Pharmaceutical Society of Australia

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Secretary
Senate Community Affairs References Committee
Parliament House
CANBERRA ACT 2600

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

On behalf of the Pharmaceutical Society of Australia (PSA) I am pleased to attach a submission to the Senate Community Affairs References Committee's Inquiry into the effectiveness of special arrangements for the supply of Pharmaceutical Benefits Scheme (PBS) medicines to remote area Aboriginal Health Services.

PSA looks forward to assisting the Committee during the course of its Inquiry.

Yours sincerely

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Pharmaceutical Society of Australia

SUBMISSION BY THE PHARMACEUTICAL SOCIETY OF AUSTRALIA TO THE SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE INQUIRY INTO THE EFFECTIVENESS OF SECTION 100 SUPPLY OF PBS MEDICINES TO REMOTE AREA ABORIGINAL HEALTH SERVICES PROGRAM.

PURPOSE

1. The Pharmaceutical Society of Australia (PSA) makes this submission to the Senate Community Affairs Committee on the effectiveness of the special arrangements established in 1999 under section 100 (S100) of the *National Health Act 1953* for the supply of PBS medicines to remote area Aboriginal Health Services (AHSs), also known as the Aboriginal Health Service Remote Access (AHSRA) program. This submission is based on review of relevant literature, including previous S100 evaluation reports, and consultation with pharmacists and AHSs involved in the AHSRA program.

ABOUT PSA

2. PSA is the peak national professional pharmacy organisation representing Australia's pharmacists working in all sectors and across all locations. The core business of PSA is practice improvement in pharmacy through the provision of continuing professional development and practice support. PSA provides an extensive program of education and professional development activities for pharmacists and intern pharmacists, and develops professional guidelines, standards and codes through its role as a standards-setting body for the profession. The PSA developed the guidelines for *The Provision of Pharmacy Services to Aboriginal and Torres Strait Islander Health Services* which aim to improve the awareness and understanding of Aboriginal and Torres Strait Islander issues amongst pharmacists and their staff.

MAIN PSA RECOMMENDATIONS:

3. In this document PSA outlines issues facing pharmacists and AHSs involved with the AHSRA program and makes a number of recommendations. These recommendations and the rationale associated with them can be found in Paragraphs 34-44. The three main recommendations are highlighted here in Paragraphs 4-6.

4. **The AHSRA program (Section 100) to be retained. (see Paragraph 34)**

5. **The Commonwealth Government to fund employment of clinical pharmacists in Aboriginal Health Services to ensure remote Aboriginal and Torres Strait Islander communities receive equitable pharmacy services. (see Paragraphs 35, 36)**

6. **Section 100 supply pharmacies to be paid a dispensing fee and a Dose Administration Aid (DAA) packing fee, not just a bulk handling fee, when these services are supplied. (see Paragraph 37)**

BACKGROUND

Rationale for AHSRA Program

7. Despite the high burden of chronic disease, there has been longstanding under-use of medicines amongst Aboriginal and Torres Strait Islander people, especially in remote areas. Barriers to accessing medicines for remote Aboriginal and Torres Strait Islander people include financial and geographic constraints, failed patient-clinician interactions, poor healthcare delivery systems and complex therapeutic medication regimens.[1] Other barriers include poverty, racism, dispossession, lack of control, the stigma associated with a diagnosis of chronic disease, educational disadvantage, shared crowded households, increased patient mobility, and inadequate health professional support.[2,3]

8. The S100 supply of medicines to remote AHSs, the AHSRA program, was established in 1999 to improve access of Aboriginal and Torres Strait Islander people living in remote Australia to Pharmaceutical Benefit Scheme (PBS) medicines by providing "free" (PBS) medicines from remote AHSs and their outstation clinics.

9. There are currently 170 remote AHSs, both community controlled and government run, participating in the AHSRA program. AHSs order bulk quantities of PBS medicines, listed under Section 85 of the *National Health Act 1953*, from approximately 50 community or hospital pharmacies. Medicines are then supplied to patients, attending the AHS or outstation, by doctors, nurses or Aboriginal Health Workers.

Expenditure and Remuneration

10. Since the commencement of the AHSRA program the Commonwealth Government's PBS S100 expenditure has steadily increased from $4 million in 1999-2000 to $32 million in 2007-2008. These figures are based on remuneration to pharmacies, rather than on medicines taken by patients, as there is little or no accurate recording or measurement of what patients receive. Pharmacies are remunerated by Medicare Australia for the bulk supply of PBS medicines. Pharmacies receive normal PBS mark-up on medicines plus a $2.74 handling fee per item (as compared to the normal dispensing fee of $6.42 per item). The Government therefore saves $3.68 per item dispensed to remote Aboriginal Australians. This

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1. Larkin, C. and R. Murray, *Assisting Aboriginal patients with medication management.* Australian Prescriber, 2005. **28**: p. 123-5.

2. Davidson, P.M., et al., *Improving medication uptake in aboriginal and Torres Strait islander peoples.* Heart, lung & circulation, 2010. **19**(5-6): p. 372-7.

3. Murray, M.D., et al., *Pharmacist intervention to improve medication adherence in heart failure: a randomized trial.* Annals of Internal Medicine, 2007. **146**(10): p. 714-25.

$3.68 per item is later referred to in this report as the PBS dispensing fee gap (see Paragraph 35).

11. To address concerns of bulk medicine supply to AHSs and in an attempt to enhance Quality Use of Medicines (QUM), a S100 Support Allowance was introduced in 2000. This is a payment to pharmacists for the delivery of support services to AHSs. There are currently approximately 19 pharmacies, providing support to 117 AHSs, receiving this allowance (Allowances range from $6000 - $10,500 per annum per AHS service + $6000 per outstation + travel loading).

Quality Use of Medicines

12. There have been numerous studies confirming that pharmacist interventions in all populations result in improved patient health outcomes, improved medication adherence, reduced hospitalizations and reduced healthcare costs.[4] [5] [6]

13. The recent report, *The health and welfare of Aboriginal and Torres Strait Islander people: an overview 2011*[7] showed that 80% of the life expectancy gap (10-12 years) between Indigenous and non-Indigenous Australians could be attributed to chronic disease (heart disease 22%, diabetes 12% and liver disease 11%). Together with lifestyle factors, long term medicine treatment is usually needed to reduce disease progression. Clinical pharmacists are needed to assist medication adherence through simplification of medication regimens and patient education.

14. Improving medication adherence is complex and requires interventions at the system, provider and patient level. Pharmacists have a role to play at each of these levels. They need to empower individuals, understand patient needs and tailor solutions, whilst also working within the system to ensure medication access and QUM education of health professionals.[8]

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4. Baran, R.W., et al., *Improving outcomes of community-dwelling older patients with diabetes through pharmacist counseling.* American Journal of Health System Pharmacy, 1535. **56**(15): p. 1535-9.

5. Roughead, E.E., et al., *The effectiveness of collaborative medicine reviews in delaying time to next hospitalization for patients with heart failure in the practice setting: results of a cohort study.* Circulation: Heart Failure, 2009. **2**(5): p. 424-8.

6. Westerlund, T. and B. Marklund, *Assessment of the clinical and economic outcomes of pharmacy interventions in drug-related problems.* Journal of Clinical Pharmacy & Therapeutics, 2009. **34**(3): p. 319-27.

7. Australian Institute of Health and Welfare. *The health and welfare of Australia's Aboriginal and Torres Strait Islander people: an overview 2011.* Cat. no. IHW 42. 2011 28 June 2011]; Available from: <http://www.aihw.gov.au/publication-detail/?id=10737418989>.

8. Davidson, P.M., et al., *Improving Medication Uptake in Aboriginal and Torres Strait Islander Peoples.* Heart, lung & circulation, 2010. **19**(5): p. 372-377.

SUMMARY OF AHSRA ISSUES

15. The AHSRA program has improved access to PBS medicines for remote Aboriginal and Torres Strait Islanders by removing some of the financial and transport barriers. However, a number of QUM and system shortcomings have been identified through consultations, field research, and program evaluations. These are listed below in paragraphs 16 – 24.

16. The AHSRA program has increased the workload of AHS staff. Aboriginal Health Workers (AHWs) and/or nursing staff are now responsible for ordering, managing and dispensing medications. The AHS has to provide an adequate area for the secure and appropriate storage of medicines.[9]

17. Medicine is often given out by nurses and AHWs who have little or no training about medicines and who are unable to give adequate medicine advice to patients. They may also have little or no understanding of the appropriate labelling or recording needed when dispensing medicine. Education and qualification requirements of AHWs vary from state to state, as does the extent to which AHWs are legally able to perform these duties.

18. There is often much confusion around medicines and many remote Aboriginal and Torres Strait Islander patients still have low levels of medicine adherence relating to lack of information, and lack of health professional engagement and patient support.[10] It is likely that life expectancy will remain lower than the national average whilst chronic disease goes untreated due to lack of medicine adherence.

19. Remote Aboriginal and Torres Strait Islander patients often have little or no access to a pharmacist. Pharmacists, who could check dosages and interactions, and ensure safe and effective medicine use, are particularly needed in remote areas, where there is often a scarcity of medical practitioners and lack of continuity of health professional staff.

20. Although there have been increases to the S100 Support allowance, it is still considered to be financially inadequate to fund more than one or two pharmacist visits per year to the AHSs. One to two annual pharmacist visits are usually insufficient to provide effective QUM services to the AHSs and their outstations. The majority of these visits relate to establishing ordering, dispensing and stock management systems, rather than QUM initiatives or staff education. The pharmacist

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9. Loller, H. *NACCHO. Final report Section 100 Support Project. Report from surveys conducted in Commonwealth funded Aboriginal Health Services and Pharmacies supplying services under Section 100 Pharmacy Allowance,*. 2003; Available from: http://www.naccho.org.au/activities/pharmaceuticalp1.html?print=yes#Pharmaceutical.

10. Emden, C., et al., *Better medication management for Indigenous Australian: findings from the field.* Australian Journal of Primary Health, 2005. **11**(1): p. 80-90, 10. Ibid.

visits are not long enough or frequent enough to build rapport, trust and effective communication with AHS staff or patients.

21. Field research with AHSs has shown that medicine is often wasted due to poor stock management and poor ordering systems.

22. Due to QUM and medication safety concerns some AHSs are requesting that pharmacies supply medicines already labelled and sometimes in Dose Administration Aids (DAAs). Community pharmacists are not being adequately remunerated for dispensing or DAA packing, under the AHSRA program, which does not pay a dispensing fee or DAA packing fee, only a bulk handling fee.

23. Some S100 supply pharmacies question the viability of their participation in the AHSRA program. The cumbersome claiming and delayed payment systems exacerbate these concerns. Payment is slow, taking 4-5 weeks, and usually takes the form of a cheque in the mail. A streamlined electronic payment system to pharmacy was recommended in the 2010 evaluation report of the S100 programs[11] but has not been implemented to date.

24. With the reduction of pharmaceutical wholesale margins, rural and remote pharmacies are worried that wholesalers will close a number of their regional depots, resulting in delayed delivery times for medicines, and pharmacies being forced to increase stock holdings of medicines and thus becoming less financially viable as a business.

PSA'S RESPONSE TO THE SENATE INQUIRY

Quality Use of Medicines

25. Although the AHSRA program has increased access to medicines, it has not adequately addressed QUM issues for the safe and effective use of medicines in remote Aboriginal and Torres Strait Islander communities. Remote Aboriginal and Torres Strait Islander communities do not receive equitable pharmacy services. Many remote Aboriginal and Torres Strait Islander people have no access to a pharmacist or information relating to the safe and effective use of their medicines. Without improved medicine information and increased medicine adherence, it is likely that chronic disease will remain poorly controlled and morbidity and mortality rates will remain high.

26. The PSA supports the continuation of the AHSRA program, that is, the supply of free medicine under S100 to remote Aboriginal and Torres Strait Islanders. The

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11. Australian Healthcare Associates. *Final Report: Review of the Existing Supply and Remuneration Arrangements for Drugs Listed Under Section 100 of the National Health Act 1953.* 2010; Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/pharmacy-4cpa-reviews.

AHSRA program, together with the Closing the Gap co-payment measure and QUMAX (Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander people), address some of the financial barriers which result in under use of medicines by Aboriginal people.

27. As well as addressing financial barriers to accessing medicines it is also important to address the barriers of suboptimal patient-clinician interactions, poor healthcare delivery systems, complex therapeutic medication regimens and poor delivery of appropriate health and medicine messages.

28. Many remote areas have limited General Practitioner services due to lack of rural and remote GP workforce. Pharmacy schools have doubled their student intake over the last 10 years and it is predicted that there may soon be an oversupply of pharmacists. Clinical pharmacists can make valuable contributions to improving health outcomes in rural and remote areas if there are new employment options, not tied to existing community or hospital pharmacy models. [12]

29. The S100 Support allowance is an attempt to address QUM issues but this program is too inadequately resourced to allow a significant number of visits by pharmacists to AHSs. Pharmacists travel long distances to visit AHSs for 1-2 days a year. The pharmacists often spend the majority of the visit occupied by logistical supply matters, together with small amounts of staff interaction, and occasionally some staff education. The patient usually gets little or no opportunity to interact with the pharmacist. Studies indicate that pharmacist interventions can improve quality of life and health outcomes, reduce hospitalisations and decrease health care costs. Remote Aboriginal and Torres Strait Islander peoples' access to pharmacists is not equitable to access provided to Non-Indigenous Australians.

Reviews of the AHSRA program

30. PSA is concerned that despite operating for over a decade, and being the subject of 3 reviews, the key shortcomings of the AHSRA program, as identified in the 2003-4, 2006 and 2010 reviews, have not been addressed. These include:

a. The costs incurred by community pharmacists in supplying "bulk" medicines, dispensed medicines and DAAs

b. The costs associated with pharmacists' visits to eligible AHSs

c. Professional concerns related to QUM, especially medication safety

d. Lack of access by remote Aboriginal patients to a pharmacist

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12. Swain, L. *Australian Pharmacy Council Remote Rural Pharmacists Project*. 2009; Available from: www.pharmacycouncil.org.au/.../ Rural%20Remote%20Final%20Report%20June%2009.pdf.

31. NACCHO's 2003 report stated that critical to the effectiveness of S100 is increasing and better targeting pharmacist support to AHSs.[13]

32. The Urbis Keys Young 2006 report recommended that S100 arrangements be retained but strengthened from a QUM perspective by increasing pharmacists' professional support to AHSs.[14]

33. The Australian Healthcare Associates' 2010 Review of Section 100 for the Department of Health and Ageing highlighted that pharmacist visits to eligible AHSs were extremely highly regarded by AHS staff. However insufficient funding often resulted in fewer visits by the pharmacist than were considered necessary to provide an adequate service.

Recommendations

34. Retain the AHSRA program. That is, continue the S100 supply of PBS medicines to remote area AHS, so allowing remote Aboriginal and Torres Strait Islander people to access free PBS medicines.

35. The Commonwealth Government to fund a pharmacist to work within each AHS. This pharmacist would provide professional pharmacy services such as medication chart reviews, home medicines reviews (HMRs), patient medicine education, chronic disease management, lifestyle interventions, preventative disease strategies, staff education and up skilling of AHWs. The pharmacist would advise on appropriate dosing, appropriate medicine choices, drug interactions, adverse effects, immunization and treatment options. The pharmacist would implement strategies to increase medication adherence and health literacy, and would optimise and/or tailor patient medication regimens. The pharmacist would refer patients to medical practitioners and other health professional when appropriate. A permanent pharmacist within an AHS would enable rapport building with patients. As the literature states "for Aboriginal patients the focus on inter-personal relationships and the building of respect and trust, between themselves and health practitioners is paramount". [15]

36. Medicine could continue to be supplied in bulk from the S100 pharmacy but the pharmacist employed at the AHS would supervise medicine ordering, dispensing,

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13. NACCHO. *Final report Section 100 Support Project. Report from surveys conducted in Commonwealth funded Aboriginal Health Services and Pharmacies supplying services under Section 100 Pharmacy Allowance,. 2003;* . 2003; Available from: Available from: http://www.naccho.org.au/activities/pharmaceuticalp1.html?print=yes#Pharmaceutical.

14. Urbis Keys Young. *Aboriginal and Torres Strait Islander Access to Major Health Programs.* 2006; Available from: www.medicareaustralia.gov.au/.../aboriginal_torres_strait_islander_access_to_major_health_programs.pdf.

15. McBain-Rigg, K.E. and C. Veitch, *Cultural barriers to health care for Aboriginal and Torres Strait Islanders in Mount Isa.* Australian Journal of Rural Health, 2011. **19**(2): p. 70-74.

labelling and recording procedures, as well as advice giving, patient education and medication review. The cost of employment of pharmacists would be offset by savings in reduced medicine wastage, disease prevention, the savings from the PBS dispensing fee gap ($3.68 per item) and by reducing the hospital costs that are incurred as a result of poorly controlled chronic disease, late presentations and/or medication mismanagement. Pharmacist services could be claimed through MBS item numbers through Medicare.

37. Section 100 pharmacies should be paid a dispensing fee and a DAA packing fee when these services are supplied. That is a tiered payment system should exist which reflects services offered. This will encourage pharmacies to provide more services when appropriate.

38. AHWs should receive more education about medicines. This medicine education should form part of their accreditation, as well as a number of appropriate continuing education modules being developed and delivered by pharmacists. AHWs also need to receive on the job training on requirements for the handling, storage and dispensing of medicines.

39. Pharmacists employed in AHSs, involved in the AHSRA and S100 Support Allowance programs, or consulting to AHSs, should undertake cultural awareness and communication training to reduce organizational and unintentional racism.

40. Research needs to be undertaken to measure clinical outcomes of access to free medicines and clinical outcomes as a result of access to pharmacist services, for Aboriginal and Torres Strait islander peoples. There is very little research relating to medicine usage in this population.

41. More Aboriginal people need to be trained as pharmacists.

42. Other options that could be employed by the Commonwealth Government to enhance pharmacist involvement with AHSs could include:

a. video-conferencing, video-cameras or webcams should be installed in clinics and pharmacies to allow interactions between clinic staff/patients and remote pharmacies. It is proposed that the Commonwealth Government would subsidise costs of this infrastructure.

b. Pharmacists should be able to claim for professional pharmacy services rendered, such as staff education, public health promotion, chart reviews, HMRs, patient education etc. on a fee for service basis through MBS item numbers or similar arrangements. This would make it more viable for pharmacists to offer clinical services. Pharmacists should be fully accountable for all visits and services claimed.

43. The recommendations of the 2010 Australian Health Associates Review of Section 100 AHSRA program need to be implemented.

44. These include:

a. Introduce a streamlined electronic ordering/claim process

b. Introduce an electronic payment system for pharmacists

c. Review the medication handling fee & remuneration formula to pharmacies – need tiered fee to allow for dispensing & DAAs

d. Allow AHSs to employ pharmacists – Medicare reimbursement

e. Extend the AHSRA program to include QUM

f. Increase number of pharmacists working in remote Australia

g. Develop a Support Allowance that takes into account the varying needs of AHSs

h. Increase the use of communication technology

Summary

45. PSA believes that employing clinical pharmacists in all AHSs, but especially in remote areas, would result in significant improvements in Aboriginal health outcomes and make a real contribution to "Closing the Gap". The provision of pharmacists, combined with subsidised medicines, is essential to the safe and efficacious use of these medicines. Supplying medicines without appropriate advice, monitoring and patient education, is not only a waste of money, but could be considered neglecting our duty of care of remote Aboriginal and Torres Strait Islander people.

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