists. Consultant accredited pharmacists argue that they are best placed to bring about a change in the attitudes of GPs towards HMRs, yet they see no benefits from any initiatives they may otherwise be willing to pursue in this regard. It would appear from the supporting information provided in the submissions that accredited pharmacists could become the ideal 'free' source of ongoing promotion and education regarding HMR among GPs, if the disincentives of the current restrictive practices were able to be changed.

Major differences in GP receptiveness to HMR

Widely differing levels of GP receptiveness to HMRs were documented and reported in the submissions. While many reasons were cited as to why this may be the case, the dominant reasons that were explored further in the qualitative phase included:

- **The effect of lack of evidence:** The fact that a GP is unlikely to have seen evidence of direct and clear advantages to his/her patient's health as a result of HMRs, due in part to its current lack of connection to the post hospital discharge 'danger' period. Future documented evidence of positive clinical outcomes for patients as a result of HMRs conducted with a much higher proportion of high risk patients, (as a result of changes to the HMR system), would be likely to contribute to a much greater level of receptiveness over time, among GPs.

- **Competing Programs:** Many stakeholders and submitters noted that HMR competes for the GP's attention and prioritisation against much more established programs with well proven clinical outcomes: HMR must reach this level if it is to be a serious contender for GP attention.

5.3 Issues requiring further exploration

There were a number of issues either raised repeatedly by high proportions of the submitters, or which emerged through an overall analysis of the submissions. Many of these issues were specifically explored in the qualitative phase of this research with grassroots health professionals and consumers, including those described in this section.

There was an emerging sense from the submissions that many GPs considered HMRs to be marginal in terms of the benefits they generate for patients and as a result gave them a very low priority.

Some submissions suggested that integration of HMR referral triggers with existing protocols for management of chronic disease states may be important for patients with co-morbid disorders and also important to streamline GP involvement and willingness to refer.

Where the connections between the GP, the community pharmacy, and the accredited pharmacist were operating effectively, there was reporting of solid, productive relationships and an efficient and valuable HMR service being provided. Based on the submissions, ideal rural models appeared to be operating in some areas: for example, Strathalbyn and surrounding areas of the Fleurieu Peninsula in South Australia and in the Bass Coast area of Victoria. These models appeared to benefit from the close relationships, both professionally and personally, within these smaller communities. Conversely, there appeared to be many other rural towns where the HMR system did not work at all and as a result, the entire population of the surrounding catchment area were excluded from any realistic possibility of a HMR, regardless of their level of risk for medication misadventure.

Throughout the submissions, consumer resistance and reluctance to agree to HMRs emerged as perceived barriers to participation. Some submitters suggested the reluctance of some patients was a reason for low HMR 'conversion' rates. Those consumers likely to be most in need of a HMR are said to be sometimes daunted by the Program components. Some submitters suggested that it was unsatisfactory that a Program aimed at assisting those in most need of HMRs had inherent characteristics that make it unlikely that such individuals will be able to benefit.

There were a number of calls for education/promotion/marketing directly to consumers on HMR. However, based on other content within the submissions, any promotional campaign would only appear to be valuable to the extent that it could reach, inform and influence much older, confused or high risk patients. Reviewing the submissions led to a conclusion that patients who are regarded as the most receptive to HMRs appear to be the very patients who are least likely to need HMRs. These observations combined to present a mixed picture as to the potential success of a consumer awareness campaign.

Throughout the earlier stages of the research project including the Call for Submissions, there were a number of suggestions put forward about specific measures that could be taken to change and enhance the HMR Program and develop it to meet its potential. Recommendations of appropriate statistical measures of the HMR Program's effectiveness were also put forward in the submissions.

There appears to be a need for: benchmarking of current HMR practice, followed by subsequent strategic action to encourage and introduce new models of HMR, develop linkages with hospitals, introduce new referral options, and a subsequent tracking of the effects of the HMRs on a population that will then have access to HMRs in a best case scenario. At present, the measures of participation that do exist are crude and ignore the realities of a lack of practical access to HMRs for many high risk patients. For GP uptake to increase, clinical evidence must be made available. The submissions

identified a need to explore what type of evidence would be most likely to trigger HMR referral by the GP.