SUBMISSION TO PBS S100 SENATE ENQUIRY

Drs Peter & Jan Bowman

26 June 2011

SUMMARY

This submission addresses the following items in the Terms of Reference for the PBS s100 Senate Enquiry. Discussion and opinion on these questions follows.

a. … the arrangements adequately address barriers to ATSI access in remote areas.

b. … the clinical outcomes achieved from the measures … understanding & adherence to prescribed treatment …

c. … Quality Use of Medicines has been achieved …

f. *… Aboriginal Health Workers in remote communities have sufficient education opportunities … for prescribing and dispensing.*

RECOMMENDATIONS

1. That the rules of s100 pharmacy supply to remote communities provide for and require a reasonable fraction of the value of the medicine supplied to be invested in direct pharmacist support at the point of patient contact.

2. That the s100 system provides for and requires the pharmacist be involved in direct service to patients at the front line, including activities such as medication education and adherence support.

3. That the s100 system encourages training and deployment of local ATSI people in the role of pharmacy technicians and/or pharmacy assistants.

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Our Authority To Comment

We [Drs Peter and Jan Bowman] are resident GPs at the remote aboriginal community of Wurrumiyanga [previously Nguiu] on Bathurst island north of Darwin, Wurrumiyanga is the largest community on the Tiwi islands with a population of about 1800 mainly aboriginal people.

We have been working in remote aboriginal health for five years now, two years at Elcho Island in Arnhem Land and nearly three years at Wurrumiyanga. Prior that we have over 35 years experience each in both country and suburban general practice.

Our daily work is the direct communication with aboriginal patients to deliver modern medical services. A large part of this involves dealing with chronic disease, including the prescribing, educating, advising, adjusting, monitoring, and follow-up of prescription drugs supplied under the s100 scheme. We work as part of a clinic team which includes Remote Area Nurses and Aboriginal Health Workers.

Working at the cutting edge of the s100 pharmacy supply system in a remote aboriginal community, we deal daily with the benefits AND the deficiencies of the system.

Prescribing and Adherence in Aboriginal Communities

Remote community aboriginal patients are a very different group of people from suburban [even suburban aboriginal] patients. In general [many exceptions accepted] the level of health literacy is very poor, understanding of the concept of preventive care is non-existent, the motivation to use ongoing medication is low and the concept of regular dosing is a mystery of no personal relevance.

The result is that compliance/adherence is a big issue, I daresay the MAJOR issue, in the control of our rampant chronic disease. It requires huge effort from the health providers, requires constant follow-up and re-education for success, and is inevitably not very successful in remote communities. [Please recognise here that medical services in remote communities are already stretched in dealing with acute conditions so resources to manage the chronic conditions are limited].

The Volume of Medications Involved

We have about 500 chronic disease patients, most of who are prescribed [and may be taking] multiple medications. The rate of chronic disease in aboriginal communities is several times that of a typical white Australian community, and the total volume of medicines prescribed is commensurately higher.

As far as possible we provide medication in blisterpack form, for simplicity, accuracy and as a rudimentary aid to checking adherence. The blisterpacks [and various original packages] are prepared and supplied by a pharmacy on the mainland. They are dispensed to the patient from the local clinic by our pharmacy technician under supervision, or by a Dr, RN or AHW.

Pharmacy Delivery Day at Nguiu Clinic 2009.

As doctors, we cannot help speculating that there must be enough money associated with this huge volume of medicine to provide funding for front-line pharmacist service. A town of 1800 people elsewhere in Australia can support a full-time private pharmacist. How is it that this volume of medicine cannot support even a part time pharmacist in remote communities?

*Note: A Darwin pharmacist, Rollo Manning, has written extensively on the issue of cash-flow and pharmacy service in the s100 system. Costing details is outside my expertise, but I have no doubt that he has made a submission to the Senate Enquiry which can be consulted. As an indication, the following is copied from his website: "*The only change to the funding arrangements has been an increase in the "handling fee" paid to supplying pharmacies from $1.14 to $2.74. Compare this with the $6.42 paid for dispensing PBS Section 85 scripts and it is clear the PBS is saving money ($3.68) every time a PBS medicine is supplied to a remote living Aboriginal person."

The Complexity of the Supply System

The process of maintaining a reliable supply of medication to each individual patient, from doctor's prescription, through data transmission, packaging, labeling, transport from the mainland, storage in the clinic pharmacy, recording, and dispensing to the patient, is complex.

The turn-around time is inevitably slower than ideal. There are numerous opportunities for error throughout the process, and errors do occur.

The model works reasonably well for small clinics, but in a large centre such as ours the volume and complexity of the medicines demands systems management and skills above and beyond what our limited medical staff can provide.

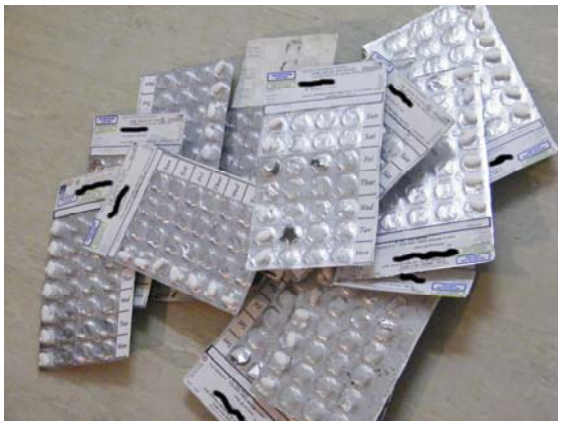
Wastage of Medicines

Medication adjustments are a frequent fact of medical management. It is not easy to modify blister packs, and the approved method of altering dosage is to discard any stock-in-hand of the old blisterpacks and organise a fresh dispensation of the modified ones.

On top of this we discard a lot of medicines unused and expired due to non-adherence by the patient.

The wastage is huge. We are told by our clinic manager that she supervises the disposal of several thousands of dollars worth of superseded blisterpacks each month. [I see the wastage happening. I have not personally confirmed this estimate of value – but it sounds about right].

Some unused medications. Nguiu 2009.



Found under the bed. Nguiu 2009.

PHARMACIST SERVICES TO THE PATIENT

The current input from the pharmacist consists of translating doctors' prescriptions into pills in blisterpacks, ensuring appropriate labeling, and organizing transport to the remote clinic in as timely a fashion as possible. There is no pharmacist input at the point of delivery. There is no direct patient access to the pharmacist. The management of adherence problems is rudimentary.

The existing contract for s100 pharmacy supply, between NT Dept of Health and the Pharmacy Guild of Australia, which binds our supplying pharmacy, has provision for 2 days per year of pharmacist time in the clinic. This is barely enough time to update the labelling on the shelves let alone manage the complex systemic issues needed for efficient supply. And actual service to the patient is not part of the deal at all.

With the best will in the world, the available staff of doctors, nurses and AHWs remains insufficient to provide the huge amount of service necessary to improve health knowledge and adherence.

Above and beyond that, pharmacists have skills which cannot be rendered by substitute health providers.

As committed clinicians we struggle with the available resources to maintain some sort of safe and adequate delivery. But the standard of pharmacy service AT THE FRONT LINE is not what a patient in any suburban or country town elsewhere in Australia would expect.

THE ABORIGINAL PHARMACY TECHNICIAN

This clinic has a rare kind of person in the Northern Territory; an aboriginal pharmacy technician. She learned her trade nearly a decade ago at a time when this community actually had a resident pharmacist. In that time she undertook the small amount of formal training; the rest she learned on the job. She is skilled and competent within the limits of her experience. There is no career path for a pharmacy technician in NT. There is no formal training course in pharmacy open for her at present. She provides basic technical services for our pharmacy essentially without peer support or pharmacist oversight. She does her work under supervision of other clinic staff. She is now completing training as an Aboriginal Health Worker as this will finally give her the qualifications to allow her to do what she actually already does extremely well.

There is no trainee or even a prospective trainee to take her place should she decide to move to an AHW role, or indeed retire.

Without a pharmacist, we have no means to train a local person for this critical job should she decide to move to an AHW job, or indeed retire.

CONCLUSIONS

Correlating with the Terms of Reference, our opinion is as follows:

a. … the arrangements adequately address barriers to ATSI access in remote areas.

The provision medicines which are "free" to the patient is a huge advantage for adherence in remote communities. But this is only a beginning in addressing the adherence problem - there is much more that needs to be done.

b. … the clinical outcomes achieved from the measures … understanding & adherence to prescribed treatment …

There is still a major problem in health literacy and adherence to medications. Although s100 supply makes effective prescribing at least possible in remote communities, there are more barriers to address than just money before clinical outcomes can match those in mainstream Australian society.

c. … Quality Use of Medicines has been achieved …

No.

f. *… Aboriginal Health Workers in remote communities have sufficient education opportunities … for prescribing and dispensing.*

No.

RECOMMENDATIONS

1. That the rules of s100 pharmacy supply to remote communities provide that a reasonable fraction of the value of the medicine supplied be invested in direct pharmacist support at the point of patient contact.

2. That the s100 system encourages and requires the pharmacist be involved in direct service to patients at the front line, including activities such as medication education and adherence support.

3. That the s100 system encourages training and deployment of local ATSI people in the role of pharmacy technicians and/or pharmacy assistants.

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http://www.aph.gov.au/senate/committee/wit_sub/index.htm

http://www.aph.gov.au/Senate/committee/clac_ctte/pbs_medicines/index.htm

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