Senate inquiry submission:

The effectiveness of the special arrangements established in 1999 under section 100 of the National Health Act 1953 for the supply of PBS medicines to remote area Aboriginal Health Services

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Summary:

There have been several evaluations of the section 100 (s100) scheme in its short history [1-5]. These have been focused on varying aspects of the scheme. However, the general conclusion is that the s100 program has improved access to PBS medications in remote Aboriginal health services (AHS) while access to support for quality use of medicines (QUM) in the remote Indigenous population remain desperately under-resourced. Supply alone does not ensure quality use of medicines. I welcome this review but urge the Senate committee to also research what has already been written on the topic.

I urgently call for more access to the professional expertise of pharmacists in Aboriginal Health Services (AHS). Redirecting the funding away from community pharmacies and towards health services may not address problems now experienced. Accountability and transparency of any system is the essential element and I would support a system of flexible arrangements so that individual pharmacists, pharmacies or AHS may apply for the funding provided there is demonstrated collaboration between parties.

I offer the following recommendation and there is further discussion below to support my recommendations. I am happy to address these further in writing or in person.

Recommendation 1:
That the supply system for s100 has been successful and should continue. However, a review of procedures including the ability for electronic claims may streamline the supply system and allow for usage data to be collected.

Recommendation 2:
It is vital that Aboriginal people living in remote areas receive advice and support for their medication from a pharmacist

Recommendation 3:
Models of practice to provide this contact may vary between AHS and it is essential that there be flexibility in the arrangements to allow a service to be tailored to individual health service needs.

Recommendation 4:
Funding should be allocated to review the effectiveness of some of the models of pharmacist services already established to inform other AHS developing a service.

Recommendation 5:
Efficient systems for labelling medications are an urgent priority and should be addressed to a universal standard.

Recommendation 6:
Funding should be provided to allow computer record systems to accommodate the dispensing functions in AHSs.

Recommendation 7:
Electronic ordering of s100 medications should be implemented as a means to collect data on medications use. This data should be collated and fed back to individual AHS as it is currently done for individual urban prescribers.

Recommendation 8
A system of funding that allows flexibility to meet the needs of the Aboriginal people living in remote areas is essential. However, whatever system is adopted, there needs to be greater accountability and transparency of what the money is being spent on. Any system that channels funding to any of pharmacies, AHS, state/territory governments or individual pharmacists is likely to meet the needs of some but not all AHS. Providing adequate safeguards against misdirection of funds are in place, funding should not be limited to any one group.

Recommendation 9
Funding for the ongoing review and updating of the CARPA standard treatment manual is essential to ensure continued quality decision making of RANs and AHWs supplying schedule 4 medications in remote AHWs without reference to a doctor.

Recommendation 10
Both RANs and AHWs must have opportunities to receive formal training in pharmacotherapeutics and dispensing. Providers of these courses should be encouraged to continue to improve and offer these courses with external funding support if necessary.

Recommendation 11
On-site supervision and informal training in dispensing and drug knowledge by a pharmacist should be recognised as an important adjunct to formal training.

Recommendation 12
Further development of Medicines Workers to support health professionals managing drug rooms in AHS should be encouraged.

Recommendation 13:
That Dose Administration Aids supplied by clinics using s100 be funded according to the same guidelines as QUMAX.

Recommendation 14
A two tiered approach to counselling of patients and medications review should be funded for remote AHS. The Pharmacy Guild should be urged to include pharmacists providing services to AHS in the business model for MURs as it is rolled out.

Recommendation 15
Programs funding PBS supply and those negotiated under the Community Pharmacy Agreement should be coordinated and patient-focused for Indigenous people rather than financial stakeholders.

My Background

I am the pharmacist academic for the Centre of Remote health in Alice Springs. The Centre for Remote Health (CRH) is a University Department of Rural Health affiliated with Flinders University and Charles Darwin University. The CRH offers post-graduate training programs for health professionals working in remote and Indigenous health. Several research programs into remote and indigenous health are also conducted by CRH.

My position is funded from the Pharmacists Academic program which is part of the Rural Pharmacy initiatives of the 5th Community Pharmacy Agreement. My role at CRH is supporting local pharmacists and promoting rural practice to pharmacy students on placement in Central Australia and to the undergraduate Pharmacy degree at Charles Darwin University. I also teach Pharmacotherapeutics to remote area nurses and to Aboriginal Health Workers.

I have worked in the Northern Territory for more than 30 years in Darwin and Alice Springs. I was the Chief Pharmacist at Alice Springs Hospital when s100 was implemented in 1999 and was on the steering group to assist negotiations between the NT government and the Commonwealth that allowed the roll out of s100 to more than 60 health services in the NT. I have taken a close interest in the developments of pharmacy services to Aboriginal health services (AHS) ever since and now regularly participate in visits as a practicing pharmacist to AHS in the Top End and Central Australia including Home Medicines Reviews (HMR). I have contributed to each of the reviews into s100 supply of medications to remote Aboriginal Health Services described below. I receive no benefit from s100 supply apart from salary paid by contracted pharmacies and the Centre for Remote Health.

I will speak only about the remote s100 system and will refer to the ‘Closing the Gap (CTG)’ and the QUMAX system in a limited way as I have no first hand knowledge of these systems. I offer the following in response to the terms of reference as far as possible and make further recommendations for the delivery of the scheme based on my knowledge and experience.

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:

(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 origin of the section 100 program to Aboriginal and Torres Strait Islanders was subsequent to the release of the Keys-Young [6]report indicating that Aboriginal people in both urban and remote areas had reduced access to PBS medicines compared to non-Aboriginal Australians. This report suggested that there was only 33c spent on the PBS bill for Indigenous people compared to $1 for non-Indigenous people and this comparison has subsequently been used as a measure of access to the PBS. The AIHW last year estimated that this amount had risen to 60c per $1 [7]. However, the same report found that in *Remote/very remote* areas, Indigenous Australians received PBS expenditure of $23 more per person than non-Indigenous Australians (a ratio of 1.12). It attributes this to the fact that Section 100 arrangements allow patients attending an approved remote area Aboriginal and Torres Strait Islander health service to receive PBS medicines without the need for a prescription form and at no charge.

A report commissioned in 2004 by the Department of Health and Ageing [8], also concluded that s100 had improved supply to remote AHS, in some case, more than had been anticipated. However this report also alerted to the need for strengthening QUM and made several recommendations to achieve this despite QUM being outside the stated aims of the evaluation. In 2010, two further reviews found that s100 '…improved the supply of medicines but…. It is time that the program evolves to focus on QUM' [4, 5]

Access to medicines has not been a significant issue in the Northern Territory, especially in remote NT government funded AHS. Before s100, a similar system of supply existed where people had immediate access to medications from the remote AHS, except that it was funded by the NT government or from Aboriginal Community Controlled organisations' (ACCHOs) block funding . However, some community controlled AHS had been juggling a complex system of having PBS prescriptions filled at a regional hospital or community pharmacy in order to replace expensive medications dispensed to patients in the AHS.

Thus it would appear that the cost barrier to PBS medications has been removed and that the s100 scheme has been successful in improving access to medications in remote AHS. However, as I will describe below, similar gains in the Quality Use of Medicines (QUM) have not been seen.

Recommendation 1:

That the supply system for s100 has been successful and should continue. However, a review of procedures, including the ability for electronic claims may streamline the supply system and allow for usage data to be collected.

(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;

I don't believe there has been any research into whether s100 has been associated with specific improvements in clinical outcomes, understanding of medicines or adherence to prescribed treatments. This is a complex question to answer in any setting. However, there are studies that show that, in general, adherence may be improved by a number of simple interventions including more 'instruction' for patients, counselling about the disease, simplifying dosage regimens, reminders, involving patients in their care and 'augmented pharmacy services' [9].

On the other hand, a qualitative study done in Australia concluded that even where co-payment is required, cost is only a secondary determinant of whether people choose to take medicines[10]. An evaluation of a program in the USA that provided reduced cost and increased access to prescribed medications in indigent populations found that there was no increased health outcomes and concluded that '…one must look beyond just expanding access to ensure that programs are indeed achieving their overall objectives'[11].

It would be difficult to conclude that s100 supply had any impact on clinical outcomes; rather it may be seen as providing financial benefits to AHS who, historically in the NT at least, always strove to provide medication free of charge to their clients.

(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;

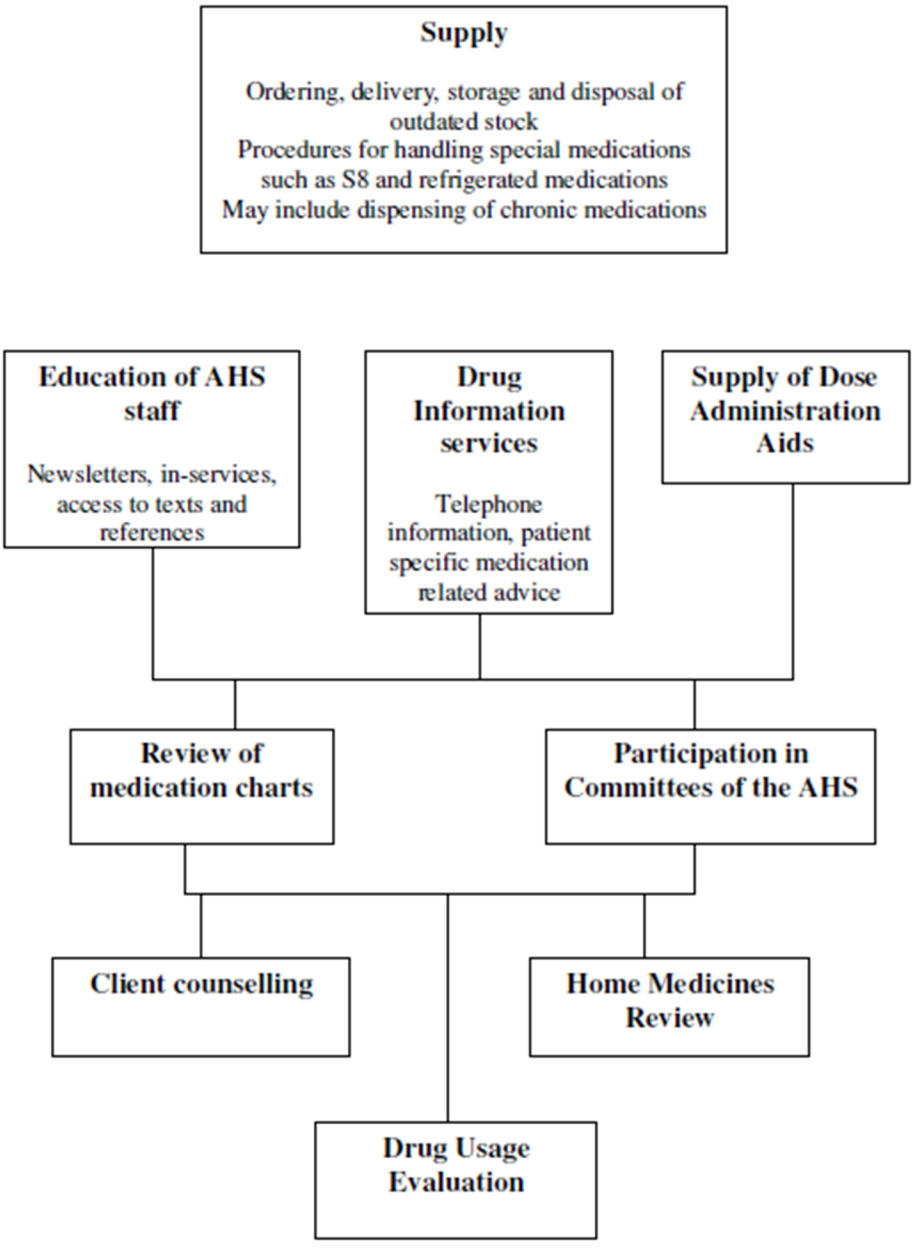
The quality use of medicines is not just about making sure the right drug gets to the right person at the right time. It is also about ensuring patients know how to take it, why they should take it, what alternatives there are to taking medicines, what will happen if they don't take it, possible side effects they should look out for and how will they know if it is helping them?

Early reviews into s100 found that increased contact with a pharmacist was welcomed by AHS staff and that the pharmacists had helped sort out systems [1, 2]. However, in most studies, patients were not directly interviewed. In one study staff of an AHS were resoundingly appreciative of the benefits of having access to a pharmacist yet a small sample of patients interviewed in the areas serviced by that health service revealed that most patients did not know the pharmacist [12].

What is it that pharmacists do that other health professionals can't? Information about medications is available for other health professionals to provide, but as medicines are usually not the focus of most encounters with doctors, nurses and Aboriginal Health Workers, it is perhaps not done as often or as effectively as it should be. As well as education about medications to patient and staff, pharmacists can assist with stock control systems, dispensing systems, and advice about quality use of medications in the AHS. The Pharmaceutical Society

have developed standards of practice that describe the role of a pharmacist in this important setting [13]. A model of a continuum of pharmacy services has been proposed which describes how supply functions need to be addressed before the implementation of QUM (Fig 1). Sadly most pharmacists currently provide only basic services. How can they provide more when they don't have the resources to visit more than twice a year?

Fig 1: The continuum of Remote Pharmacy Services. Each level needs to be implemented to a satisfactory degree before the next level can be provided. The former level can continue to develop as other levels are introduced ***Ref: Vaughan & Wakerman, 2007.***



All five reviews into the effectiveness of the s100 arrangements have commented on the value of

pharmacist input and recommended the importance of increased access to pharmacists even where this has been outside of their terms of reference [1-5].

Andrew Roberts (Robbo) is a pharmacist who has been directly employed at the Ngaanyatjarra Health Service for the last 6 years and has stories of the improvements in medication use by residents of the area it serves as a direct result of having a pharmacist (now 2 pharmacists) on staff. Applications for funding to document these benefits in a rigorous way have so far been unsuccessful.

Another successful model is that supported by the Central Australian Aboriginal Congress (CAAC) where a pharmacist was employed at the introduction of s100 with savings realised from not paying directly for PBS medications. This service has expanded as the value of what a pharmacist can offer has been appreciated and now employs 1.5 pharmacists and 2 FTE technicians. This service is provided by a local community pharmacy at a cost that would not be possible if the health service were to manage the service themselves. Procedures and standards have been implemented based on quality pharmacy standards by people experienced in the managing of professional pharmacy services and supply. The community pharmacy is part of a larger group of pharmacies in the region and are committed to continually staffing the service from their pool of pharmacists, something which an individual AHS would struggle to do if their pharmacist were to resign.

I am confident that a review of both of these (quite different) models of service would show the benefits of pharmacist input into AHS, while not dictating the type of service a AHS must have. However, in both cases, the AHSs involved have contributed significant funds to the operation of the pharmacy service and have not relied on s100 funds.

Recommendation 2:

It is vital that Aboriginal people living in remote areas receive advice and support for their medication from a pharmacist

Recommendation 3:

Models of practice to provide this contact may vary between AHS and it is essential that there be flexibility in the arrangements to allow a service to be tailored to individual health service needs.

Recommendation 4:

Funding should be allocated to review the effectiveness of some of the models of pharmacist services already established to inform other AHS developing a service.

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

The standards of practice in remote AHS with respect to recording and labelling of medications is appalling. At the National Medicines Symposium in 2010, a doctor from a remote AHS, Dr

Alex Hope showed a slide of the way he had been forced to hand write instructions labels on medication. This has been identified as a direct result of the issue of computer systems that are commonly used in remote AHS. These systems are based on GP or prescribing software packages. In urban Australia, prescribing and dispensing are separated as are the computer systems that doctors and pharmacists use. Indeed it is seen as an indicator of quality and an essential double check that prescribing and dispensing are done by different people. In the remote setting, however, these two functions are done in the same place and often by the same person. Apart from the obvious question about the quality, this means that AHS computer systems generally do not have a dispensing and labelling function.

As a result of this, a meeting was hosted by DOHA to review the situation and despite attendance in Melbourne by several key people from remote health and a written submission to DOHA for funding to support the development of standards, there have been no further commitments to improving standards by either DOHA or the commercial software providers. A copy of this paper is available on request.

Drug Usage review is an important quality improvement activity in the health care industry. This is usually facilitated by a pharmacist in conjunction with good data collection systems. It ensures medications are used appropriately and educates users about appropriate use when deficiencies are uncovered. These are reliably available in remote AHS.

Recommendation 5:

Efficient systems for labelling medications are an urgent priority and should be addressed to a universal standard.

Recommendation 6:

Funding should be provided to allow computer record systems to accommodate the dispensing functions in AHSs.

Recommendation 7:

Electronic ordering of s100 medications should be implemented as a means to collect data on medications use. This data should be collated and fed back to individual AHS as it is currently done for individual urban prescribers.

(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;

Currently s100 support allowance is paid to the supplying pharmacy as is the reduced PBS dispensing fee. In some cases, it may be paid to an alternate pharmacy if the supplying pharmacy declares that they are unwilling or unable to provide the QUM services. However, individual pharmacists or AHS themselves are not entitled to apply for the funding. It is also not possible for AHS to choose their QUM pharmacist as the supplying pharmacy needs to declare that they

will not provide services.

Under current business rules, it is impossible for pharmacies (or pharmacists) outside of the regional town to compete with the supplying pharmacy on a fly-in-fly-out basis. It is most logical that a remote AHS obtain their supplies from the closest pharmacy. This allows for emergency supply and economies of freight as people travelling in and out of the regional centre can collect medications on their way back. However, there is no such necessity for QUM pharmacists to be in the nearest town. Any services provided by phone or email can be done from across the country as easily as in the closest town and on-site visits that required travel may also be done to remote communities with just a few more hours travelling.

It has also been proposed that a wholesaler can manage bulk supply as effectively as a community pharmacy. However, with the increased use of dose administration aids packed by pharmacies, this may complicate supply issues by bringing in yet another provider that the AHS has to deal with.

The QUM services supplied by individual pharmacies currently vary greatly in extent and quality. There were guidelines developed in 2008 to guide the provisions of services [14]. This coincided with the tripling of the allowance and the dispensing fee more than doubling. However, in some cases, pharmacies continued to provide the same service (or lack of) that they have always provided. It appears there has been no auditing by Medicare and any funds not expended by the pharmacy are not required to be returned. In an examination of the Workplans for the NOVA review there was ' …great variability in the level and types of service provided (by pharmacies) and the nature of engagement with the AHS:

• in some cases multiple sites are visited in a single day with apparently short periods spent in each and frequent cancellations

• in others there is a significant commitment of time over an extended period with strong professional relationships developed.' [5]

There are good examples of community pharmacies who supply medications under s100 providing an excellent service within the parameters of available funding. However AHS vary in their location, sophistication and level of funding and there should be choice for AHS to make their own arrangement with a pharmacy or pharmacist if they choose.

It may be argued that the money should be paid to the AHS who then contracts the pharmacist to provide services. This may meet the needs of some AHS but if there is no experience within the AHS of what a QUM service could be, they are likely to miss out yet again. Also, it should be pointed out that state health departments manage more than two thirds of the number of health centres accessing s100. The potential for misdirection of funds is present even here unless there is tight restriction on how the money can be spent.

The recent amendments to the method of payments to support pharmacists providing services to residential aged care facilities (RACF) provides a precedent for a system that separates supply and QUM services. Under the revised arrangements, apart from PBS dispensing, services may be contracted with individual pharmacists rather than pharmacies and:

- supply is provided under regular PBS s90 rules from the resident's preferred pharmacy

- residential medication management reviews (RMMR) are provided by an accredited pharmacist who is contracted by the RACF
- a separate QUM services payment is paid to a pharmacist that is not required to be accredited for RMMRs that covers medication advisory activities, education and continuous improvement. [15]

A system of paying QUM allowances directly to approved pharmacists without connection to supply is a model that should also be considered.

Recommendation 8

A system of funding that allows flexibility to meet the needs of the Aboriginal people living in remote areas is essential. However, whatever system is adopted, there needs to be greater accountability and transparency of what the money is being spent on. Any system that channels funding to any of pharmacies, AHS, state/territory governments or individual pharmacists is likely to meet the needs of some but not all AHS. Providing adequate safeguards against misdirection of funds are in place, funding should not be limited to any one group.

(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 Central Australian Rural Practitioners Association (CARPA) have developed a set a standard treatment protocols that are accepted by AHS throughout the NT and in several other parts of Australia and overseas. These protocols have been based on national best practice evidence, while allowing for the practical issues of remoteness. The use of these protocols allow standardisation of treatment and have also been credited with providing important educational support for nurses and AHWs supplying medicines that normally require a doctor's prescription.

Under the Section 29 (s29) of the NT Poisons legislation registered nurses (RN) and Aboriginal Health workers (AHW) in gazetted locations have the delegation to possess and supply certain scheduled medications in accordance with defined clinical protocols (CARPA Standard Treatment Manual). The course that CRH provides, Pharmacotherapeutics for Remote Area Nurses, is a 2 day workshop with a comprehensive workbook to assess knowledge and problem solving skills. It professes to do no more than support the appropriate use of protocol based supply as well as to recognise and refer potential drug related problems with prescribed medications. This course is a requirement of all RNs employed in the NT Department of Health and Families (DHF) as part of their orientation and is fully supported and funded by DHF. This course or a similar one is required under legislation in WA and QLD before supply in remote areas under standing orders or protocol based therapy.

My experience with over 600 participants in this course is that there is a progression from a traditionally trained RN who simply administers according to an order, to an advanced practice remote area nurse (RAN) who uses knowledge of drug therapy and decision making skills to ensure that the medication described in the protocol is appropriate. Much of the feedback I have received from nurses is that this course has helped them make this transition. The national nurses

& midwifery board now have an endorsement on registration that refers to a "scheduled medicines endorsement" that accommodates states such as WA & Qld requiring extra qualifications for scheduled medicines supply. A paper by AHPRA states that *"The Board considers this approach would create a genuinely national endorsement".[16]*

AHWs have the same delegation under the law and have a VET competency HLTAHW406A that they are required to meet before registration. If we compare the undergraduate HLTAHW406A to the semester long unit of pharmacology which is part of the undergraduate nursing degree as well as the post-graduate Pharmacotherapeutics course that DHF nurses are REQUIRED to complete, the training of AHWs is rather deficient. HLTAHW406A competencies are process competencies, eg being able to read a prescription, select the right drug and able to administer. There is no requirement to know anything about the actions of medicines. The only element that refers to treatment protocols is *'5.2 correctly identify medicine dosage in standard treatment manual or calculate mathematically'* One might compare it to the competencies of an enrolled nurse, which requires level 5 VET competency but only allows them to administer medication on the order of an approved prescriber. The AHW competencies were developed nationally as entry level competencies for registration as an AHW. However, in the NT, no further qualification is required to become an "approved AHW" able to supply selected S4 and S8 medications except having a job in an approved remote health centre.

The CRH has just this year started to develop a course similar to the Pharmacotherapeutics course for RANs. However, despite being 3 days, the literacy, knowledge of drug therapy and prior competency in medication supply of the participants are such that there is just no comparison at the end of the course to the level of most RANs. I agree there are some shining stars out there who have learned from others in their workplace and have developed good skills in medication management. I also agree that AHWs who do not feel competent to supply a medication generally refer to other health professionals for advice. However, I believe that it is essential that AHW be given more opportunity to improve their skills in medication before supplying s29 medications.

There is already another national competency for AHWs at the level 6. HLTAHW606A contains an element of competency that is not included in HLTAHW406A namely *'5.1 Initiate assessment and treatment using standard treatment manuals as used in the workplace'* which more closely aligns to what is required of AHWs providing medication under s29. Note that level 6 VET is a lower educational level than a bachelors degree (required by a nurse to practice). Currently there are no courses offered in Australia that specifically address the HLTAHW606A competencies.

The above argument refers to the selection of medications to treat a patient. There are also the skills of managing stock control functions and dispensing, labelling and recording from a doctor's prescription that are required in the remote AHS without a pharmacist. Another solution to ensuring good management of drug rooms in AHS is the development of a role for Medicines Workers. This role is similar to that of a Pharmacy Technician in a hospital or community pharmacy, ensuring good stock control, clean, tidy shelves and dispensing under supervision of a registered health practitioner authorised to supply medications. This position could be filled by a local Aboriginal person who need not necessarily have formal health qualifications. A project

exploring appropriate educational pathways was undertaken by CRH in 2009 [17]. The course selected as worthy of adaption is being undertaken by an employee of a community controlled AHS under the supervision of a pharmacist and an experienced AHW. He is due to complete the course later this year. However, the widespread acceptance of the concept has been limited by the lack of resources to provide positions in AHS for such a role. There are also concerns that some state (not NT) Poisons legislation may limit this role unless under the direct supervision of a pharmacist. The value of a Medicines worker and of the course has not yet been evaluated.

Recommendation 9

Funding for the ongoing review and updating of the CARPA standard treatment manual is essential to ensure continued quality decision making of RANs and AHWs supplying schedule 4 medications in remote AHWs without reference to a doctor.

Recommendation 10

Both RANs and AHWs must have opportunities to receive formal training in pharmacotherapeutics and dispensing. Providers of these courses should be encouraged to continue to improve and offer these courses with external funding support if necessary.

Recommendation 11

On-site supervision and informal training in dispensing and drug knowledge by a pharmacist should be recognised as an important adjunct to formal training.

Recommendation 12

Further development of Medicines Workers to support health professionals managing drug rooms in AHS should be encouraged.

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

I have already alluded to the various reviews that have been conducted into s100 supply and QUM support and to the lack of response to recommendations in these reviews. If resources had been invested in reading and responding to these reviews, we perhaps would not be responding to this Senate committee.

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

Dose Administration Aids

Dose Administration Aids (DAAs) supplied by a supporting pharmacy under controlled conditions are much more accurately filled than by staff on-site who may be subject to

interruptions and conflicting demands on their time and attention. Pharmacies are required to package and label to industry standards which also addresses the lack of consistency in labelling of medications by staff in remote clinics. Currently AHS using this service pay for it from unfunded sources.

The precedent of QUMAX funds being spent on DAAs has resulted in particular attention being given to this issue. Aboriginal people living in remote areas are no less needy of reliable DAA supply than urban Aboriginal people and a universal system should be investigated.

Recommendation 13:

That dose administration aids (DAAs) supplied by clinics using s100 be funded according to the same guidelines as QUMAX.

Home Medicines Review as a way to provide QUM in remote areas.

The Home Medicines Review (HMR) program allows pharmacists to provide education on medications directly to patients. It allows patients to talk about difficulties they are having with medications, which then may be addressed by the pharmacist in collaboration with the prescribing GP. Various pharmacists have delivered these services in remote areas and have reported favourable outcomes for patients and AHWs, where they have been involved. A recent review of one such program [18] found that there are differences between HMRs conducted in an AHS and those conducted in urban consumers. The pharmacist was employed by the AHS and had access to the patients' medical records, making comprehensive review more streamlined. The pharmacist also found that, by taking an AHW with her on home visits, it improved the knowledge and confidence of AHWs to discuss medications with patients. The report classifies the type of intervention and showed that the most frequent was the reconciliation between what was on the patient's prescription and what was being taken by the patient.

I have also conducted HMRs in remote and rural AHS, and although I have not collated results, anecdotally I feel that many of the interventions are things that might be picked up at dispensing & counselling in a suburban pharmacy eg dose administration aids (DAAs) & prescriptions not matching, common side effects such as cough on an ACEI, preferences for one form or strength of tablets with the same drug content etc. – in other words they just need a pharmacist, not necessarily a formal HMR; a pharmacist, not necessarily an accredited one – just one that has time to see the patients because they go there more than twice a year. It seems we may be using HMR to provide simple pharmacist advice. In most cases, HMRs have become the only mechanism available for patients living in remote areas to speak to a pharmacist about their medications.

This is not to say that HMRs are not a valuable tool to provide patient advice and to address more complex medication issues. However, it requires an accredited pharmacist and considerable organisation of referrals and consent. A system of opportunistic counselling by a pharmacist, who is not necessarily accredited, of patients as they come into the clinic to collect their medications may address some simple medication issues. If this were to be funded as a clinical item under Medicare, it may support a pharmacist. The development of the system of

'Medication Use Reviews'(MUR) which is due to be implemented in community pharmacies under the 5th Community Pharmacy Agreement may provide a mechanism for this. However, current advertised business rules for this program are that it is only available within the walls of community pharmacies [19].

Recommendation 14

A two tiered approach to counselling of patients and medications review should be funded for remote AHS. The Pharmacy Guild should be urged to include pharmacists providing services to AHS in the business model for MURs as it is rolled out.

Reconciliation with other programs for Indigenous Health & clinical programs available in community pharmacies

There are now three systems providing access to PBS medications to Indigenous Australians, s100, QUMAX and closing the gap (CTG). While I accept that each has evolved to address a separate issue, there appears to be no one rational program governance. Each program has its own rules and its own lines of communication. A coordinated approach may mean that an AHS is not required to choose between these programs and that a set of 'business rules' that allows for individual patients to choose the mechanism they prefer may be optimal.

S100 was the first program to attempt to address the needs of Indigenous people accessing PBS medicines and groups lobbying for other programs have pointed out the benefits of s100 and urged equity in urban areas. Yet, at this time it appears that s100 is the poor cousin in terms of PBS funding and that remote Australians are missing out yet again.

At the same time, the Pharmacy Guild have been able to successfully argue that pharmacists are able to provide extended clinical programs such as medicines use reviews, dose administration aids, disease state management for diabetes & asthma, health promotion etc and government has agreed to funding these extra clinical activities. The fact that these have been limited to 'in-pharmacy' is understandable considering the financial interests of Guild members. However, there are no pharmacies in most of the areas covered by s100 and a system of allowing for the provision of these services to special cases such as AHS with pharmacists employed would improve access of these patients to valuable clinical services.

Recommendation 15

Programs funding PBS supply and those negotiated under the Community Pharmacy Agreement should be coordinated and patient-focused for Indigenous people rather than financial stakeholders.

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