The Pharmacy Guild of Australia

# Submission

# to

# Senate

# Community Affairs Committee

# in response to the

# "Inquiry into the effectiveness of special arrangements for the supply of Pharmaceutical Benefits Scheme (PBS) medicines to remote area Aboriginal Health Services"

**29 July 2011**

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# Glossary

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|---|---|
| **ATSI:** | Aboriginal and Torres Strait Islander |
| **AHA:** | Australian Healthcare Associates |
| **AHS:** | Aboriginal Health Services |
| **AHW:** | Aboriginal Health Worker |
| **ATSIHS's:** | Aboriginal and Torres Strait Islander Health Services |
| **DAA's:** | Dose Administration Aids |
| **EAP:** | Expert Advisory Panel on Aboriginal and Torres Strait Islander Medicines |
| **NACCHO:** | National Aboriginal Community Controlled Health Organisation |
| **PBAC:** | Pharmaceutical Benefits Advisory Committee |
| **PBS:** | Pharmaceutical Benefits Scheme |
| **S100 RAHSP:** | Section 100 Remote Aboriginal Health Services Program |
| **S100 PSAP:** | Section 100 Pharmacy Support Allowance Program |
| **QUM:** | Quality Use of Medicines |
| **QUMAX:** | Maximised for Aboriginal and Torres Strait Islander peoples |

*"In the 11 years that we have been involved in the S100 RAHSP I believe we have come a long way from just being a bulk supply facility to offering a lot more than what some people may think.*

*And although I am unsure as to whether there has been any studies done on the difference that these changes have made, I am certain that our Aboriginal population has definitely benefited from the services that we provide to them.*

*What people must realise is that it is an evolving process that will take time to get right, so let's not undo all the hard work that we have put into it over the years, let's build on what we have put in place, rather than change things dramatically and be back at square one."*

***Troy Bodle, Cable Beach Pharmacy, WA***

# 1. The Pharmacy Guild of Australia

The Pharmacy Guild of Australia (the Guild) is the national peak pharmacy organisation representing community pharmacy. It strives to promote, maintain and support community pharmacies as the most appropriate primary providers of health care to the community through optimum therapeutic use of medicines, medicines management and related services.

The Guild is in a unique position to represent all the community pharmacies who actively participate in the Section 100 Remote Aboriginal Healthy Services Program ('S100 RAHSP'). To accurately represent their opinions and concerns the Guild conducted a survey of community pharmacies who between them service up to approximately 170 remote Aboriginal and Torres Strait Islander Health Services (ATSIHS's or 'AHS's'). This submission acknowledges the contribution these community pharmacies have made to the content of this submission and also to the dedication and time they devote to ensure the clients of remote AHS's have access to the medicines and quality services they need.

A submission from the Western Australian Branch of the Pharmacy Guild highlighting the Branch's concerns has also been included as an Appendix.

> *"Throughout the Review, AHA has been impressed by the level of commitment of community pharmacists working with AHS's. They are driven by a desire to improve health outcomes for people residing in remote Australia."*
>
> *Australian Healthcare Associates (2010)*[1]

The following is a list of all the pharmacies and pharmacists known to the Guild, which service AHS's and the number of AHS's which they service:

| **Pharmacy** | **Pharmacist** | **Suburb** | **State** | **AHS's serviced*** |
|---|---|---|---|---|
| Dareton Pharmacy | Mr Hany Morkos | Dareton | NSW | 1 |
| The Walgett Pharmacy | Ms Carolina Ines | Walgett | NSW | 2 |
| Towers Drug Co Pharmacy | Mr Peter Crothers | Bourke | NSW | 2 |
| United Discount Chemist | Ms Maria Giacon | Alice Springs | NT | 3 |
| Priceline Pharmacy | Mr Peter Hatswell | Alice Springs | NT | 53 |
| Katherine Terrace Pharmacy | Ms Mel Goss | Katherine | NT | 8 |
| Tennant Creek Pharmacy | Mr Cyprian Sibeko-Mbina | Tennant Creek | NT | 6 |
| United Discount Chemist | Shelley Forester and Leah Carter | Palmerston | NT | 11 |
| Gove Pharmacy | Mr Darryl Stewart | Nhulunbuy | NT | 7 |

| Pharmacy | Pharmacist | Suburb | State | AHS's serviced* |
|---|---|---|---|---|
| | | | | |
| Northpharm Hospital Pharmacy | Mr Adam Bennett | Tiwi | NT | 19 |
| Harrison's Pharmacy | Mr Skevos Lelekis | Casuarina | NT | 1 |
| Priceline Pharmacy Mareeba | Messrs J & M Wadley & Anderson | Mareeba | QLD | 2 |
| Mount Isa Central Pharmacy | Mr Steve Hon and Ms Selina Taylor | Mount Isa | QLD | 1 |
| Thursday Island Pharmacy | Ms Lynn Short | Thursday Island | QLD | 20 |
| Ravenshoe Pharmacy | Mr Trang Quach | Ravenshoe | QLD | 1 |
| Endeavour Pharmacy Cooktown | Mr Quang Hang | Cooktown | QLD | 2 |
| Crossroads Pharmacies | Ms Lucy Chow | Port Augusta | SA | 2 |
| Ceduna Pharmacy | Mr Kenneth McCarthy | Ceduna | SA | 3 |
| Kimberley Pharmacy Services | Mr Andrew Duan Hui Loi | Derby | WA | 10 |
| Chinatown Pharmacy | Mr Anthony Masi | Broome | WA | 1 |
| Broome Pharmacy | Mr Anthony Masi | Broome | WA | 2 |
| Cable Beach Pharmacy | Mr Troy Bodle | Broome | WA | 1 |
| Amcal Chemist Kalgoorlie | Ms Elise Wheadon | Kalgoorlie | WA | 3 |
| Kununurra Pharmacy | Mr Gareth Gearon | Kununurra | WA | 6 |
| Amcal Chemist Carnarvon | Mr P J Willis | Carnarvon | WA | 2 |
| South Hedland Pharmacy | Mr Matthew Baas and Mr Terry Battalis | South Hedland | WA | 1 |
| Boulevard Pharmacy | Ms Julia Kagi | Newman | WA | 2 |
| Karratha 777 Pharmacy | Ms Laura Stewart | Karratha | WA | 1 |
| Rangeway Pharmacy | Mr Ross McKay | Geraldton | WA | 1 |

** The services include not only the supply of PBS medicines to remote AHS's but also the provision of a range of additional services to support Quality Use of Medicines (QUM).*

## 2. Executive Summary

The S100 RAHSP for remote area AHS's has greatly improved access to medicines on the Pharmaceutical Benefits Scheme (PBS). It represents one of the most substantial positive developments in remote Aboriginal and Torres Strait Islander (ATSI) health service delivery for many years.

The S100 RAHSP scheme utilises the infrastructure of the network of community pharmacies around Australia, and their expertise in administering the PBS. This removes the need for busy AHS staff to manage medicine supply, and provides them with a valuable, professional and well-staffed resource to assist in managing medication related issues.

Access to medicines is a priority in the provision of effective primary health care. The S100 RAHSP provides a solid base for ensuring access to medicines, and should be allowed to evolve to offer more Quality Use of Medicines (QUM) to patients of remote AHS's. Further development of the scheme has stalled over the years due to lack of sufficient funding.

The program has been extensively and regularly reviewed throughout its 12 year history. The reviews have been overwhelmingly consistent in their recommendations and have been unanimous in recognising the value of the scheme. The only failure has been that most of the review's recommendations have not been progressed and additional funding for proposed Program enhancements has not been forthcoming. This means the Program, while successful, has yet to realise its full potential.

**The Guild's submission, in essence, is that the S100 RAHSP has worked well over a number of years and has achieved its main objective of ensuring access to PBS medicines for ATSI people in remote parts of Australia. However, in order to reach its full potential, several enhancements can and should be made to the program. These are set out in this submission.**

# 3. Recommendations

In summary the Guild recommendations are as follows:

1. The essential features of S100 RAHSP, which have ensured its success, must be retained. These include:
   - supply of PBS-medicines to AHS's through the existing network of community pharmacies, and at no cost to the patient,
   - utilising the existing infrastructure provided at the local remote AHS's, and not requiring the patient to travel to other venues,
   - providing a one stop-shop at the AHS (patient gets medications and advice for using them at the time of visiting the AHS),
   - allowing the patient to access medicines in a culturally appropriate setting,
   - not requiring the patient (or staff) to provide Medicare cards, Pension or Health Care concession cards for eligibility purposes or to keep track of PBS Safety-Net information.

2. Medication utilisation data should be the accepted indication of the program's success.

3. A review of the S100 PSAP should be undertaken to identify the number of visits by a pharmacist that best support the AHS's and QUM.

4. Transport costs for community pharmacies servicing remote AHS's should be separately funded based on a model which reflects the variables which drive these costs.

5. The current funding arrangements for supplying PBS medicines to remote AHS's through the existing network of community pharmacies should be retained and enhanced.

6. When the Australian Health Practitioner Regulation Agency (AHPRA) takes responsibility for the registration of AHW's in 2012 the relevant Board should set standards for continuing professional development for AHW's. Educational activities, accredited by the relevant bodies, could be delivered by visiting professionals such as doctors, nurses or pharmacists to improve education opportunities for AHW's.

7. A three-tiered handling fee should be adopted to include a basic fee for 'bulk supply', plus a dispensing fee and a fee for DAA when requested by the AHS.

8. The inter-government Memorandums of Understanding established at the inception of the S100 RAHSP should be reviewed and reinstated.

9. An inter-government committee should be established that has oversight of the S100 RAHSP and the S100 PSAP.

10. The Department of Health and Ageing should establish a dedicated role to manage the S100 RAHSP and S100 PSAP and be the key point of contact for pharmacists and AHS's.

11. Medicare Australia should develop an electronic claiming method for S100 RASHP claims that utilises PBS Online and Electronic Funds Transfer. Information gathered in this way could be used to provide drug utilisation data.

12. Medicare Australia should collect medicine utilisation data and provide this to AHS's to enable them to keep track of their own performance.

13. The Department of Health and Ageing should acknowledge that some remote AHS's are meeting the cost of freight for medications supplied under S100 RAHSP and should consider reimbursement of these costs to both AHS's and pharmacists.

14. Additional funding should be injected into the scheme to allow for the provision of extended pharmacy services. Public–private partnerships should be developed to improve continuity of care where community pharmacy, hospital pharmacists, and all prescribers (GPs, specialists, nurses and health workers in remote settings) co-exist as an integrated primary health care team.

15. The increasing mobility of people living in remote areas should be recognised, along with their need to travel for specialist treatment and hospitalisation. Initiatives to improve ATSI people's access to PBS benefits in urban areas (QUMAX and CTG co-payment relief) have been successful. Mechanisms are needed to make these schemes work together to allow patients to travel between remote and urban areas and between hospital and home and still have access to their PBS medicines.

# 4. Background

Access to PBS medicines has traditionally been much lower for ATSI people than other Australians. This is reflected in PBS expenditure figures, with the Australian Institute of Health and Welfare identifying per capita PBS spending for ATSI people to be of the order of a quarter to a third of that spent on the rest of the population[2]. The report prepared by Keys Young in 1997 *'Aboriginal and Torres Strait Islander Peoples Access to Medicare and the PBS across Australia'*[3] identified that the key barriers to accessing medicines for ATSI people were:

- a greater level of poverty than other Australians;
- inoperability of the PBS Safety-Net scheme for ATSI patients;
- increased patient mobility due to social obligations;
- frequent non listing of children on guardian's concession cards;
- 'shame' involved in accessing prescriptions in a culturally alienating setting;
- lack of timely supply, with prescriptions having to be sent away to the closest pharmacy;
- cultural and literacy issues;
- lack of supports for continued use of medications;
- geographic isolation.

In 1997, to address some of these barriers, the Guild, the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Department of Health and Family Services (now the Department of Health and Ageing (DoHA)) developed a scheme to increase access to medicines for Aboriginal people in remote areas. A special provision of the *National Health Act 1953* (Section 100) allowed for special access arrangements where pharmaceutical benefits cannot be conveniently supplied. Since then, under the S100 RAHSP, clients of remote area AHS's have been able to receive PBS medications from AHS staff at no cost at the time of consultation.

Medications are ordered by the AHS through a local community pharmacy and then supplied "in bulk" (ie without dispensing from a prescription) to the AHS. The pharmaceutical benefit items are then supplied to patients, with no co-payment charged, by an appropriate health professional (either a medical practitioner, or an Aboriginal Health Worker (AHW) or nurse working under the supervision of a medical practitioner, where consistent with the law of the relevant State or Territory). A patient who is supplied with a pharmaceutical benefit under this arrangement is not charged a patient co-payment. Since the medications are supplied "in bulk" the pharmacist is paid by the Australian Government a 'supply fee' or 'handling fee' at a rate lower than the standard dispensing fee.

The remuneration provided to the supply pharmacy is calculated using the following formula:

**Supply Fee per item= Approved Price to Pharmacist of PBS item + PBS Mark-up + Handling Fee.**

The handling fee remained unchanged at $1.14 from 1998 until early 2009, when it was temporarily increased by $1.55 to $2.69 per PBS item supplied. This was the result of discussions between the Australian Government, the Guild, and a number of individual pharmacists. The need for an increase in the fee arose because of the impact of PBS Reforms which caused a decrease in remuneration to pharmacists supplying PBS medicines to remote AHS's thereby affecting their viability to supply medicines under the S100 RAHSP. The fee increase was included as a measure in the 2009-10 Federal Budget and was effective from 1 January 2009 to 30 June 2010. An ongoing increase to the S100 RAHSP handling fee was announced in the 2010/2011 Budget. The fee was increased to $2.74 on 1 July 2010, and is now indexed annually[4].

In addition to the S100 RAHSP, community pharmacies also visit remote area AHS's, often hundreds of kilometres away, to provide them with a range of services to support Quality Use of Medicines (QUM). These services are offered in accordance with the 'Section 100 Pharmacy Support Allowance Program' (S100 PSAP), and are funded through the Community Pharmacy Agreements often with the pharmacy contributing to the cost of travel through income generated by the 'supply fee'. The services are based on an agreed work plan between the AHS and the pharmacy, and can include, for example,

- assistance in the implementation of appropriate protocols for managing S100 RAHSP arrangements;
- the development/maintenance of a medicine store;
- assisting the AHS staff with stock control;
- assisting clinical staff in the AHS with any clinical inquiries, and
- providing continuing education to AHS staff in aspects of medication management.

The assistance is generally provided through the community pharmacy that supplies the S100 RAHSP medicines. This enables the pharmacy to utilise medication profiles and claims data, which are essential for ensuring effective and efficient S100 RAHSP order processes. This support allowance ensures ongoing face-to-face support by pharmacists to remote area AHS's participating in the S100 RAHSP, and was evaluated favourably in the 'Evaluation of Indigenous Pharmacy Programs' carried out by Nova Public Policy in June 2010.

Since the introduction of the S100 RAHSP there have been a number of reviews and evaluations of the Program. These reviews and evaluations, while reporting positively on the scheme, have made a number of recommendations to improve the scheme.

It should also be noted that Memorandums of Understanding (MoU's) have been signed between the Commonwealth and the States and Territories. These MoU's set out a framework for cooperation between the Commonwealth and the State/Territory to improve access by clients of remote AHS's to essential medicines and related goods and services. These MoU's allow the various States and Territories to access the Commonwealth Government funded PBS for their government managed AHS's, resulting in cost savings from their own State/Territory budgets. This offers substantial saving to those States and Territories with significant numbers of ATSI remote communities.

Where State and Territory governments are managers of remote AHS's (eg in the Northern Territory, Queensland and Western Australia), some have elected to use a tender process to decide which pharmacy will supply its service under the S100 RAHSP. These tenders have become increasingly competitive and typically now include extra conditions or services that the supplying pharmacy must provide. For example, in the Northern Territory all chronic medications must be dispensed by the supply pharmacy i.e. not provided as 'bulk supply' but dispensed as if it was a normal section 85 supply. This State and Territory specific tender process means that the S100 RAHSP supply model can differ significantly both between States and Territories and also between government and community controlled AHS's within the same State/Territory.

# 5. Previous Reviews and Evaluations

A number of reviews and evaluations of the ATSI access to PBS medicine have been undertaken. A summary of the findings and recommendations from these reviews/evaluations are included in Appendix 1. A brief description of these reviews/evaluations are as follows:

- ***Aboriginal and Torres Strait Islander Peoples' Access to Medicare and the PBS across Australia, Keys Young, November 1997***[5]

This research was commissioned by the Health Insurance Commission (now Medicare Australia) and was undertaken by the consultancy firm Keys Young. Its purpose was to provide information regarding ATSI peoples' access to Medicare and the PBS across Australia. The study also sought to document ATSI people's attitudes and experiences in relation to Medicare and the PBS and the range of strategies currently in place to address problems of access, as well as to identify ways in which service delivery and the provision of program information could be improved for ATSI people.

- ***A Summary of the prescribing and dispensing issues and needs in the remote health clinics of the Northern Territory.*** **General Practice Divisions Northern Territory and National Prescribing Service. Hudson P. August 2001**[6]

This project was undertaken with the support of General Practice Division Northern Territory with oversight from the NT Prescribing Reference Committee comprised of representatives from the relevant stakeholders across the Territory. The National Prescribing Service, an independent organisation whose purpose is to provide leadership and coordination for quality prescribing, funded the project. The purpose was to expand the understanding of prescribing practices in remote Indigenous communities in the Northern Territory, identify current issues and needs, and make a contribution to QUM in the remote regions of the NT through recommendations for policy and operational changes.

- ***Report from surveys conducted in Commonwealth funded Aboriginal Health Services and pharmacies supplying services under S100 pharmacy allowance.*** **Loller, H May 2003**[7]

This report describes the outcomes of a project commissioned by the Guild and NACCHO, undertaken between June 2002 to May 2003. The project was funded through a Third Community Pharmacy Agreement Research and Development project, as an extension of the Quality Use of Medicines in Aboriginal Communities Project. The project aimed to contact and visit where possible each of the pharmacies and Commonwealth funded AHS's operating under the S100 RAHSP in order to:

- provide support on the ground to Commonwealth-funded AHS's registered for the S100 RAHSP and relevant pharmacies;
- survey AHS's and pharmacies to identify problems with S100 RAHSP arrangements and solutions;
- increase uptake of pharmacist allowance payable for support to S100 RAHSP sites;
- revise or update the information booklet "Medication Management Guidelines for preparing for the Section 100 scheme in Aboriginal Primary Health Care Services" and make suggestions for other resources for Aboriginal health services; and
- report on results of the survey.

- ***Evaluation of PBS Medicine Supply Arrangements for Remote Area Aboriginal Health Services Under S100 of the National Health Act*, Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH), Menzies School of Health Research and the Program Evaluation Unit, University of Melbourne, Margaret Kelaher et al. July 2004**[8]

This project was funded by the Pharmaceutical Access and Quality Branch, Department of Health and Ageing, Australian Government. The evaluation examined the performance of the S100 RAHSP in terms of its aims, which were to improve access to PBS medicine by clients of remote area AHS, maintain compliance with existing State and Territory statutory requirements and minimise administrative complexity, within the context of appropriate accountability. In addition to evaluating S100 RAHSP against its aims, the project evaluated the impact of the initiative on pharmacists, AHS staff and AHS clients.

- ***Aboriginal and Torres Strait Islander Access to Major Health Programs*, Urbis Keys Young, July 2006**[9]

This study was conducted during 2005-06 for the Department of Health and Ageing and Medicare Australia. Its purpose was to provide an up to date picture of ATSI people's access to major health programs. The work included consideration of a range of Australian Government initiatives that have been implemented since the submission of an earlier report on Indigenous access to Medicare and the PBS, prepared by Urbis Keys Young in 1997.

- ***Review of the Existing Supply and Remuneration Arrangements for Drugs Listed under Section 100* of the *National Health Act 1953*, Australian Healthcare Associates (AHA) February 2010**[10]

This review was funded by the Australian Government and was a joint commitment of the Government and the Guild under the Fourth Community Pharmacy Agreement. The objectives were to assess the effectiveness and efficiency of the current arrangements as they relate to community pharmacy, identify the impact of the supply and remuneration arrangements on community pharmacy and develop options to address any identified impact of the current arrangements.

- ***Evaluation of Indigenous Pharmacy Programs* NOVA Public Policy, June 2010**[11]

Nova Public Policy was contracted by the Department of Health and Ageing to evaluate three of the Indigenous Pharmacy Programs from the Indigenous Access Program and funded under the Fourth Community Pharmacy Agreement. The evaluation was aimed at determining the level of need for the specific Indigenous Pharmacy support programs, assessing the extent to which the current programs met the identified needs of Indigenous pharmacy services in Australia and assessing the efficiency of the administration and delivery of the Indigenous pharmacy programs.

# 6. Addressing the Terms of Reference

This section of the submission addresses in turn each of the Inquiry's Terms of Reference. As noted earlier, the Guild carried out a survey of its members involved in the S100 RAHSP and the S100 PSAP to inform responses to the Terms of Reference. The submission also makes reference to the previous reviews and evaluations in order to address these Terms of Reference.

**The effectiveness of the special arrangements established in 1999 under section 100 of the National Health Act 1953, for the supply of Pharmaceutical Benefits Scheme (PBS) medicines to remote area Aboriginal Health Services, with particular reference to:**

**6.1 (a) whether these arrangements adequately address barriers experienced by Aboriginal and Torres Strait Islander people living in remote areas of Australia in accessing essential medicines through the PBS;**

The survey responses from community pharmacies confirm that the S100 RASHP has made a major impact in removing the barriers to PBS access for ATSI people. This positive response is also reflected in a number of the reviews and evaluations of the program. It was noted by many of the pharmacists that access for ATSI people could be further improved by addressing the recommendations from the number of reviews and evaluations that have taken place.

The Keys Young Report (1997) noted that wide gaps existed in the level of access enjoyed by many ATSI people and noted that the major obstacles to access were:

- **Entitlement numbers**. Clients often are unable to provide a valid entitlement number to the dispensing agent, despite being eligible for concessions and benefits.
- **Co-payments.** Inability to afford either the concessional or full co-payment was a major barrier, regardless of location. A consequence of these two problems is that the ability to obtain medication inevitably depends on the judgement of the pharmacist, ACCHS etc.
- **Immediacy of supply.** Factors such as isolation, inability to afford medication and lack of entitlement numbers frequently result in delays in obtaining prescribed medicine, which in many instances has serious health consequences.
- **Funding of PBS pharmaceuticals**. Certain medications felt to be of particular importance to ATSI communities were rendered all but unaffordable if they were not listed on the PBS.

The S100 RAHSP has addressed these barriers as patients are supplied medicines by the AHS staff without the requirement to process a PBS prescription form which would require the patients' entitlement numbers and for co-payments to be charged. In addition, the supply can be made immediately at the AHS, in a culturally appropriate manner (e.g. in the patients' own language), at the time of the patients' consultation.

This is borne out by the findings of the Loller and Kelaher reviews:

> *"The implementation of Section 100 medications for remote area Aboriginal Health Services, (AHS's) has completely revolutionised medicines access and has been one of the most substantial, positive developments in remote Aboriginal health service delivery for many years. Already evidence is emerging regarding the health outcomes for Aboriginal people."*
>
> *Hannah Loller (2003).*

> *"S100 has met its aim of improving access to PBS medicine to clients of remote area ATSIHSs and should be continued. All sources of data suggest a significant increase in medicine utilisation".*
>
> *Margaret Kelaher et al (2004)*

It is also important to note that the 2004-05 Budget measure *"Primary Health Care Access Program for Aboriginal and Torres Strait Islander People"* indicated that the inclusion of medicines on the PBS to treat conditions particular to ATSI health needs would be facilitated. The measure suggested that treating conditions particular to ATSI health needs may require consideration of medicines not yet registered for use in Australia, as well as consideration by the Pharmaceutical Benefits Advisory Committee (PBAC) of medicines not yet subsidised under the PBS. Assessment of these medicines would be made through existing mechanisms for marketing approval and listing for PBS subsidy.

An Expert Advisory Panel on Aboriginal and Torres Strait Islander Medicines (EAP) was formed to progress the Budget measure. As a result of the EAP's recommendations, several medicines have been listed on the PBS exclusively for ATSI patients. The PBAC evaluates and recommends the listing of medications specifically to help with the health needs of ATSI people. The Schedule of Pharmaceutical Benefits now includes listings to support the treatment of conditions common in ATSI health settings. Whilst some listings are medicines new to the PBS, others vary the restrictions for prescribing existing PBS items. Examples of such listings are mupirocin nasal ointment, nicotine transdermal patches, a range of topical antifungal products for the treatment of fungal and yeast infections, thiamine, albendazole and ciprofloxacin ear drops.

**Recommendation 1**

**The essential features of S100 RAHSP, which have ensured its success, must be retained. These include:**

- **supply of PBS-medicines to AHS's through the existing network of community pharmacies, and at no cost to the patient,**
- **utilising the existing infrastructure provided at the local remote AHS, and not requiring the patient to travel to other venues,**
- **providing a one stop-shop at the AHS (patient gets medications and advice for using them at the time of visiting the AHS),**
- **allowing the patient to access medicines in a culturally appropriate setting,**
- **not requiring the patient (or staff) to provide Medicare cards, Pension or Health Care concession cards for eligibility purposes or to keep track of PBS Safety-Net information.**

**6.2 (b) the clinical outcomes achieved from the measure, in particular to improvements in patient understanding of, and adherence to, prescribed treatment as a result of the improved access to PBS medicines;**

Most of the respondents to the Guild survey agree with the sentiments of the Kelaher evaluation which noted that as the S100 RAHSP is a supply program, drug utilisation data is the most reasonable indication of the program's success and while it may be appealing to make claims regarding clinical outcomes this confuses the issue of access to medicine with the issue of QUM and effectiveness of medicines.

> *"If the medication was not provided free of cost, there would be many more hospitalisations for chronic as well as acute medical conditions. It is easy to see how not taking chronic medications can lead to hospitalisations but with acute conditions such as staph infections, URTI's and UTI's for example leaving them untreated could cause sepsis, pneumonia or bronchitis and kidney damage leading to hospitalisation.*
>
> *The S100 program and the AHS who deliver the medication to the indigenous population of Australia do an amazing job. They allow easy access of medication often in very remote locations as well as providing counselling both in regards to their medication and medical conditions but also emotionally. Culturally the Aboriginal people would rather see an AHS worker or medical practitioner of the same sex and the AHS is aware of this and by understanding their cultural needs, offer a better service than would otherwise be offered. They help to increase both the length and the quality of life of the aboriginal population and should be commended."*
>
> *Elise Wheadon, Amcal Chemist, Kalgoorlie, WA*

As noted in the original Keys Young report (1997) there were major obstacles experienced by ATSI people accessing PBS medicines. The S100 RAHSP has gone a long way in removing these obstacles meaning that access has improved. Without such a scheme in place it would be difficult for these patients to access the medicines they need in a culturally appropriate manner and at the time of consultation at the AHS. Whilst it is accepted in many of the reviews and evaluations that access has increased it is difficult and perhaps inappropriate to make a judgement regarding the clinical outcomes achieved by the measure. Many variables affect clinical outcomes and it is difficult to identify those that relate exclusively to this particular measure.

The Loller report (2003) indicated that a number of AHS's reported anecdotally that there were already better health outcomes apparent as a result of the S100 RAHSP. These anecdotes included lower hospitalisation rate of children, lower infertility rates due to increased access to antibiotics and better controlled diabetic patients (eg reduced glycated haemoglobin levels (HbA1c)). The Loller report further recommended that it would be important to put in place an evaluation process to capture this data and gain a comprehensive picture of the positive health outcomes as a result of access to medications under the S100 RAHSP program.

The Guild notes that in the Kelaher evaluation (2004) it stated that while Loller suggested that health outcomes associated with S100 RAHSP should be researched and there are a number of questions that could be legitimately asked, *'changes in health outcomes should not be considered to be the test of the S100 arrangements' success.'* The evaluation goes on to say that, whilst this may be intuitively appealing, it confuses the issue of access to medicine with the issue of the QUM and effectiveness of the medicine.

The Guild agrees with Kelaher in that the S100 RAHSP as it currently stands only directly affects the supply of medicine to AHS's. Health outcomes associated with increased medicine use will depend on the effectiveness of the medicine and QUM and, as stated by Kelaher, the S100 RASHP does not directly influence these factors so it would be inappropriate to evaluate the success of the program on this basis. The S100 RASHP is a supply program and Kelaher suggests that medicine utilisation data is probably a reasonable indication of the program's success.

**Recommendation 2**

**Medication utilisation data should be the accepted indication of the program's success.**

### 6.3 (c) the degree to which the 'quality use of medicines' has been achieved including the amount of contact with a pharmacist available to these patients compared to urban Australians;

The survey responses received by the Guild indicate that QUM has improved since the start of the S100 RAHSP. However, the pharmacies serving the AHS's believe that they could do more to ensure that QUM is improved if they could make more frequent visits to AHS's, especially to the more remote AHS's.

> *"We work hard to supply our Aboriginal Health Services and although there may not be a 'pharmacist in sight' there is indeed a pharmacist on the end of the phone the entire working day whose sole job is to help."*
>
> *Mel Goss, Terrace Pharmacy, Katherine, NT*

> *"The current funding available for the S100 Pharmacy Support Allowance Program may appear to be generous from a metropolitan point of view but from a remote point of view the current funding is not adequate to allow me to visit my 20 AHS's more than one day per year. If you study a map of the AHS's I visit, review the current schedule of flights and the cost of those flights available in my area, combine this with a study of which communities have accommodation and food... you will realise why I had to purchase a ship to allow me to service my AHS properly."*
>
> *Lynn Short, Thursday Island Pharmacy, QLD*

#### 6.3.1 Quality Use of Medicines

The term "Quality Use of Medicines" (QUM) is widely used but often misunderstood. A short description of this important concept will hopefully help to clarify its meaning and dispel any misunderstandings.

QUM is one of the central objectives of Australia's National Medicines Policy[12]. QUM means selecting management options wisely; choosing suitable medicines if a medicine is considered necessary; and using medicines safely and effectively. QUM applies equally to decisions about medicine use by individuals and decisions that affect the health of the population.

QUM can involve the identification and implementation of methods to select and communicate the most appropriate medicine or non-medicinal option from all available prevention and treatment options, so that the individual gains optimal, cost effective health outcomes; and methods to monitor the outcome of the selected treatment option, to allow rapid modification according to response, so that optimal health outcomes are maintained over time.

At a community level, QUM can provide a guide to the development of these methods by outlining evidence-based steps that facilitate the development of processes and resources that allow the identification, selection and effective implementation of treatment options, which best meet the individual needs and management objectives of the consumer, health care professional and community.

It can also be used to develop educational and information materials to support health care professionals and consumers in the selection and use of medicines according to appropriate

individual needs and management goals. It can help construct an evaluation framework, which allows the continued monitoring of the selected treatment option against health goals, and processes to reassess choice according to these outcomes.

### 6.3.2 QUM for Remote Area AHS's – Allowance Payment

The payment of an allowance to pharmacists for the delivery of support services to remote area AHS participating in S100 RAHSP was first made available through the Third Community Pharmacy Agreement (2000-2005). The payment followed the successful completion of the Quality Use of Medicines in Aboriginal Communities (QUMAC) project, conducted by the Guild, the NACCHO and Charles Sturt University between June 1999 and February 2001.

The Fourth Community Pharmacy Agreement (2005-2010) introduced new payment scales, minimum standards, enhanced accountability measures and a broadening of the eligibility criteria to provide services under the Section 100 Pharmacy Support Allowance Program (S100 PSAP) (see Appendix 2). The aim of this Program is to assist pharmacists to provide a range of QUM and medication management services to support approved remote area AHS's that participate in the S100 RAHSP.

The Nova review (2010) of the S100 PSAP noted during consultations that some pharmacists reported that the following QUM issues continue to persist and need to be addressed by the S100 Support Program:

- Legislative compliance resulting from the turn-over of staff and the lack of labelling of dispensed medicines.
- Untrained staff: the requirement for staff training is constant and for some locations, retraining of staff is reportedly required at each visit by the pharmacist. For example one pharmacist reported that many AHS staff are not aware of what is and is not on the PBS and there continues to be quality and safety issues associated with AHW's not understanding medication charts and labelling.
- Lack of knowledge of medications which is exacerbated by different doctors prescribing different medications for similar conditions.
- The rotation, refrigeration and security of stock.
- The attitude of AHS management – it was reported that where there was a strong interest on the part of the AHS management, the management of medicines was significantly improved.
- Paucity of information about medications and disease management that is provided to patients.
- Doctors who "fly in and fly out" and don't really know patients.
- Co-morbidities and continuity of care in chronic disease management.
- Clinics under the direction of nursing staff who are short term and lack knowledge of medicines.
- Handling cold chain issues.
- Ensuring correct dosages and medications are actually taken.

The Nova review also included feedback on the degree to which QUM issues are addressed. The review noted that stakeholder feedback supported the view that the S100 PSAP had been influential in promoting QUM especially through promoting safe storage and medication handling compliance. Most AHS's responded to a survey conducted by Nova that the impact of the program on the safe storage of medicine in their service was 'high' or 'very high'. In addition it was noted that the majority of pharmacists interviewed indicated that the S100 PSAP provided an essential complement to the S100 RAHSP.

However, not all respondents believed that the S100 PSAP adequately addresses basic QUM issues. For example the review noted that one of the state regulatory bodies believed there were insufficient checks and balances in place to ensure safety, and cited the following issues:

- Correct labelling - only a small percentage of AHS are able to label appropriately and that many medications are distributed unlabelled.
- Staff non-compliance with legislation, and a perceived limited capacity to assess patient compliance with medication regimes.
- Insufficient time allocated/provided to address QUM issues "two visits per year is not enough time to provide assistance required with QUM".
- Medication wastage resulting from over-ordering or changes in prescriptions subsequent to bulk supply (pharmacists may supply 2-3 months of medications and they cannot be returned once supplied).

The Nova review noted that the key services pharmacists provided under the S100 PSAP included:

- the introduction of audit procedures;
- education (utilising NPS) resources;
- getting drug rooms functional;
- improving security particularly with respect to drugs that are subject to abuse;
- checking of stock levels and currency;
- examination of storage and handling facilities;
- support for appropriate prescribing practices including checking and labelling of products.

One response to the Guild survey question regarding the functions performed (and the time spent) in the AHS as part of the S100 PSAP was as follows:

> *"Visiting pharmacists are engaged in many varied professional activities whilst in the AHS. These include:*
>
> *a) Stock control (approx 20%) (ie: provision of training for ordering procedures, maintaining records, developing maximum stock levels, installing shelf tags, expiry checking and rotating stock, etc)*
> *b) Drug storage room maintenance (approx 20%) (ie: implementing Standard Drug List guidelines, Return of Unwanted Medicines protocol, Dose Administration Aids for chronic disease medicines, provision of shelving where necessary, etc)*
> *c) Medication chart reviews (approx 20%) (ie: checking prescription records, indications and dosages, and identification of possible interactions, prescribing errors, etc)*
> *d) In-service training (approx 10%) (ie: delivering a wide range of relevant educational topics to Aboriginal Health Workers (AHWs), Registered Nurses (RNs) and Medical Officers (MO))*
> *e) Labelling (approx 5%) (ie: provision of computer hardware, labels library and labels to facilitate labelling of medicines, etc)*
> *f) Refrigerators (approx 5%) (ie: checking cold chain, temperature records, expiries, stock levels, etc)*
> *g) Schedule 8 and Restricted Schedule 4 medicines (approx 5%) (ie: checking registers, counts and expiries, and assisting with suitable disposal of unwanted S8 and RS4 drugs where necessary, etc)*
> *h) HMR (approx 5%) (ie: patient interviews, case conferences and reports to doctors, etc)*
> *i) References (approx 5%) (ie: checking availability of recommended references, etc)*
> *j) Emergency kits (approx 5%) (ie: checking expiries and content of emergency, anaphylaxis, obstetric, intubation and fit kits, etc)"*
>
> *Shelley Forester, Palmerston, NT*

Most of the pharmacists who responded to the Guild survey believe that the S100 PSAP has done a great deal to address QUM issues in remote AHS's. However, the majority of pharmacists who responded suggest that they could provide a better service if they could find more pharmacists willing to work in remote areas and if the allowance were increased to cover the costs of travelling to many of the remote health services.

> *"I could do a much better and more fulfilling QUM job if I could get another pharmacist to work here on a full time basis"*
>
> *Peter Crothers, The Towers Drug Co Pharmacy, Bourke, NSW*

> *"I would like to see more funding available to enable the supporting pharmacists to remain on site visits longer where there is work to be done. I am aware that, at best, many AHS's only see their pharmacist two days bimonthly. Between October 2010 to June 2011, I visited my AHS six times and each visit has been a week including travelling time. The duration of my visits have been necessary for a proper set up to ensure that things run smoothly, but it is at my expense if I want to spend more time onsite to do it well."*
>
> *Lucy Chow, Crossroads Pharmacy, Port Augusta, SA*

**<u>Recommendation 3</u>**

**A review of the S100 PSAP should be undertaken to identify the number of visits by a pharmacist that best support the AHS's and QUM.**

### 6.4 (d) the degree to which state/territory legislation has been complied with in respect to the recording, labelling and monitoring of PBS medicines;

Many of the respondents to the Guild's survey stated that if the recommendations from the Kelaher report were implemented it would help AHS's address legislative compliance issues. In addition many pharmacists mentioned that if they were able to visit the AHS's more regularly they could provide more assistance to the AHS's in addressing these types of issues.

> *"Overall the evaluation suggested that many AHS's were not fully compliant prior to the introduction of* S100 RAHSP*. In some cases problems with compliance may have been exacerbated by* S100 RAHSP*, but generally the program had helped identify and address compliance issues in a number of settings. At the outset of the evaluation the team felt it would be difficult to collect data about levels of compliance. However, AHS staff and pharmacists were not only honest but also pro-active in pointing out areas where compliance was problematic. Generally instances of non-compliance were not the result of lack of will, or even lack of knowledge by AHS's, but lack of resources."*
>
> *Kelaher et al (2004)*

The Guild notes that the Kelaher report made the following recommendations to address compliance issues:

- The Department of Health and Ageing (DoHA) should examine mechanisms for providing more extensive support to ensure that S100 RAHSP is implemented in a way that is compliant with State and Territory legislation and regulations.

- A self-assessment tool addressing legislative compliance issues should be made available to AHS's to complete with their supporting pharmacists.

- DoHA should develop a central resource for S100 RAHSP to enable sharing of information and lessons.

- DoHA in conjunction with State and Territory governments, the Guild and NACCHO should develop a resource that clearly states how the laws and regulations should be applied to remote AHS's.

- DoHA should work with State and Territory governments, the Guild and NACCHO to identify ways of facilitating the operation of S100-approved services in jurisdictions where there are legal and regulatory barriers to program implementation.

To the best of the Guild's knowledge few if any of the above recommendations have been addressed since the Kelaher report was released in 2004.

It was the opinion of many of the survey respondents that if more frequent visits to the AHS were possible by the pharmacy providing the S100 PSAP, issues of compliance with state and/or territory legislation could be identified and the pharmacist could work with the AHS to address these issues. In many cases due to poor funding and the distances involved, a pharmacist is only able to visit some AHS's once a year. The Nova evaluation noted that some AHS's interviewed claimed that the support pharmacist *'kept them on their toes'* ensuring that a safe and appropriate service was being provided.

**Recommendation 4**

**Transport costs for community pharmacies servicing remote AHS's should be separately funded based on a model which reflects the variable which drives these costs.**

**6.5 (e) the distribution of funding made available to the program across the Approved Pharmacy network compared to the Aboriginal Health Services obtaining the PBS medicines and dispensing them on to its patients;**

The NACCHO stated, during the development of the S100 RAHSP, that the inclusion of pharmacy as the agent for the S100 RAHSP would overcome concerns about the possible impact of the initiative if applied in areas where pharmacies are operating[13]

Respondents to the Guild survey felt that providing funds to the community pharmacy network to supply AHS's is the best way to provide services to AHS's as they can benefit from the expertise of their nearest community pharmacy and it fosters integration of the primary health care system.

> *"You have to be careful not to compare the S100 RAHSP to the wholesale model. This model implies merely sending medicines to AHS's without any professional involvement whatsoever. A storeman in a warehouse can send medicines to an AHS whereas a pharmacy sending medicines to an AHS will be overseen by a pharmacist who will pick up anomalies such as "Do they need this quantity?", "Do they have this many patients who qualify for this medicine under PBS conditions", "Are these medicines likely to be used or will they just go out of date". The S100 RAHSP as it exists encourages remote pharmacies to exist, and in turn creates employment, develops training opportunities for pharmacy students, pharmacy assistants and creates employment opportunities for indigenous Australians..."*
>
> *Darryl Stewart, Gove Pharmacy, Nhulunbuy, NT*

The Guild notes that when developing the S100 RAHSP, NACCHO and DoHA realised the importance of including the network of community pharmacies. By using the community pharmacy network the AHS had the support that goes with ordering from a pharmacist - an expert in medicines and also the PBS.

> *"In looking at the ratio of pharmacist to clients in remote regions, somehow bringing more pharmacists into these regions would be of great benefit, but again, who pays, and where will the pharmacists come from?"*
>
> *Lyn Short, Thursday Island, QLD*

As noted by the Geraldton Regional Aboriginal Medical Service (see Appendix 3) some services appreciate the availability of having a pharmacist as part of the supply function as they can also act as a resource at the "end of the phone". Many AHS's do not wish to operate their own pharmacy as they find utilising a current resource ensures supply and dispensing from a fully qualified pharmacist with none of the concerns associated with management and workforce issues if they were to operate a dispensary as well. The nearest community pharmacy has the expertise in PBS issues and administration and this is something that the AHS's can take advantage of.

> *"To remove community pharmacy from supply and push the supply back onto the AHS would be a regressive step in my view – that is in effect what we had prior the S100 RAHSP. Recruiting pharmacists into remote AHS's to undertake a supply role that can be done very well remotely would also be problematic and not a good use of a scare resource. I do not believe it is a good use of resources to recruit pharmacist into every AHS. Many are small and do not even have a resident doctor. It would make much more sense to have a doctor with increased pharmacist support visits".*
> *Shelley Forester, Palmerston, NT*

It has been argued that the funds currently used in supplying medicines to AHS's under the S100 RAHSP could be directed to the AHS's which would enable the services to set up their own dispensaries and employ a pharmacist to dispense all PBS medicines to clients as required. However, it should be remembered that even if a pharmacist could be found to work in a remote area there are insufficient funds available to make this a viable option. There are also practical considerations such as the lack of housing in remote areas and professional isolation that make it difficult to attract and keep staff in rural and remote areas. In addition it would impose upon the AHS the added responsibility of ordering stock for the pharmacy. Community pharmacy is well positioned and trained to deal with the vast array of suppliers and wholesalers, not to mention the constantly changing commercial and government policy environment. This was recently highlighted with the move to direct supply arrangements by Pfizer. If the AHS was required to deal with multiple vendors it would become a major distraction and reduce the time available to see patients.

*"The support and long term stability provided via engagement of a local community pharmacy is a far superior model when compared, for example, to a stand-alone pharmacist operating within the AHS.*

*A fully functioning regional community pharmacy is able to provide a much larger team to consult with and to provide support on a day to day basis without disruptions due to sick leave, annual leave or times of recruitment difficulties. This ensures a continuous supply chain not only of bulk stock but also of DAA's which can be extremely labour intensive. It also takes the extra pressure of rural pharmacist recruitment away from the AHS, freeing up more time and resources for their team to focus on the provision of adequate health care to their patients.*

*Having the local community health care team involved with the AHS is critical. Specifically, the community pharmacy is ideally placed to be the supplier as well as advisor of medicines as they see the full picture as well as possessing the necessary skills set to look after their specific needs.*

*Many of the AHS's clientele often visit the local town pharmacy, hospital, specialists, dieticians, diabetic educators and audiologists etc so it ensures the whole process is integrated and moves us culturally as a sector towards improved cultural awareness and reduced interracial segregation from a health care perspective."*

*Laura Stewart, Pharmacy Help Karratha, WA*

**Recommendation 5**

**The current funding arrangements for supplying PBS medicines to remote AHS's through the existing network of community pharmacies should be retained and enhanced.**

**6.6 (f) the extent to which Aboriginal Health Workers in remote communities have sufficient educational opportunities to take on the prescribing and dispensing responsibilities given to them by the PBS bulk supply arrangements;**

The Guild believes that educational opportunities for AHW's should be provided as part of a nationally consistent Continuing Education Program. The requirements for continuing education should be determined by the national registration body responsible for AHW's. The Guild suggests that when the Australian Health Practitioner Regulation Agency (AHPRA) takes responsibility for the registration of AHW's in 2012 the relevant board could set standards for continuing professional development similar to those set by the Nurses and Midwifery Board of Australia. By having set standards for continuing professional standards AHW's will be required to spend a number of hours pursing continuing educational activities which could be provided by the various professional bodies. These activities could be delivered by correspondence or in person eg relevant units in medication management could be delivered by the pharmacist as part of the QUM activities.

> *"It was noted that there is limited training available for AHW's in medication management, and information regarding medications in the current certificate courses for AHW's is of a limited nature. The AHS site that excelled in their medication management practices was a site where some of the AHW's had completed the Guild's dispensary technician's course. At this site the AHW's worked with the local pharmacist over a period of time to gain the necessary skills to achieve this qualification. In some clinics, the role of a dispensary technician may be performed by other clinic staff, enabling the AHW to focus on their primary health care role. There may also be cost advantages for some AHS to use staff other than the AHWs."*
>
> *Hannah Loller (2003)*

The Guild notes that the prescribing and dispensing responsibilities of AHW's in remote communities is not given to them by virtue of the S100 RAHSP but rather by the particular State and Territory legislation under which they work. For example, in the Northern Territory the *Health Practitioners Act* provides for the registration of persons practising health care and the regulation of those persons, and for related purposes. The Act's objective is to protect and promote the health and safety of the people of the Territory, to promote the highest standard of professional health care practice in the Territory, to determine the standards for registration of health practitioners, including AHWs, and to facilitate the continuing competence of health practitioners in the Territory.

The Guild also notes that in 2012, the Australian Health Practitioner Regulation Agency (AHPRA) will oversee the national regulation of an additional four health professions one of which will be Aboriginal and Torres Strait Islander health practice.

Whether or not AHW's have sufficient educational opportunities is not within the remit of the S100 RAHSP but rather the registration process.

Notwithstanding the fact that S100 RAHSP is not responsible for providing educational opportunities, the pharmacist supplying Section 100 supplies and delivering S100 PSAP has the opportunity to provide certain educational opportunities to the staff of AHS. For example a pharmacy that responded to the Guild's survey stated that they spend approximately 20 hours per week on training AHW's and are putting two AHW's through the Certificate 2 and 3 Community Pharmacy course to increase their effectiveness in the health service.

In fact, the Nova evaluation noted that "the aspect of support most valued by the AHS was in the training and development of staff. A number remarked that the pharmacist provided education sessions for staff on medications and safe and appropriate management of medicines."

It should also be noted that community pharmacists involved in the S100 RAHSP acknowledge the important role played by AHW's in delivery of care to ATSI patients because they have the ability to communicate with AHW's in a culturally appropriate manner and in most cases in their own language. Community pharmacy provides AHW's with support and education to enable them to fulfil their role in the integrated health care team so that AHW's are able to provide a better service to ATSI peoples in a culturally appropriate framework.

> *"Culturally, ATSI people would rather see an AHW or medical practitioner of the same sex and the AHS is aware of this and by understanding their cultural needs, offer a better service than would otherwise be offered. They help to increase both the length and the quality of life of the ATSI population and should be commended."*
>
> *Elise Wheadon, Amcal Chemist, Kalgoorlie, WA*

> *"The strength of the S100 RAHSP is the close relationship between the pharmacy and the AHS's. We know the staff and they know us, so information and assistance flow more readily as a result. Pharmacy's strength is in medication management and therapeutics; we help AHS's maintain a consistently professional approach to medication ordering, storage and provision."*
>
> *Gareth Gearon, Kununurra Pharmacy, WA*

**Recommendation 6**

**When the Australian Health Practitioner Regulation Agency (AHPRA) takes responsibility for the registration of AHW's in 2012 the relevant board should set standards for continuing professional development for AHW's. Educational activities, accredited by the relevant bodies, could be delivered by visiting professionals such as doctors, nurses or pharmacists to improve education opportunities for AHW's.**

### 6.7 (g) the degree to which recommendations from previous reviews have been implemented and any consultation which has occurred with the community controlled Aboriginal health sector about any changes to the program;

The pharmacies that responded to the Guild survey expressed disappointment that, despite the number of reviews and evaluations into the S100 RAHSP, and the numerous recommendations they have produced, little has changed since the Program's commencement some 12 years ago.

Additionally, many pharmacists feel that if the recommendations had been implemented it would have further improved access to the PBS by the ATSI population as well as the efficiency and effectiveness of the program's administration.

> *"After three reviews of the Section 100 supply arrangements little change has occurred ... the Senate Inquiry should be able to identify what needs to be improved and which agenda should be responsible for making it happen. The involvement of pharmacists in this process should be a leading principle"*
>
> *Rollo Manning*[14]

Following a study of the survey responses received by the Guild and an examination of the recommendations from the evaluations and reviews, this submission has collated the various recommendations under the headings of 'Quality Use of Medicines' and 'National Organisation and Co-ordination'.

#### 6.7.1 Recommendations relating to Quality Use of Medicines

Many of the surveys received by community pharmacists raised the issue of QUM and many made suggestions on how this could be improved. A common suggestion made was that QUM could be further improved in AHS's if the number of visits by pharmacists could be increased and extra services such as Dose Administration Aids (DAA's) were subsidised.

The Guild notes that a number of the reviews and evaluations have also made recommendations relating to QUM as follows:

The AHA review (2010) made the following recommendations relating to QUM:

- That a three-tiered handling fee be introduced to include a basic fee for 'bulk supply', plus a dispense fee and a fee for DAA when requested by the AHS.
- A review be undertaken of the S100 PSAP to evaluate the outcomes for AHS's and identify the number of visits by a pharmacist that best support the AHS's and QUM.
- Establish a quality standard for the provision of pharmacy support to AHS's
- Provide a subsidy or grant for the purchase of labelling equipment for AHS's
- Establish a dedicated funding pool specifically for AHS staff training purposes

The Urbis Keys Young (2006) report made the following recommendations relating to QUM:

- Funding for the use of DAA's in association with the S100 RASHP.
- Systematic arrangements to provide medication management training for AHW's and nurses.
- Development of a model of medication review that is appropriate for ATSI communities.

Many of the survey responses from pharmacists noted that although S100 RAHSP was originally a 'bulk supply' program it has since become more than this and pharmacies are continually being asked to provide further services that improve QUM.

> *"Since its inception in 1999, where it was simply a matter of collating an order and putting it in a box for delivery to the AHS, we have made changes which have evolved over time in accordance with the push for QUM in this population.*
>
> *We now find ourselves packing a lot of these medications in DAA's which was the first step in improving compliance. This has taken the pressure off the AHW at the clinic as they now have more time to see patients, and has resulted in far less errors in medication. However, it now takes up out pharmacists' time in store so we find ourselves having to employ extra pharmacists"*
>
> *Troy Bodle, Cable Beach Pharmacy, WA*

The Guild notes the AHA review (2010) of the S100 RAHSP highlighted the problem of increased demand from AHS's for additional services from community pharmacies. Pharmacists consulted during the course of the review reported that, due to QUM concerns and ongoing requests from AHW, that pharmacists were increasingly preparing DAAs for individual clients (using clients' medication charts) prior to delivery to the AHS. Pharmacists were concerned that the cost they incur in providing these additional services (such as the purchase of the DAAs and the professional time in packing and checking) is unable to be claimed through the current S100 RAHSP.

The AHA review noted that it was important to note that the S100 RAHSP was created to provide bulk supply of PBS medicines to remote AHS's and did not include such services as providing DAAs. However, stakeholders consulted believed that the increasing use of DAAs helps to maintain medicine hygiene, promotes QUM, compliance and reduces wastage and errors at the AHS. The review proposed that that a S100 RAHSP DAA fee could be paid, similar to that paid by the Department of Veterans' Affairs.

It was highlighted in the AHA review that some legislative differences and additional requirements are imposed by some state and/or territory governments on community pharmacies involved in the S100 RAHSP. These result in variability in the operation of the program and additional pharmacy costs that are not able to be claimed, which may affect the viability of community pharmacies providing the service.

In its response to the Guild survey, the Rangeway Pharmacy in Geraldton stated that the services they provide Geraldton Regional Aboriginal Medical Service (GRAMS) included the following:

- Weekly medication packs (DAA's) are supplied monthly along with medications for patients who are capable of taking these themselves
- All medicines are dispensed with full and clear instructions
- Patient history and up to date medication charts for each patient are maintained and communicated with doctors from GRAMS, Royal Flying Doctor Service and Geraldton Regional Hospital via phone, fax and email
- A Home Medicines Review (HMR) accredited pharmacist on staff to perform medication reviews if requested by doctor.
- Asthma and diabetes accredited pharmacist on staff
- Regular contact is made with GRAMS health workers to ensure all details are correct and up to date
- Pharmacist staff accompany the GRAMS vans to remote outstations to provide advice to patient

This highlights the range of activities provided by pharmacies involved in this program that extend beyond just 'bulk' supply of PBS medicines to AHS's.

#### 6.7.1.1 Continuity of Care

An associated issue of importance is the continuity of care between the various special systems of access to pharmaceutical benefits by ATSI peoples. PBS medicines can be accessed in the regular way via section 85 of the PBS with or without co-payment relief via the Closing the Gap measure or via the Section 100 RAHSP if the patient is visiting a remote AHS. In addition patients may also visit the public hospital system where they may access medicines.

The problem of continuity occurs when a patient who, for example, usually obtains medicines from an AHS, without charge, in a remote area travels to an urban area but cannot access the Closing the Gap program or vice versa. There is also a problem where a patient accessing medicines from either a remote AHS or Closing the Gap attends a public hospital for treatment as the public hospital cannot supply the patient under the remote scheme or the Closing the Gap measure.

> *"Nursing Home – when a patient needs care in an aged care facility, they are no longer allowed to access medications via the S100 RAHSP. This comes as a shock as they haven't had to pay for medication and in their last years, they have to start paying. Closing the Gap has definitely helped in this respect; however, CTG has its limitations"*
>
> *Elise Wheadon, Amcal Chemist, Kalgoorlie, WA*

The increasing mobility of people living in remote areas must be recognised, along with their need to travel for specialist treatment and hospitalisation. Initiatives to improve ATSI people's access to PBS benefits in urban areas (QUMAX and CTG co-payment relief) have been successful in these areas. However, the opportunity exists to ensure that mechanisms are employed to make these schemes work together to allow patients to travel between remote and urban areas and between hospital and home and still have access to their PBS medicines.

Therefore it is important that there is a mechanism to address this continuity of care issue as they become apparent and modify the varying programs to ensure that ATSI peoples can access their medicines in a range of health care settings.

### 6.7.2 Recommendations relating to National Organisation and Co-ordination

Many of the recommendations made by the reviews and evaluations appear to be related to the lack of a dedicated role in the DoHA to manage the S100 RAHSP which results in an absence of national organisation and co-ordination.

The AHA review (2010) made the following recommendations relating to national organisation and co-ordination:

- Separately fund transport costs based on a model which reflects the variables which drive these costs.
- Develop a clear declaration about the nature of the AHS services, which is supported by guidelines, protocols, procedures and contract or service agreements.
- Review the inter-government Memorandums of Understanding established at the inception of the S100 RAHSP.
- Establish an inter-government committee that has oversight of the S100 RAHSP and S100 PSAP.
- The Department should establish a dedicated role to manage the S100 RAHSP and S100 PSAP and be the key point of contact for pharmacists and AHS's.

The Nova evaluation (2010) made the following recommendations relating to national organisation and co-ordination:

- Sponsor an annual conference for pharmacists involved in S100 and a representative group of AHS's.
- Clarify and articulate the responsibilities of key stakeholders with respect to the administration and governance of the program.
- Establish a coordinative mechanism between key stakeholders and agencies.

The Kelaher report (2004) made the following recommendations related to national organisation and co-ordination:

- The DoHA should review access to Schedule 8 (Dangerous Drugs) medicines in remote areas.
- The Health Insurance Commission (now Medicare Australia) should provide medicine utilisation data to AHS's to enable them to keep track of their own performance.
- A system to assess the amount of medicine that expires in AHS's should be considered to enable further evaluations.
- DoHA should examine mechanisms for providing more extensive support to ensure that S100 is implemented in a way that is compliant with state and territory legislation and regulations.
- DoHA and Medicare Australia in consultation with state and territory governments, the Guild and NACCHO should develop an electronic means for AHS's to order from pharmacies.

All of the survey results received by the Guild made some comment about the inability of pharmacists to process S100 claims electronically as they would with other PBS items.

> *"The manual nature of the claiming process needs to be changed to an electronic means to streamline the process. This would provide better audit trails and reporting to monitor the volume of PBS items being supplied under S100 RAHSP."*
>
> *Troy Bodle, Cable Beach, WA*

The Guild notes Loller (2003) recommended that the HIC (now Medicare Australia) should develop an electronic claiming method for S100 RASHP claims. It was noted that 84.6% of pharmacies surveyed as part of the report indicated a preference for electronic claiming to be introduced.

The reasons cited were to reduce the time required to submit a claim, improve stock control, ensure faster payment from Medicare Australia and improve the ability to provide reports to AHS's of medications ordered. The report also noted that there is a precedent in dispensing software utilised by pharmacies in the Emergency Drugs Supplies ("Doctors' Bag") supply mechanism. Whilst it was noted that there would need to be software modifications it would allow faster transmission of claims and less input from Medicare Australia to process claims.

An electronic claiming process would also assist in addressing another recommendation made in the Loller report that Medicare Australia should provide information to each AHS about individual drug usage and cost on an annual basis. The Kelaher evaluation also recommended that Medicare Australia should provide medicine utilisation data to AHS to enable them to keep track of their own performance as well as developing an electronic means for pharmacist to claim from Medicare Australia.

The review carried out by Australian Healthcare Associates (AHA) in 2010 also noted that all stakeholders commented that the current S100 RAHSP claiming process that uses a paper-based

multiple copy claims book has not changed in the last ten years. The review noted that, whilst simple in some aspects, the current claiming process is regarded by all participating pharmacists consulted to be cumbersome, frustrating and time consuming and results in unnecessary and costly delays in payment. It does not take advantage of the technological advances such as PBS Online and Electronic Funds Transfer. Claims are generally submitted monthly but community pharmacists reported that it can take up to six weeks or longer to receive a cheque from Medicare Australia, which increases the financial burden borne by community pharmacies.

One respondent to the Guild's survey noted that processing for S100 RAHSP claims are done manually by a Brisbane Medicare office and this can take anywhere from 30 to 45 days or more, a request for payment is then sent to finance in Canberra by mail when a cheque is then raised and mailed to the claimant. The same respondent suggested that there should be a facility for electronic lodgement and processing of claims, electronic funds transfer of claims and the ability to more regularly lodge. In addition the Guild notes that the absence of an electronic claiming process results in a lack of accessible data that could be used to review and monitor the program.

> *"The S100 system needs to get into the 21st century and pay electronically. As I supply 20 clinics the remuneration for S100 is a major part of my cash flow. I supply express bags to Canberra so the cheque is not delayed a further couple of weeks in surface mail to Thursday Island. I am currently experiencing a delay of 7-10 days from when the claim is signed off from Brisbane to Canberra and when we receive the express bag from Canberra. This delay was only a few days normally but has taken much longer the last couple of months. When I supply the drugs I have already paid for, I make a claim at the end of the month and it takes another month to be paid from Canberra. Compared with PBS online, which is how all the other pharmacies are paid, the s100 system of payment is a complete dinosaur."*
>
> *Lyn Short, Thursday Island, QLD*

A majority of pharmacists replying to the Guild's survey also mentioned the difficulties and costs in transporting medicines to remote AHS's.

> *"Funding for transportation between the pharmacy and remote clinics should be considered as it can be very expensive to supply medicines. Often medicines can only be transported by chartered plane and this cost is currently borne by the pharmacy. It's especially difficult during the wet season when remote clinics are unable to be reached by road."*
>
> *WA Pharmacy*

> "*We need to have remuneration for transporting the stock. Currently we are paying between $20-$100 for road transport depending on location and weight of stock. Depending on how much and how often the AHS ordering determines our costs. We try to get AHS's to request an order once a month with a 'top-up' order as required but this is not always possible".*
>
> *Elise Wheadon, Kalgoorlie, WA*

The Loller report noted that when S100 RAHSP was implemented it was agreed that the cost of transport of medication to an AHS should be met by the pharmacy. However, the report noted that it appears in some cases it is the AHS that is paying for this cost as the cost has historically been the responsibility of the AHS, and the remuneration for the pharmacist supplying the PBS items is not sufficient to cover high freight costs in remote locations. The Loller report recommended that the DoHA acknowledge that some remote AHS's are meeting the cost of freight for medications supplied

under S100 RAHSP and should consider reimbursement of these costs to both AHS's and pharmacists.

The AHA review also noted that, whilst they considered the fee for the S100 RAHSP reasonable overall, their analysis showed that the actual cost incurred by a community pharmacy to supply an item via bulk supply can vary substantially from the fee. In particular, the transport costs could vary widely.

**Recommendation 7**
**A three-tiered handling fee should be adopted to include a basic fee for 'bulk supply', plus a dispensing fee and a fee for DAA when requested by the AHS.**

**Recommendation 8**
**The inter-government Memorandums of Understanding established at the inception of the S100 RAHSP should be reviewed and reinstated.**

**Recommendation 9**
**An inter-government committee should be established that has oversight of the S100 RAHSP and S100 PSAP.**

**Recommendation 10**
**The Department of Health and Ageing should establish a dedicated role to manage the S100 RAHSP and S100 PSAP and be the key point of contact for pharmacists and AHS's.**

**Recommendation 11**
**Medicare Australia should develop an electronic claiming method for S100 RASHP claims that utilises PBS Online and Electronic Funds Transfer. Information gathered in this way could be used to provide drug utilisation data.**

**Recommendation 12**
**Medicare Australia should collect medicine utilisation data and provide this to AHS's to enable them to keep track of their own performance.**

**Recommendation 13**
**The Department of Health and Ageing should acknowledge that some remote AHS's are meeting the cost of freight for medications supplied under S100 RAHSP and should consider reimbursement of these costs to both AHS's and pharmacists.**

**Recommendation 14**
**Additional funding should be injected into the scheme to allow for the provision of extended pharmacy services. Public–private partnerships should be developed to improve continuity of care where community pharmacy, hospital pharmacists, and all prescribers (GPs, specialists, nurses and health workers in remote settings) co-exist as an integrated primary health care team.**

**Recommendation 15**
**The increasing mobility of people living in remote areas should be recognised, along with their need to travel for specialist treatment and hospitalisation. Initiatives to improve ATSI people's access to PBS benefits in urban areas (QUMAX and CTG co-payment relief) have been successful. Mechanisms are needed to make these schemes work together to allow patients to travel between remote and urban areas and between hospital and home and still have access to their PBS medicines.**

### 6.8 (h) access to PBS generally in remote communities; and

The Guild's survey responses indicate that access to PBS in remote communities has improved markedly since the introduction of the S100 RAHSP.

> *"Overall the S100 RAHSP has been a great success and a quantum leap forward from what occurred before. I have been working with AHS's since 1984 and from a supply point of view the scheme has been very successful. The AHS's have a good supply and they are supported by the pharmacist to run a drug room well."*
>
> *Shelley Forester, Palmerston, NT*

Clients of around 170 remote area AHS's, including Aboriginal community controlled AHS's and remote services operated by the states and territories, benefit from improved PBS access through these arrangements and this is borne out by the following statistics sourced from the DoHA website[15] which show the Australian Government expenditure for medicines used at participating AHS's in the year 2009-10:

**Aboriginal Community Controlled Health Services**

| | NSW | NT | QLD | SA | TAS | WA | TOTAL |
|---|---|---|---|---|---|---|---|
| **Number** | 5 | 44 | 3 | 5 | 2 | 17 | **76** |
| **TOTAL ($)** | $329,540 | $12,776,784 | $1,877,972 | $631,097 | $113,902 | $7,724,987 | $23,454,282 |

**Aboriginal Health Services Operated by the State/Territory Government**

| | NSW | NT | QLD | SA | TAS | WA | TOTAL |
|---|---|---|---|---|---|---|---|
| **Number** | 0 | 35 | 39 | 2 | 0 | 19 | **95** |
| **TOTAL ($)** | $0 | $7,177,709 | $5,644,207 | $133,903 | $0 | $2,434,875 | $15,390,694 |

**Total Aboriginal Health Services**

| | NSW | NT | QLD | SA | TAS | WA | TOTAL |
|---|---|---|---|---|---|---|---|
| **Number** | 5 | 79 | 42 | 7 | 2 | 36 | **171** |
| **TOTAL ($)** | $329,540 | $19,954,493 | $7,522,179 | $765,000 | $113,902 | $10,159,862 | $38,844,976 |

The Guild notes that these data are not as detailed as they could be and that if (as in Recommendation 11 and 12) Medicare Australia implemented an electronic claiming system that utilised PBS Online it would not only improve the efficiency of the program but provide useful medicine utilisation data that could inform future policy decisions.

The Guild also notes the establishment of the Expert Advisory Panel on Aboriginal and Torres Strait Islander Medicines (EAP). This panel was set up to provide expert advice to the DoHA and to the PBAC on medication needs in ATSI health settings which are unmet by medicines available through the PBS. The panel has also developed guidance for sponsors and the PBAC for use in the development and assessment of applications for inclusion of medicines on the PBS to treat conditions particular to ATSI health needs.

The listing of items on the PBS, as Authority Required for an Aboriginal or a Torres Strait Islander, such as mupirocin nasal ointment, nicotine trans-dermal patches, a range of topical antifungal products for the treatment of fungal and yeast infections, thiamine, albendazole and ciprofloxacin ear drops using the EAP process has addressed some of the special needs of ATSI patients.

**6.9 (i) any other related matters.**

The Guild's survey of community pharmacies involved in the S100 RASHP and S100 PSAP raised other various issues, such as cultural awareness training for pharmacy staff, difficulties in providing services to remote areas and benefits of an electronic health care platform to improve communications amongst all members of the primary health care team. The Guild notes that the AHA review recommended the establishment of a dedicated role to manage the S100 RAHSP and S100 PSAP in the Department with an inter-government committee that had oversight of these two programs. This would provide a mechanism for these other issues to be addressed when they arise.

# 7 Appendix 1 Previous Reviews/Evaluations: Summary

- ***Aboriginal and Torres Strait Islander Peoples' Access to Medicare and the PBS across Australia, Keys Young 3 November 1997***

This research was commissioned by the Health Insurance Commission (now Medicare Australia) and was undertaken by the consultancy firm Keys Young. Its purpose was to provide information regarding ATSI peoples' access to Medicare and the PBS across Australia. The study also sought to document Aboriginal and Torres Strait Islander people's attitudes and experiences in relation to Medicare and the PBS and the range of strategies currently in place to address problems of access, as well as to identify ways in which service delivery and the provision of program information could be improved for ATSI people.

In relation to issues relating to the PBS the report made the following recommendations:

27. The Department of Social Security, in consultation with the HIC, needs to address the privacy issue in order to enable pharmacists to access entitlement numbers at source. Clients would need to be made fully aware of what this meant, as there is a general suspicion about the use of private information and the option of refusing the release of the entitlement number should be given.

28. If direct access by pharmacists to entitlement numbers were achieved, the requirement that a concession card be sighted each time a client purchases PBS medication could be relaxed.

29. The Department of Social Security and the HIC and need to develop an efficient mechanism for children in the care of someone other than the parents to be included on their guardian's entitlement.

30. As a matter of urgency, the Department of Social Security and ATSIC, in conjunction with the HIC and the Department of Health and Family Services, should ensure that a system is established in which CDEP participants automatically receive Health Care Cards unless they do not pass the means test (thus reversing the burden of proof) and also that much better information is continually provided to CDEP coordinators and participants.

31. If access to the PBS is to be achieved for ATSI people, adequate funding for ACCHSs, sufficient to cover PBS copayments, is required. The Department of Health and Family Services needs to identify a mechanism for facilitating this, either through PBS or via Department of Health and Family Services grants.

32. The Department of Health and Family Services, in consultation with the RACGP the and AMA, should explore means of raising awareness among general practitioners of the implications for ATSI people of their prescribing habits.

33. The Department of Health and Family Services, the Pharmacy Guild of Australia and training institutions should examine the best means of making educational/awareness programs standard for all pharmacy undergraduates and for pharmacists working in communities with ATSI populations.

34. The Department of Health and Family Services should, as a first priority, seek Ministerial approval to expand Section 100 arrangements to other remote and rural ACCHSs. Consideration should also be given to the possibility of extending Section 100 to urban ACCHSs. Administrative support would need to be provided to some ACCHSs, particularly with tasks such as negotiating with distributors, ordering and managing stocks of medication. 35. The placement of medicine chests in

remote/outstation communities which currently have no access to medication of any kind is clearly beneficial. The Department of Health and Family Services should make available to the RFDS to expand this arrangement to more Aboriginal communities. 36. The Department of Health and Family Services should consider paying a modest fee to pharmacists for delivery of medication to ATSI people who are isolated or semi-isolated and for whom there exists no other mechanism for the supply of pharmaceuticals.

37. The Department of Health and Family Services needs to collaborate with OATSIHS, pharmacy and health care provider interest groups and the pharmaceutical industry to devise and trial labelling systems which take into account different cultural understandings and different levels of literacy. Any labelling system needs to have the input of ATSI peoples.

38. The Department of Health and Family Services needs to support information provision and education about medication to Aboriginal Health Workers and to draw on their knowledge and experience to produce the materials.

39. The Department of Health and Family Services should consider meeting the costs of providing medication aids such as customised packaging (eg dosette and Webster Packs).

40. The Department of Health and Family Services, in conjunction with the pharmaceutical industry, needs to ensure that dosages, packaging and listing of medication on the PBS take into account the efficacy of single dose agents in treating ATSI peoples. Further, pharmaceutical manufacturers should be encouraged to produce single dose agents.

41. When making decisions regarding the PBS list, the Pharmaceutical Benefits Advisory Committee needs to take into account the particular impact these decisions will have on ATSI populations.

- ***A Summary of the prescribing and dispensing issues and needs in the remote health clinics of the Northern Territory.*** **General Practice Divisions Northern Territory and National Prescribing Service Hudson P. August 2001**

This project was undertaken with the support of General Practice Division Northern Territory with oversight from the NT Prescribing Reference Committee comprised of representatives from the relevant stakeholders across the Territory. The National Prescribing Service an independent organisation whose purpose is to provide leadership and coordination for quality prescribing funded the project. The purpose of the project was to expand the understanding of prescribing practices in remote ATSI communities in the Northern Territory, identify current issues and needs, and make a contribution to QUM in the remote regions of the NT through recommendations for policy and operational changes.

Recommendations arising from the report relating to the Section 100 RAHSP were as follows:

1. Section 100 arrangements to Territory Health Service (THS) remote health clinics should be outsourced to community pharmacists as a matter of priority to enable these clinics to receive the full benefits of Section 100.

2. Investigation of ways for non-PBS items to be provided more economically through community pharmacy.

3. Financial savings from s100 to remain in each THS remote health clinic

4. Remote health clinics to receive expert advice to assist a determination of their priorities for S100 savings expenditure.

5. Savings from Section 100 should have performance indicators and expenditure linked to QUM.

6. Dose Administration Aids to be funded by DHAC for remote ARIA populations.

7. Future resourcing to assist QUM in remote health clinics should have clear specific targets.

8. The annual allowance for remote pharmacy visits to AHS's participating in S100 arrangements should be adjusted to provide additional weighting for travel to 'very remote' (ARIA classification) health clinics.

9. Funding formulae should utilise the ARIA or PhARIA classification system to distinguish between 'remote' and 'very remote' when allocating funding and determining policies related to remoteness.

10. Expansion of S100 to cover 'very remote' pastoral residents, along with continued support for training, medication distribution and emergency services to pastoral and other remote property residents.

11. Specific resources be allocated by HIC to develop simple electronic ordering and claiming systems for S100, providing appropriate technology and resources to enable these systems to function effectively in remote areas.

Additional key recommendations put forward are:

12. The establishment of an NT Pharmacy Committee to oversight QUM standards across the NT. The structure of the committee to be drawn primarily from the professional organisations.

13. Methods to upskill RNs and AHWs to be evaluated.

14. Information on modules and courses available to assist RNs and AHWs should be provided to all remote health clinics.

15. Employers should meet their education and training obligations and provide flexible arrangements to enable staff to undertake their own additional training.

16. Flexible workforce arrangements to facilitate further study, rest and recuperation from demanding clinical workloads need further development.

- ***Report from surveys conducted in Commonwealth funded Aboriginal Health Services and pharmacies supplying services under S100 pharmacy allowance.*** **Loller, H May 2003**

This report describes the outcomes of a project commissioned by the Pharmacy Guild of Australia and the National Aboriginal Community Controlled Health Organisation (NACCHO), undertaken between June 2002 to May 2003. The project was funded through a Community Pharmacy Agreement Research and Development project, as an extension of the Quality Use of Medicines in Aboriginal Communities Project. The project aimed to contact and visit where possible each of the pharmacies and Commonwealth funded Aboriginal Health Services operating under the Section 100 supply scheme in order to:

6 Provide support on the ground to Commonwealth-funded AHS's registered for s.100 and relevant pharmacies;
7 Survey AHS's and pharmacies to identify problems with s.100 arrangements and solutions;
8 Increase uptake of pharmacist allowance payable for support to s.100 sites;
9 Revise or update the information booklet "Medication Management Guidelines for preparing for the Section 100 scheme in Aboriginal Primary Health Care Services" and make suggestions for other resources for Aboriginal health services; and
10 Report on results of the survey.

The following recommendations were by in the report:

1. Supply of medication to AHS's should continue through the current s.100 scheme via community pharmacies.

2. Health outcomes of s.100 should be researched

3. Items covered by both the General Pharmaceutical Benefits schedule and the Repatriation Benefits schedule should be covered under the S.100 scheme for use in AHS's.

4. The issue of eligibility for s.100 medications should be addressed through consultation between stakeholder groups comprising PGA, NACCHO and the Commonwealth Department of Health

5. NACCHO and the PGA continue to provide ongoing support to both AHS's and pharmacies participating in the s.100 scheme and that NACCHO be funded to engage a support person with pharmaceutical expertise to do so.

6. Review of Poisons Acts in each state to take into consideration the role of Registered Nurses and Aboriginal Health Workers in possessing, administering, prescribing and supplying medication in AHS's.

7. Dispensary technicians training should be trialled in more sites to enable clinic staff to obtain further qualifications and confidence in performing the dispensary management functions expected in AHS's.

8. The Health Insurance Commission to develop an electronic format for pharmacies supplying medication to AHS's under s.100.

9. That the Guild and NACCHO, through the Third Community Pharmacy Agreement Management Committee, explore opportunities for increasing the Pharmacist support allowance for remote area health services, to enable 3 - 4 visitations per annum.

10. Pharmacist payment for the delivery of support services to remote area AHS's become based on a national pharmacy standard of practice developed through consultation with NACCHO and the PGA, with the operational aspects of the overall scheme to be developed through discussion with major stakeholders, the PGA, NACCHO and the Commonwealth Department of Health

11. The travel component of the support allowance be adjusted to become a tiered payment. Recommended payments, based on the cost of travel to clinics on average three times a year, are:
    Round trip of < 200km $1,000
    Round trip of < 400km $2,000
    Round trip of < 600km $3,000
    Round trip of < 800km $4,000
    Round trip of < 1000km $5,000
    Round trip of 1000km + $6,000

12. The Emergency Rural Locum Scheme be extended to provide locum relief to pharmacists accessing payments for the provision of support services to AHS's accessing s.100.

13. The restriction for pharmacies to operate only when a pharmacist is present be reviewed to enable pharmacists to visit AHS's during their normal operating hours to assist with the provision of support services.

14. NACCHO and PGA to explore alternative mechanisms of supply to individuals that remove disincentives associated with co-payments, ensure maximal involvement of the primary health care team of the AHS including the pharmacist in quality use of medicines and do not financially disadvantage community pharmacy.

15. NACCHO and PGA continue to facilitate a process with software providers that will enable computerized dispensary packages to be available at AHS's. AHS's will need to be adequately funded for the implementation and on-going costs of computerized systems.

16. The HIC notify all AHS's and pharmacies involved in s.100 supply to remote health centres that ordering procedures other than the original carbon copy ordering pads are acceptable forms for HIC auditing purposes. Examples of these alternate formats should be forwarded with this advice.

17. The Health Insurance Commission to provide information to each AHS including information about individual drug usage and cost on an annual basis.

18. In partnership with NACCHO, the Pharmacy Guild of Australia to support a workshop on medication management in Aboriginal Health Services every two years which would be open to both pharmacies and AHS's.

19. The Commonwealth Department of Health and Aging to acknowledge that some remote AHS's are meeting the cost of freight for medications supplied under s.100, and should consider reimbursement of these costs to both AHS's and pharmacists.
20. The Commonwealth Department of Health and Aging to fund community pharmacists for supplying medications to AHS's in dose administration aids.

21. An appropriate scheme to improve access to medication for Aboriginal people in non-remote areas should be developed and implemented as an urgent priority.

- ***Evaluation of PBS Medicine Supply Arrangements for Remote Area Aboriginal Health Services Under S100 of the National Health Act*, Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH), Menzies School of Health Research and the Program Evaluation Unit, University of Melbourne, Margaret Kelaher et al. July 2004**

This report noted that medicine utilisation data showed strong evidence of increased claims overall and the use of a broader range of medicine over the life of the program. The impact of S100 was somewhat greater for community-controlled services than State and Territory-operated services, particularly NT DHCS. The NT DHCS had the least change in practice with the introduction of S100 and not surprisingly showed the least change due to S100. However, NT DHCS pre-post data did demonstrate that S100 had had a significant impact of S100, suggesting that even more positive results may have been detected if such data was available for other jurisdictions. Increases in medicine utilisation supplied through S100 were much greater than for medicine supplied through the normal PBS mechanism (section 85 [S85]) of the National Health Act of 1953), suggesting that increases were due to the program and not natural growth.

The survey results and the case studies both suggested that S100 had increased access. ATSIHS surveys suggested that access was most improved in services where there was a doctor. Medicine utilisation increased more in services where pharmacists visited than in services where they did not. Breakdown in ordering was more common in services where supply was from a hospital pharmacist rather than a community pharmacist.

The report made the following policy recommendations:

1. **S100 has met its aim of improving access to PBS medicine to clients of remote area ATSIHSs and should be continued.** All sources of data suggest a significant increase in medicine utilisation.

2. **Bulk supply has increased medicine utilisation; however, it would be enhanced by further attention to QUM.** A number of case study sites suggested that the shift to bulk supply was a key factor in overcoming geographic boundaries and improving access in their ATSIHS. However, some smaller clinics had difficulty managing bulk supply.

3. **S100 should encompass flexible options to enable its implementation in sites where bulk supply cannot be adequately supported.** S100 could not be fully implemented in a few areas because of barriers to the implementation of bulk supply. Incorporating flexible options would enhance the ability of the program to improve access to medicine. These options should address methods for enabling individual supply in the context of S100 while ensuring appropriate reimbursement and without reintroducing the financial barriers to access.

4. **DoHA should expand the range of medicine covered by S100 to include non-PBS medicine commonly used in Aboriginal and Torres Strait Islander communities (e.g. topical antifungals).** S100 does not cover non-PBS medicine. This created additional costs for ATSIHSs and in some cases created perverse incentives to use PBS medicine when a non-PBS option was more appropriate.

    4.1 **DoHA should review access to Schedule 8 medicines in remote areas.** Schedule 8 medicines are not covered under S100 as they are subject to stringent controls because of their addictive potential. A number of sites suggested that difficulties in accessing such medicine in remote areas had negative health impacts, particularly for palliative care clients.

5. **Geographic restrictions in eligibility for S100 have caused difficulties in accessing and implementing the program and these should be reviewed.** For example, Gurrinny Yealamucka Health Services, Yarrabah falls just outside the remote zone and so is not eligible for S100 despite being located 35km from its nearest pharmacy. In Geraldton the catchment area of the ATSIHS includes an eligible and an ineligible area, which creates difficulties when clients use different services in the area. In some other areas there is large seasonal migration, sometimes to sites that would not otherwise be approved for S100 (e.g. Birdsville and Darwin).

6. **DoHA should retain 'clients of approved ATSIHS' as the criterion for individuals to benefit from the program.** There are areas where this criterion is ambiguous which has led to people inappropriately accessing medicine through S100, with an adverse impact on community pharmacists. In many cases strategies to address these issues have been introduced by ATSIHSs. The alternative would be to base eligibility on whether a person was an ATSI or not. This would either require documentation potentially creating a barrier to access, or Aboriginal or Torres Strait Islander status would have to be determined by ATSIHS staff, which would basically be equivalent to the current system.

7. **DoHA should ensure that all MOU indicate that a high priority for reallocating funds resulting from S100 is to ensure that ATSIHSs have sufficient staff and resources to effectively implement the program**. In many cases funds reallocated from medicine budgets were spent on increasing capacity in relation to S100. In others they remained unspent despite the health service being stretched to capacity. In some instances this was due to delays in the consultation process, and in others it was due to difficulty finding staff.

8. **DoHA should ensure that funding for doctors at S100-approved ATSIHSs is maintained and further facilitated.** ATSIHSs with a doctor were more likely to report an increase in the amount of medicine prescribed and supplied as a result of S100. Maintaining and improving the involvement of doctors in the program is likely to have benefits in terms of its implementation as well as overall quality of care.

The report made the following operational recommendations:

9. **DoHA should clarify the program in relation to whether prescriptions made at another facility can be filled at S100-approved sites, repeat prescriptions and the ability of visiting physicians to supply medicine using S100.**

10. **Information about the performance of S100 would be improved if the following changes were made:**

    10.1 HIC should provide medicine utilisation data to ATSIHSs to enable them to keep track of their own performance. Originally HIC was to provide clinics with data on their medicine utilisation, but this has not occurred to date.

    10.2 A system to assess the quantum of medicines that expires in ATSIHS should be considered to enable further evaluations. This would help ATSIHSs judge the effectiveness of their inventory management. If such data could be collected in a consistent way it would also assist further evaluation by making it possible to show that increases in medicine utilisation were not due to waste.

    10.3 DoHA should update records of ATSIHS client numbers to ensure that any comparisons between centres are accurate. In order to assess trends in medicine utilisation among different ATSIHSs the size of their client populations needs to be taken into account.

In relation to compliance with state and territory requirements the report made the following policy recommendations:

11. **DoHA should examine mechanisms for providing more extensive support to ensure that S100 is implemented in a way that is compliant with State and Territory legislation and regulations.** Best practice may require review and amendment of existing legislation in some cases. These additional support mechanisms should take into account that ATSIHS are at different stages of their implementation of S100 and have different needs.

12. **A self-assessment tool addressing legislative compliance issues should be made available to ATSIHSs to complete with their supporting pharmacists. This tool could be designed in collaboration with DoHA, the Guild, NACCHO and State and Territory governments. It could be used both as a way of reflecting on progress at ATSIHSs and also as a way of informing decision makers of both new and persisting issues in regard to compliance with State and Territory legislation and regulations.** While many ATSIHSs had made significant progress towards improving legislative compliance, many of the staff felt frustrated that their ability to address legislative compliance issues on their site was limited and that there was no clear pathway to overcoming these barriers. A regular process of self-assessment that was also used to inform decision makers could be a useful tool in improving communication between different levels of program operation and enabling limitations to be addressed.

13. **DoHA should develop a central resource for S100 to enable sharing of information and lessons**. A number of ATSIHSs and pharmacists felt that access to resources developed by others would have helped their implementation of S100 and would have saved labour associated with repeating work conducted by others. The importance of sharing information across community controlled and State and Territory-operated ATSIHS was also stressed by some key informants.

14. **DoHA in conjunction with State and Territory governments, the Guild and NACCHO should develop a resource that clearly states how the laws and regulations should be applied to remote ATSIHSs. This process should also be used to identify legislative barriers to the implementation of S100.** The laws and regulations for most jurisdictions are quite complex and there is no one resource that brings together all relevant regulations and laws and discusses their application.

15. **DoHA should work with State and Territory governments, the Guild and NACCHO to identify ways of facilitating the operation of S100-approved services in jurisdictions where there are legal and regulatory barriers to program implementation (see Recommendation 14).** This would include Poisons Licence issues in WA and repackaging rules in QLD. It should be noted that State and Territory governments are in some cases working independently to resolve these issues.

In relation to compliance with state and territory requirements the report made the following operational recommendations:

16. **DoHA with State and Territory governments, the Guild and NACCHO should examine ways of supporting systemic changes in ATSIHSs that would lead to improvements in legislative compliance and QUM. Specific examples of possible areas for improvement include the following:**

16.1 IT funding and support is needed to address gaps in record keeping and legislative compliance problems arising from these gaps. A number of ATSIHSs suggested that compliance would be assisted by development of computer programs to streamline ordering, dispensing and supply. They could be linked with labelling and claiming systems.
16.2 Funding is needed for support to assist with dispensary organisation. The case study checklist indicated that the organisation of dispensaries was an area for improvement, particularly in terms of aspects such as shelf labelling.
16.3 A set of standards for delivery of pharmacy services should be developed. Guidelines for the delivery of pharmacy services would assist pharmacists in supporting ATSIHSs.
16.4 A generic set of procedures and protocols should be developed that can be adapted for local use. This should be located on a central website (see Recommendation 14). This would prevent work being replicated at different ATSIHSs.
16.5 Designated staff should manage dispensaries where possible. Legislative compliance was better in ATSIHSs where responsibility for managing the dispensary was limited to particular staff members.
16.6 Enhanced training should be provided to ensure medicine is supplied appropriately. This training should be supported by systems in the ATSIHS. Provision of information and use of cautionary labels were identified as areas of weakness by all data sources.
16.7 Processes should be introduced to review errors in order to inform future training and quality management. Mistakes are sometimes made in all environments where medicines are supplied. Improving service quality is dependent on ensuring that problems can be identified and addressed.
16.8 ATSIHSs and pharmacists should develop communication strategies to ensure imprest lists are regularly reviewed and problems with stock at the pharmacy and transport to the ATSIHS are addressed. Both pharmacists and ATSIHSs indicated that lack of availability of medicine still adversely affected access.

In relation to administration of s100 the report made the following policy recommendations:

17. **DoHA and HIC in consultation with State and Territory governments, the Guild and NACCHO should develop an electronic means for ATSIHSs to order from pharmacists.**

18. **DoHA and HIC in consultation with stakeholders State and Territory governments, the Guild and NACCHO should develop an electronic means for pharmacists to claim from HIC.**

19. **DoHA and State and Territory governments should develop a mechanism to provide greater support to alleviate increased workload at ATSIHSs.** Bulk supply moved work formerly done at a pharmacy to an ATSIHS. Some services were able to use money reallocated from their pharmacy budget to fund extra staff to do this work but others did not have sufficient funds. A particular area of concern was that a number of ATSIHSs had equipment (e.g. for labelling) that was not being used. Better support of systems would alleviate these problems.

- ***Aboriginal and Torres Strait Islander Access to Major Health Programs*, Urbis Keys Young 18 July 2006**

This study was conducted during 2005-06 for the Department of Health and Ageing and Medicare Australia. Its purpose was to provide an up to date picture of ATSI people's access to major health programs. The work included consideration of a range of Australian Government initiatives that have been implemented since the submission of an earlier report on ATSI access to Medicare and the Pharmaceutical Benefits Scheme (PBS), prepared by Urbis Keys Young in 1997.

Proposals which were raised in the course of the study to improve access to the PBS:

- improvement of the S100 arrangements in remote areas by ensuring more substantial QUM input from community pharmacists or others
- a NACCHO/AMA/Pharmacy Guild proposal (2004) for extension of S100 arrangements to ATSIHSs in all areas, plus capacity for health services to write prescriptions that can be filled at a community pharmacy without any co-payment, payment to community pharmacists of the full dispensing fee per item, and appropriate funding to address QUM needs
- extension of S100 provisions to non-remote areas but with certain modifications (eg clearly limited to ATSI patients)
- provision of funding to ATSIHSs to cover the cost of the co-payments that they currently meet on behalf of patients
- introduction of a general scheme to cover co-payments for ATSIHS patients, or for those with a health care card, etc
- coverage of urban ATSIHSs' costs of making co-payments on behalf of patients visiting from rural or remote areas
- introduction of a system for subsidising the purchase by ATSIHSs of non PBS (over the counter) items
- funding for the use of dose administration aids in association with the S100 scheme
- introduction of other QUM initiatives, such as systematic arrangements to provide
- medication management training for AHWs and nurses
- development of a model of medication review that is appropriate for ATSI communities – possibly by analogy with the RMMR
- providing ATSIHSs with flexible funding for pharmaceutical purposes, to be used as seems most appropriate in various situations – eg to purchase additional training, professional support and the like, or possibly to employ a pharmacist
- support for wider take-up of the possibility of providing on-site pharmacy services at ATSIHSs – eg along the lines of the current service at Congress in Alice Springs (which makes use of the S100 arrangements).

- ***Review of the Existing Supply and Remuneration Arrangements for Drugs Listed under Section 100* of the *National Health Act 1953*, Australian Healthcare Associates (AHA) February 2010**

This review was carried out as part of the Fourth Community Pharmacy Agreement and included the Aboriginal Health Service Remote Access (AHSRA) Program. During consultation phase of the review a number of issues were raised in relation to the existing supply and remuneration arrangements and included such things as the handling fee, transport costs, additional services, jurisdictional and legislative differences, professional concerns about QUM and the Section 100 Pharmacy Support Allowance. Options proposed by stakeholders to address the issues were:

- implement a three-tiered handling fee to include a basic fee for bulk supply, plus a dispense fee and a fee for supply using DAAs (on AHS authorisation).
- separately fund transport costs, based either on a funding structure which reflects that the variables which drive these costs, or based on reimbursement of cost receipts, depending on the Government's determination regarding the cost effectiveness of these methods;
- develop a clear declaration about the nature of the AHSRA services, which is supported by guidelines, protocols, procedures and contracts or service agreements; and
- review of the inter-government Memorandum of Understandings that were established at the inception of the AHSRA Program.

The review stated that there was a consensus amongst the stakeholders that the AHSRA Program has improved the supply of medicines, but all stakeholders argued that it is time that the Program evolved to focus on QUM. This could be achieved by creating a Program that includes both the bulk supply of PBS medicines and support to AHS's, for example it may combine the current AHSRA Program and Allowance. All stakeholders consulted believed that the AHSRA Program needs to be better linked with the Allowance. To achieve this stakeholders believe that greater oversight of the Program is needed. Stakeholders preferred options are that:

- An inter-government committee be established that has oversight of the AHSRA Program and Allowance;
- The Department establishes a dedicated role to manage the AHSRA Program and Allowance and be the key point of contact for pharmacists and AHS's;
- A review be undertaken of the Allowance, to evaluate the outcomes for AHS's and identify the number of visits that best support AHS's and QUM. It appears that many AHS's are requesting and receiving significantly more visits than the required two per year. Two visits per year may be feasible for AHS's that are well staffed and have high quality medicine practice, but insufficient for an AHS with high staff turnover and poorer medicine practice. More comprehensive information is required to understand how best to provide pharmacy support and services to remote AHS's; and

The remuneration for the Allowance be revised to better reflect the costs (travel, time, accommodation, developing resources and educational materials) incurred by community pharmacists and the AHS's needs and service requirements. A review of this Allowance could provide the data required.

The review also noted that all stakeholders commented on the current Remote Access claiming process that uses a paper-based Departmental claim book that has not changed in the last ten years. It does not take advantage of the technological advances such as PBS Online and Electronic Funds Transfer. The review proposed a number of options to address these concerns which would make a significant difference to participating pharmacists.

- ***Evaluation of Indigenous Pharmacy Programs*** **NOVA Public Policy 28 June 2010**

NOVA Public Policy was contracted by the Department of Health and Ageing to evaluate the three of the Indigenous Pharmacy Programs from the Indigenous Access Program and funded under the Fourth Community Pharmacy Agreement. The three programs evaluated were the S100 PSAP, the Aboriginal and Torres Strait Islander Pharmacy Scholarship Scheme (ATSIPSS) and the Aboriginal and Torres Strait Islander Pharmacy Assistant Traineeship Scheme (ATSIPATS).

**Section 100 Pharmacy Support Allowance Program**
The NOVA evaluation noted that the S100 Support Program provided an important level of professional support to AHS's in the management of S100 Supply. This was a level of support which is largely valued by the AHS to which it is provided. The program has addressed some significant QUM issues, particularly with regard to the safe storage, handling and dispensing of medicines. However, the review indicated that improvements to the program could be made. The following suggestions were made in the review:

Promote best practice in Section 100 Support Services by:
- Establishing a quality standard for the provision of pharmacy support to indigenous health service
- Promoting best practice and quality improvement in pharmacy support
- Promoting engagement of pharmacist in primary care tasks
- Sponsoring an annual conference for pharmacist providing s100 support and a representative group of AHS

Accountability and reporting
- Improve accountability of pharmacist to AHS by considering transferring responsibility for subsidy payments to AHS
- Refine program reporting to enhance accountability of pharmacist

Funding
- Provide an option of cashing out existing subsidies to make possible direct employment of pharmacist
- Provide a subsidy or grant for the purchase of labelling equipment by AHS
- Establish a dedicated funding pool specifically for AHS staff training

Improvement of administrative arrangements

1. clarify and articulate the responsibilities of key stakeholders with respect to the administration and governance of the program
2. establish a coordinative mechanism between key stakeholders and agencies

# Appendix 2 New S100 Support Service Arrangements from 1 January 2009



Where Medicare Australia receive claim forms for the period after 1 January 2009, Medicare Australia is to forward the documentation to DoHA. (In this scenario Medicare Australia must forward documentation to DoHA regardless of what type of AHS claim forms are received)

Copies of any forms received by Medicare Australia from Eligible Applicants during the Transition Period will be forwarded to the Department.

## NEW ARRANGEMENTS

***1 January 2009 onwards***

The new s100 Support Service arrangements will take effect from **1 January 2009** and no further quarterly payments in arrears will made by Medicare Australia after that date, with the exception of those payments due relating to the quarter between 1 October 2008 and 31 December 2008.

To receive this final quarterly instalment, a Certification of Continued Support Service Form (Form B – June 2001 Information Kit) must be submitted to the Department no later than six (6) weeks (i.e. thirty (30) working days) after the completion of that three-month period.

**From 1 January 2009, all currently participating Eligible Applicants (if they have not already done so) will need to submit a new, signed application using the revised Form A and Workplan templates available as part of the Program's 2008 Information Kit. The new Application Form (Form A) and Workplan must be submitted to and received by the Department for approval six (6) weeks (i.e. thirty (30) working days) after the next period commences.**

**The Department will provide formal notice of the approval of the Application and the Allowance amount payable to Medicare Australia and the Eligible Applicant, if and where all eligibility criteria are met. The date of this approval advice will then become the Eligible Applicant's new anniversary date. Payment will then be made to the Eligible Applicant by Medicare Australia.**

Subject to the Rules relating to payments set out in the table below, the Allowance will be paid to Eligible Applicants in three annual instalments:

- a 50% instalment on approval of the Eligible Applicant's initial or renewal Application Form (Form A), including agreed Workplan;
- a further instalment of 25% of the annual allowance, on the submission of the Certification of Continued Support Service Form (Form B), including a six-month Progress Report against the Workplan; and
- a final instalment of 25% on the submission of the Certification of Continued Support Service Form (Form B), including a final six-month Progress Report against the Workplan.

Any Application (Form A) including the agreed Workplan, or a Certification of Continued Support Service Form (Form B) received by Medicare Australia after 1 January 2009 will be forwarded to the Department for assessment and processing.

The allowance will be subject to review at intervals of not more than 12 months.

The annual allowance payments will be based on Script Volume data provided by Medicare Australia and calculated by the Department in accordance with the following table:

| | | |
|---|---|---|
| Primary AHS | **Annual base amount is dependent on the volume of medicines supplied to the AHS via section 100 arrangements during the previous calendar year (or for new services, an estimate of PBS items calculated by multiplying the number of registered clients by 12.6):** | |
| | < 5,000 PBS items per annum | $6,000 pa |
| | 5,001 – 10,000 PBS items per annum | $9,000 pa |
| | > 10,000 PBS items per annum | $10,500 pa |
| | Additional loading if the AHS is on an island, or the usual mode of travel to AHS is by boat or aircraft | $1,000 pa |
| Outstation | For each Outstation being provided services, a flat rate allowance is payable, irrespective of the volume of medicine supply | $6,000 pa |
| | Additional loading if the Outstation is on an island, or the usual mode of travel to the Outstation is by boat or aircraft | $1,000 pa |
| Travel Loading | "Round-Trip" Distance travelled: | |
| | <50km | $0 |
| | 50km - <150km | $500 pa |
| | 150km - <400km | $1,000 pa |
| | 400km - <600km | $1,500 pa |
| | 600km - <800km | $2,000 pa |
| | 800km - <1,000km | $2,500 pa |
| | >1,000km | $3,000 pa |

# Appendix 3 Geraldton Regional Aboriginal Medical Service


PO Box 4109
Geraldton WA 6531
Clinic (08) 9956 6555
Fax (08) 9964 3225
Admin Fax (08) 9956 6599
ABN 98 653 603 543

To Whom It May Concern:

The structure implemented by the Geraldton Regional Aboriginal Medical Service in to manage the supply of medicines to our clients involves a close working relationship with the Rangeway Pharmacy.

This business is adjacent to our service and offers support and back up to both our clinicians and our patients.

The Geraldton Regional Aboriginal Medical Service does not operate its own Pharmacy as we find utilizing a current resource ensures supply and dispensing from a fully qualified Pharmacist with none of the concerns associated with management and workforce issues.

The Geraldton Regional Aboriginal Medical Service will continue with this relationship firstly as a functional working relationship and also as it adds considerable capacity within the Rangeway community as clients have access to all the other benefits offered by a large community Pharmacy

Yours sincerely

Terry Brennan
CEO
Geraldton Regional Aboriginal Medical Service

# Appendix 4 Pharmacy Guild of Australia WA Branch

## Introduction

The Pharmacy Guild of Australia WA Branch is a branch of the Pharmacy Guild of Australia (PGA) and represents the owners of West Australian community pharmacies.

Due to variations between state and territory pharmaceutical legislation the regulations relating to the S100 RAHSP can differ between jurisdictions.

This appendix relates to the WA Branch's concern that one of the best examples of sustainable and successful interdisciplinary health services existing in the extreme rural and remote parts of WA may be put at risk.

The submission of the Pharmacy Guild of Australia makes the case to retain and enhance the essential features of the S100 RAHSP. This is particularly important in Western Australia. Success in operating this critical program has been based on local flexibility and local partnerships.

The aspects of the scheme that have worked well particularly in remote areas of Western Australia include:

- Sustainable long term partnerships between community pharmacy, WA Country Health Services (WACHS) and the Aboriginal Community Controlled Health Sector where and as appropriate
- Local flexible arrangements
- Guarantee of access at all times to a sustainable workforce of registered community pharmacists
- Strong regulatory control over the supply of PBS medications
- Mutual agreement on roles and responsibilities

**Areas of Concern: Setting Up Silos of Health Care for Aboriginal and Torres Strait Islander peoples**
The proposal that the S100 RASP be reconfigured such that AHS's employ pharmacists has received some comment.

The current Director of the WA Branch of the Guild during his employment as Director of Regional Health Services in Derby and Fitzroy Crossing developed the partnership model for the S100 RAHSP currently successfully meeting the needs of the population residing in the Fitzroy Valley. The President of the WA Branch also worked as a community pharmacist in a pharmacy provided S100 RAHSP services for many years in the Pilbara.

The West Australian Branch of the Guild strongly recommends that the proposal to change the employment of pharmacists to the AHS is not sustainable on several grounds:

- Over 100 more pharmacists would need to be employed directly in the WA AHS's. This is a pipe dream. Even large regional towns like Albany offering higher wages, accommodation, internet access, and transport have difficulty attracting and retaining pharmacists
- Workforce sustainability is a critical limiting factor in rural/remote WA mainly due to difficult living conditions exacerbated by social and professional isolation. Professional isolation for the pharmacist in any remote location is a significant barrier to retaining pharmacists in these areas.

- Staff turnover is endemic in rural/remote WA especially in the Kimberley and Pilbara. Both the Country Health Service and the AHS often go without sufficient nursing, allied health and medical staff for extended periods from time to time. Derby and Kununurra district health services struggle to attract and retain hospital pharmacists. This is the closest example of a model of employment within an AHS, and there is no evidence to suggest the same experience would not be repeated.
- Some AHS's do not and have never wanted to employ pharmacists. Geraldton Regional Aboriginal Medical Service and Nindilingarri Cultural Health Service have both previously stated they do not want to assume this responsibility.
- It is our understanding that both Nindilingarri CHS and Geraldton AHS have no desire to commit to the infrastructure and processes necessary to order and safely store and dispense medications. In Nindiligarri's case they have chosen to deliver cultural preventive and public health care and do not want to employ pharmacists or other health practitioners for acute or chronic disease management.
- Community Pharmacy has the benefit of the Community Service Obligation (CSO) under the Fifth Community Pharmacy Agreement. This ensures that wholesalers supplying PBS medicines must deliver to community pharmacies anywhere in Australia within 24 hours. This enables community pharmacies to provide PBS medicines at a known price to every Australian no matter where they live. There would be no such arrangement for an AHS when ordering medicines.
- There is an obligation under the *National Health Act 1953* for community pharmacies to keep sufficient stock of PBS medicines on hand. There would be no such obligation for AHS's.
- The cost of employment in rural/remote WA is prohibitive and the scheme could never afford this model in WA.
- Under circumstances described above the regulatory mechanism governing safe dispensing and supply of medicines would be compromised.
- The existing model works because roles and responsibilities are well understood and are appropriately carried out.
- The model of employment of a pharmacist within the AHS creates silos of health care which is the opposite to contemporary health policy which aims to develop systems providing interdisciplinary care across all sectors of health.
- A health policy imperative driving systems change in the ATSI health sector is to provide improved access to mainstream health care. Creating isolated silos of medicines supply will not contribute to this outcome.

**S100 Saves and Protects Lives**

It is worth noting the top 14 PBS medicines in a typical S100 pharmacy (by volume, not value) and the conditions they treat for a typical AHS through S100 RAHSP:

- Salbutamol Metered Dose Inhaler: asthma
- Permethrin Cream: scabies (which left untreated could lead to renal failure)
- Albendazole 200mg tablets: intestinal worms (which if untreated could lead to malnutrition)
- Salbutamol Elixir: asthma
- Clotrimazole cream 20g tube: antifungal
- Atorvastatin (40mg or 20 mg): high cholesterol
- Ramipril (5mg or 10mg): hypertension
- Amoxycillin antibiotic
- Paracetamol 500mg tablet : pain management

- Azithromycin antibiotic
- Metformin XR 500mg: diabetes
- Omeprazole 20mg: heart burn and gastro reflux
- Aspirin: pain and stroke prevention
- Atenolol 50 mg tablet: hypertension

It is essential that any changes made to the S100 RASHP ensure this critical supply of medicines is maintained and more importantly sustained.

**Areas for Enhancement**

As the Guild submission notes, previous reviews overlap in their recommendations to enhance the program:

- Increased commitment to quality use of medicines training for AHS staff
- Commitment to improve continuity of care, where community pharmacy, hospital pharmacists, and all prescribers (GPs, specialists, nurses and health workers in remote settings) exist as a primary health care team, and provide them with a valuable, professional and well-staffed resource to assist in managing medication related issues.
- Use of contemporary training and education processes to lift the standard of education and quality use of medicines knowledge and skills. A modest increase in funding would enable community pharmacists (with the assistance of the Guild should it be required) to provide:
    - Train the Trainer education packages
    - E Learning and On Line training packages
    - Funded centralised workshops bringing the AHS practitioner into the regional centre

**Conclusion**

Many of the reviews and evaluations of the S100 RAHSP have a similar finding that the program works well. However it needs enhancing, and many of the reviews suggest a better commitment to the Quality Use of Medicines component. Fundamental change to the structure of the S100 RASHP will threaten its ongoing viability and in Fitzroy Valley, for example, any change has the potential to threaten the health outcomes for all residents.

The WA Branch strongly recommends the senate enquiry ensures that lifesaving PBS medicines continue to be supplied by guaranteeing the model of partnership and shared responsibility that characterises the current S100 RAHSP scheme in Western Australia.

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