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Review of Pharmacy Remuneration and Regulation - Response to the Interim Report

HOME MEDICINES REVIEWS (HMRs):

“The Australian Government should investigate options to optimise the current HMR program”
“In particular an increase in the current cap on services should be considered”

I agree the government should investigate options to optimise the HMR program and increase the current cap on services provided. In fact this is a matter of urgency. The program has stood idle for the past 2 years whilst restraints have limited access to many Australians. This is especially evident in rural Australia where, in many areas, services have discontinued completely over this period. Whilst evidence exists in support of HMRs, I am yet to see evidence to the contrary. There is no evidence to suggest it is beneficial to cap HMRs at 20 patients/month. A projected overspend merely suggests program underfunding. If a program is proven to reduce expenditure through reduced hospital admissions and PBS prescriptions, it only makes sense to expand this service to produce further savings. This is why the program is so popular and why there should not be a cap of 20 patients/month.

“....combined with more targeted eligibility criteria”

There is no doubt that patients at greater risk would benefit most from a HMR. A more “targeted eligibility criteria” may assist in reaching patients of greatest need. However it must be emphasised, unlike any other pharmacy initiative, this is a referral based program. Patients are not selected by the accredited pharmacist but the GP. Patients are already being selected based on assessed need.

“....the government should investigate the potential benefits of opening referral pathways”

I agree and this should be considered as a matter of urgency. Opening referral pathways only increases accessibility to the program and assists in flagging high-risk patients. Some GPs don't use the HMR program and many are not aware the program exists, so affiliated patients are automatically excluded from the service. However, without lifting caps, expanding the referral pathway would be a moot point. Delays between the referral and review would be even lengthier. To receive several urgent referrals at a time and try and triage patients in terms of need, due to an arbitrary cap, is potentially harmful. Constantly explaining to GPs (who remain uncapped) that those conducting the reviews are restricted and their patients have to wait several months for review is a difficult task. Expanding referral sources cannot be achieved effectively without removing the current cap.

“The Panel disagrees with reversing the direct referral system”

I agree entirely that HMRs should not be linked solely to their community pharmacy. Although I believe the referral should be directed to either an individual accredited pharmacist or the patient's community pharmacy (not a corporation). As was seen previously, pharmacies were tendering out referrals. The result of this scenario was poor quality reviews (directly reflective of the pharmacy's reimbursement) and extended wait times for patients. The direct referral pathway was introduced to

reverse this trend. I would argue direct referrals improve quality, timeliness and flexibility of the service. A GP would not directly refer to someone that provides a substandard review. Those with a particular skill set/specialty or extensive experience can be sourced via direct referral.

“The Panel agrees and supports the current additional training requirements and standards”

I agree HMR accreditation is an advanced area of pharmacy practice and with it comes great responsibility. Conducting HMRs must be a viable full-time career path to maximise review quality and cost-effectiveness. The current cap of 20 patients/month does not allow this.

Overall the Panel has done a reasonable job capturing the essence of the HMR program and assessing its need for improvement. HMRs are the only pharmacy program available that fit the Panel’s criteria for support as they are evidence-based, are of benefit to patient health outcomes, provide value for money and are collaborative.

Noticeable exclusions, specific to the HMR section, of the report:

- The absence of an emphasis on rural HMRs and the impact of the current cap. I personally travelled, at great expense, to areas of the Kimberley to conduct HMRs. Since the introduction of the caps in 2014 services have discontinued completely. Whilst new allocations of funds from the CPA state their intention to have an improved focus on Aboriginal and Torres Strait Islander people and consumers in rural and remote areas there has been no change to HMR accessibility. There continues to be no exemptions to imposed caps for patients under these criteria. If there is not a plan to remove or increase HMR caps there is a need, as an absolute minimum, to remove caps for rural and remote areas.
- The government should consider that HMRs be funded outside of the CPA. Whilst The Panel recognises the importance of HMRs and the intent of the PGA to redirect HMRs through community pharmacy, there has been no suggestion of additional funding models (MBS) to resolve this obvious conflict of interest in fund allocation.

Yours sincerely,

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