Personal reflections on some things pharmacy

With an ageing population comes an increased incidence of chronic disease, polypharmacy and the myriad of confusion that surrounds medicines. About 40% of hospital admissions for the elderly are attributed to medicines – too many, not enough, adverse effects or drug interactions. About 25% of patients prescribed medicines for chronic disease are non-adherent after 1 week and over 50% are non-adherent after 12 months. But who can blame them? Managing medicines is time consuming, confusing, scary and dangerous.

This year, I have seen my sister grapple with managing her pain medications, my father having bleeds because he wasn’t managing his warfarin, my friend suffering her depression rather than suffer the side effects of the anti-depressants, and a colleague deciding to take herbals rather than anti-hypertensives. If the educated and privileged aren’t managing, how are the homeless, the psychotic, the illiterate and the disadvantaged coping? We operate in an environment where there is so much information and yet so little effective communication and too few skills being taught as to how to interpret and implement this information.

In Australia we have 21,000 pharmacists – with about 70% practicing in community pharmacies and 20% in hospitals. Historically, pharmacists’ roles have been related to medication supply, but dispensing is a robotic process and pharmacists need to become first and foremost providers of patient care, rather than dispensers and suppliers of medicines. Pharmacists need to take on the role of medicines advisor, educator, coach, investigator and liaison officer, working alongside other health professionals to ensure improved medication adherence and monitoring, and improved health outcomes and lifestyle for patients.

For over 20 years I’ve been working with community pharmacists trying to create change. Community pharmacy has been described as being “a profession at the crossroads” for at least that long. Professional organisations, industry leaders, accountants, marketeers and government have all been pressing for change and yet community pharmacists, young and old, continue to practice under the same paradigms, concentrating on medication supply rather than professional services. Many believe that community pharmacies have less than 2 years to move to a health solution business model to avoid the big financial gaps that recent government rebate reductions will cause in their businesses. The next decade is going to be tough for pharmacists but maybe financial pressure will be the impetus for change. I believe we will end up with 2 types of community pharmacies, the large discounters and the smaller clinical pharmacies. Many of the pharmacies that take the middle road will fail.

Pharmacists that do offer clinical services, such as BP testing, anti-coagulation monitoring, smoking cessation clinics, medication reconciliation and review, will become valuable primary health care providers. Chronic disease patients visit their pharmacy on average 12 times a year, as opposed to 2-3 annual visits to the GP. These pharmacy visits need to be converted into important health consultations that make up part of the patient’s overall care plan, especially in the rural areas where health professionals are scarce. Pharmacists increasingly provide services that help people stay well and use their medicines to best effect.
However, the pace of change remains slow, and financial and structural incentives are not sufficiently aligned to support it.

Although advocating that community pharmacists become more involved in clinical services I believe that the most significant changes to health prevention, medication rationalisation and medication adherence would occur if pharmacists were employed in a variety of health service settings, other than just community pharmacies and hospital pharmacies. As well as employing more pharmacists in the hospital settings, pharmacists need to be employed in GP practices, in Aboriginal Health Services, in mental health services, in community outreach teams, in homeless shelters and palliative care teams. Pharmacists need to be remunerated for their clinical services through Medicare as for other health professionals. Studies show that pharmacist interventions in GP surgeries showed significant improvements in blood pressure, glycosylated haemoglobin, cholesterol and reductions in overall cardiac risk in intervention patients compared to control patients.

The Grattan Institute report, *Access all areas: New solutions for GP shortages in rural Australia* suggested that better use of the pharmacy workforce could ease many pressures being experienced by doctors in rural areas and fill some gaps for rural patients where there are no GPs. Pharmacists are well trained to treat common illnesses, support patients with long term illness and can challenge wasteful, dangerous or inefficient use of medicines. We have over 2000 pharmacy students graduating each year and many of these are struggling to find employment. Most of Duckett & Beardon’s solutions in the report were neither economically viable nor practical for many community pharmacies. In many areas where there are GP service gaps, it is not viable to have a community pharmacy, so other pharmacist remuneration methods are needed. I have a database of pharmacists who would love to work in remote areas and in Aboriginal communities if there was some means of remuneration for some of their services.

Throughout Australia there is a need for better services to assist patients with their medicines. In rural and remote Australia the need is enormous. So many rural patients never see a pharmacist or a doctor. Their medications may arrive by mail, school bus or boat. Many medications are “dispensed” by people with limited medication knowledge. The lower PBS spend on medications in rural areas, despite the higher incidence of disease and trauma, clearly points to a huge medicines inequity in rural Australia. Pharmacy, as a profession must start to speak with one voice and work harder to drive the legislative change that is needed to ensure pharmacy services are available to all Australians, and so improve health outcomes and quality of life. Pharmacy needs also to co-opt the assistance of other health professions to lobby for these changes. The needs of rural Australians offer both a challenge and an opportunity for pharmacy. If we are serious about tackling the epidemic of chronic disease we need to reimburse clinical pharmacists for clinical services. We need to offer challenging, rewarding and sustainable careers for pharmacists in rural and remote areas. There are huge opportunities for us all “to do medicines” much, much better.

I feel blessed to work in rural health as it is filled with wonderful people who continue to fight against poverty and injustice and work to achieve human rights, equity and sustainability. Thank you all for your wonderful enthusiasm and passion. I will continue the pharmacy fight in the hope that one day we can create change – in the meantime, I am going to take my dog for a long walk on the beach.