This submission addresses the Consumer experience as one of the Key Drivers of the Review of pharmacy remuneration and regulation. Professor Stephen King summarises this aspect of the review with the words “appropriate medicine at the appropriate time for the best health outcomes.” Whilst the PBS system primarily focuses on the supply and dispensing of medicines along the supply chain – this is not the beginning and the end of the consumer experience. Its only part of it.

The best health outcomes come with improving medication adherence, whereas non-adherence delivers poorer health outcomes and increases health care costs (1).

**Medication adherence is not governed by lower cost medicines alone.**

Whilst there is substantial evidence that the cost of medicine presents as a barrier to medication adherence, there are many other factors that impact on medication adherence;

- Demographic – age, sex, education, employment, income, family support.
- Ethnic background – health literacy, beliefs about medicines, community network
- Behavioural – cognitive function, mental health, lifestyle stresses, substance abuse
- Healthcare provider – communication skills, patient relationship, professional collaboration
- Medicines – adverse effects, administration and storage, simplicity of medicines regimen,
- Healthcare system – cost, co-payments, private health insurance, access to continuity of care (2).

**Price competition drives austerity and reduces professional services**

As the government demands price efficiency and value for money from PBS expenditure, necessarily, the pharmacy market can only maintain viability and profitability through austerity measures and other avenues. Some of this market based measures include the following;

- Increasing turnover and volumes in other retail areas to generate sufficient income to maintain profitability – hence the reasons for the myriad of retail products available in pharmacy today.
Cost cutting and economies of scale at the expense of innovation in quality and patient care (3).

Increased productivity (more scripts per pharmacist each day) and lower staffing levels (reduced services). This diminishes both the consumer experience and patient care with nominal consumer counselling being limited to brief interventions following the dispensing process.

Only a few big discount players being able to survive with economies of scale driving profitability at the expense of patient (and not consumer) services.

A culture of low cost medicines may inadvertently promote health solutions based predominantly upon drug therapy, and preclude options for non-drug therapies. In other words, the discounting of drugs promotes a mentality amongst consumers that there is ONLY a drug solution for any given health problem. For example, the relatively low cost of codeine based analgesics ($10?) for back pain is seen as a cheaper alternative to physiotherapy treatment ($80?), and therefore, perpetuates both a drug taking psychology and reinforces the culture of a discount drug industry.

Is this the sort of consumer experience that the Review of Pharmacy Remuneration and Regulation envisages for the future?

What is the value of Medication Adherence? As opposed to its cost!

The World Health organization reported in 2003 that almost 50% of patients with chronic illnesses, do not take medications as prescribed. This means that the potential for medication related problems is a real life problem for many people, both young and old (4). There are estimates that poor medication adherence costs the hospital system in Australia around $660M per year (5).

And yet, the government has valued medicines management/adherence programs at around 5 cents for every $20 spent on the supply of PBS medicines (compare $407M to $14792M). What sort of medication adherence dividend does the government expect from this small investment in medication management services?

Whilst medication management reviews provide significant cost savings for distinct high risk patient cohorts (6), there is also the opportunity for HMRs and RMMRs to improve medication adherence and deliver better health outcomes by;

1. Increasing health literacy and drug knowledge – better self-management for the patient
2. Reaffirming the use of medication aids (inhalers, spacers, blood pressure monitoring, etc) (7)
3. Identifying complimentary medicines and OTC medicines that may reduce the effectiveness or conflict with prescription medicines
4. Providing opportunity for lifestyle counselling (diet, exercise, smoking, alcohol consumption)
5. Remove unwanted medicines or expired medicines
6. Reduce confusion over multiple brands of the same generic medicines in the home.
7. Screen for associated health problems and or adverse drug reactions.
8. Improving the appropriateness of prescribing in chronic disease (8)

Importantly, there are many collaborative benefits to pharmacists working in a GP practice setting, especially with regard to facilitating the completion of HMRs (increased timeliness and HMR uptake)(9) However, it should be noted that points 2, 3, 5, 6, 7 above are more likely to be successful where the medication review is conducted in the patient’s home or place of residence.
Time as a critical factor to the patient centred care model (10)

As a consultant pharmacist conducting medication reviews in the community, I have had the opportunity to spend more time (1 hr or so) with patients, and in the process, observe health problems not previously reported by the patient to the doctor. These include:

- Peripheral neuropathy (DN4 questionnaire)
- Malnutrition (Mini Nutritional Assessment)
- Signs of depression (PHQ-9 Questionnaire)
- Poor sleep architecture (NPS sleep right sleep tight brochure provided to patient)
- Relapse of alcohol dependence

The case for the simple HMR – the home can be quite revealing.

In my consultancy practice, I have come across instances where the Home Medicine Review seems very simple, and yet, it has produced important interventions, resulting in improved compliance and avoidance of medication misadventure. In both instances, the patients were suffering from episodic bouts of low blood pressure, which is a leading cause of fall and injury for the elderly.

1. Case one: Antihypertensive dose for the patient was too high with the patient taking the drug every second day to minimise dizziness with low blood pressure. HMR recommendation – halve the daily dose and monitor BP and adverse effects accordingly.

2. Case Two: The patient was taking a combination of drugs for BPH and Blood pressure with intermittent dosing of another drug for erectile dysfunction, causing episodic hypotension. HMR recommendation – cease two drugs and trial only one drug for both BPH and ED, hence reducing exposure to an adverse drug interaction that was causing low blood pressure.

In both cases, the drug regimens for these patients were not complex (less than 5 different drugs daily) but adverse events (first case) and drug interactions (second case) necessitated and justified the HMR. Understanding the high level of medication non-adherence in chronic disease (up to 50%), it is not possible to simply quantify the provision of the HMR based upon the number of medicines a patient takes, or the number of comorbidities a patient may have at any given time.

The Pharmacy remuneration and regulation review addresses three simple questions with regard to the robust provision of “new programs” offered through community pharmacy.

1. Should all patients be entitled to an annual HMR? Yes, as part of the continuity of care and the general practitioner management plan.
2. Should HMRs be linked to a health event? Yes, it should but if a HMR was performed annually, this may actually reduce the incidence of future health events.
3. Should they only occur following referral from medical practitioner? No. However, common courtesy and the collaborative approach should ensure that an accredited pharmacist advises the general practitioner that a HMR is required listing the reasons for the review (see - http://www.checkmymedicines.com.au/wp-content/uploads/Check_my_Medicines_Referral_Form_HMR_WEB.pdf)
(To expand further on point 3 above - where drug interactions and medicine related adverse events are strongly suggested, the general practitioner should be contacted to collaborate with the provision of the HMR/RMMR. This is important because part of due diligence for the medication review requires the patient’s medical and pathology history, and this necessarily requires GP collaboration.

Whilst the collaborative model proposed the pharmacist in GP practice model has its merits, for the reason listed above, medication reviews in the home or place of residence (RMMR) ensure that the cycle of patient focussed care is not diminished by the sake of convenience. Prescriptions medicines are not the only thing patients take, and importantly, it takes time for many patients to willingly divulge this information. In my consultancy practice, it is not unusual for the HMR to take 60 to 90 minutes - it takes that long for the patient to get to know you, and for you to really get to know the patient.

Consider the following Proposals as part of the review of medication management programs by the Review of Pharmacy Remuneration and regulation task force:

1. Higher funding for dosage administration aids, and Staged Supply (especially where opioid addiction is a problem).
2. Mandatory annual Medication reviews (or as clinically required) for all patients with chronic disease under the health care homes model and or General Practitioner Management Plan.
3. Increasing the current cap of 20 HMRs to 40 HMRs (minimum) per month so that accredited pharmacists may specialise in personalised medication review services. There are higher travelling and time costs associated with the provision of HMRs/RMMRs and the current fees and cap (20 per month) do not reflect the true cost of providing this service.
4. Where the total quota of HMR funding is not allocated each month, the cap (and funding) should be carried forward to the provision of additional needs based HMRs for patients in the ensuing months. Necessarily, accredited pharmacists who have not met their monthly quota/cap should be able to conduct additional HMRS on this basis, in the following months. That is, the total pool of funding remains within budget but the spread of HMR services is based upon patient need and accessibility by the accredited pharmacist. For example, there may be a greater need medication reviews in poorer socioeconomic areas, indigenous areas (11), people with limited English, rural areas, palliative care patients, and or people with special disabilities - this is akin to needs based funding for education under Gonski reforms.
5. What is the fate of the HMR (and RMMR) funding where the monthly quote is not reached? Ideally, HMMR/RMMR funding should come from the same Medicare funding pool as the General Practitioner management plan. This makes sense as this is a collaborative service which would provide Medicare with valuable reconciliation data. Do all HMRS have a GPMP?
6. An accredited pharmacist should be given full responsibility for medication management (including medication reconciliation) in a residential aged care facility – this provides another opportunity for specialised career planning, collaboration, and expanding patient centred care.
7. One community pharmacy, one accredited pharmacist, and one GP practice should be aligned to an aged care facility, ensuring the provision of a more coordinated and consistent standard of care across all allied health service providers. This is the basis of the “Pharmacists improving care in (Aged) care homes’ campaign being facilitated by the Royal Pharmaceutical Society of Great Britain and the Aged Care sector in England. See the following links: http://www.rpharms.com/our-campaigns/pharmacists-improving-care-in-care-homes.asp and http://www.rpharms.com/promoting-pharmacy-pdfs/care-homes-report.pdf.
Importantly, the Care Homes Model proposed in England promotes the viability of local pharmacies, which are often in the best position to provide more targeted and personalised professionals services - simply because of their proximity to the aged care facility and for the time that they invest in their local community. Needless to say, “We believe, and evidence shows, that this improves care, reduces NHS medicines waste and reduces the serious harm that can be caused by inappropriate use of medicines” – Royal Pharmaceutical Society, England – “The Right Medicine: Improving Care in (Aged) Care Homes, February 2016.

In conclusion, medication management services require the expansion of existing services (HMRS/RMMRs) and more targeted funding (GP/Pharmacist collaborative model, Pharmacists in Aged Care facilities), in order to foster better health outcomes in the Australian healthcare system (12-14). This can only be achieved by collaborative models of care that promote the continuity of care (rehabilitation, transition, prevention) for patients suffering with illness and chronic disease.

Yours sincerely,

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Bibliography