NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION (NACCHO) SUBMISSION

To the Senate Inquiry-Community Affairs References Committee:

INQUIRY INTO THE EFFECTIVENESS OF THE SPECIAL ARRANGEMENTS FOR THE SUPPLY OF PHARMACEUTICAL BENEFITS SCHEME (PBS) MEDICINES TO REMOTE AREA ABORIGINAL HEALTH SERVICES (RAAHSs)

Submission prepared by NACCHO

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SUMMARY OF RECOMMENDATIONS

General

1. The supply of PBS medicines to RAAHS through S100 has substantially increased medicines access to the Aboriginal and Torres Strait Islander population in RRMA 6-7 regions, and should continue to be the predominant form of medicines supply to these services.
2. Despite the gains in PBS utilisation from the S100 program, NACCHO does not believe that current expenditure in the S100 program is sufficient to meet Aboriginal people's health needs. PBS utilisation may need to increase substantially (and exceed that for the non-Aboriginal population) to address the three times higher rate of death before age 65 years.

CTG Scripts and S100 supply

3. At present, remote area ACCHSs cannot offer clients both CTG scripts and PBS medicines under S100 (Table 3). Where a community pharmacy and private general practice are located in RRMA 6-7 regions, Aboriginal and Torres Strait Islander patients no longer need to attend a RAAHS or ACCHS to receive affordable medicines. Increased affordability is important, but as vehicles for improving patient's medication adherence and QUM, ACCHSs provide significant advantages over private general practices (see TOR(c)). It is preferable for Aboriginal and Torres Strait Islander patients to have access to QUM supports.
    a. ACCHSs in RRMA 6-7 locations should therefore be given the option of also providing CTG scripts to clients as well as the option to stock medicines on site through the S100 program.

Financing Dose Administration Aids

4. Affordability is a major factor influencing Aboriginal people's equitable access to medicines and by addressing that, the S100 supply program has accomplished significant gains towards equity. Medication adherence is also influenced by a range of other factors and can be enhanced through QUM strategies (see TOR (c)) including dose administration aids (DAA's). The S100 Program does not provide funding support for DAA's and many ACCHSs pay for these through their core budgets.
    a. NACCHO believes it is vital that financing for DAA's to Aboriginal clients of remote area ACCHSs be supported in order to improve Aboriginal people's medication adherence.
5. DAAs for remote area ACCHSs may be financed through:
    a. a program such as QUMAX extended nationally, and/or other DAA program financed by extension to the 5th Community Pharmacy Agreement.
    b. a DAA service similar to that provided by the Department of Veterans Affairs (DVA) for eligible clients funded by the Australian Government.

c. specific QUM related grants (a service-specific *QUM budget* including for DAAs) to ACCHSs. See TOR (c).

Quality Use of Medicine involving RAAHSs

6. The S100 supply of medicines to ACCHSs has evolved to encompass a range of ancillary programs that support the quality use of medicines (QUM) in RAAHSs. The often unconnected nature of these programs adds to their complexity for primary health care services. These programs need better integration within primary health care.
   a. This can be achieved by the introduction of a scheme to allocate *QUM budgets* to remote area ACCHSs from which services can draw from, and negotiate service-specific activities with community pharmacy or academic pharmacists.
   b. The difference between the S100 program handling fee ($2.79) and the PBS dispensing fee ($6.42) per item comprises a PBS underspend that could be used to fund a range of service specific QUM initiatives within remote area ACCHSs.

Governance of S100 supply and related QUM programs

7. Governance for the broad range of QUM programs established to support RAAHSs in the S100 program needs to be improved.
   a. This will require the establishment of a broader and multidisciplinary steering committee structure that has significant NACCHO membership, but also includes the involvement of a range of pharmacy groups.
   b. In addition, consideration should be given to integrating or creating cross membership between remote-area QUM governance structures with governance committees responsible for QUMAX and the CTG PBS co-payment relief measure (CTG scripts).
   c. NACCHO should be invited to be a member of a governance structure to monitor the implementation, uptake and evaluation of the CTG scripts measure, especially in the disaggregation of data between ACCHSs and private general practices.

Pharmacist employment within RAAHSs

8. Multiple independent reviews have confirmed that a greater level of pharmacist involvement in RAAHSs is needed. RAAHSs should be supported to employ salaried and sessional positions for pharmacists alongside other primary care staff.
   a. This can be achieved by transferring responsibility for the payment of QUM related pharmacist services to RAAHSs, as they move towards adopting pharmacists as core members of the primary health care team. Funding sources for these positions needs to be agreed upon and a range of options considered.
   b. NACCHO recommends that 'pharmacists' be added as additional allied health professionals under the Practice Nurse Incentive Program (PNIP).

This will provide the option for ACCHSs to (partly) fund a pharmacist (in any location across Australia).

c. Introduce Medicare Rebates for the delivery of pharmacist services within ACCHSs (remote and non-remote) in recognition of their role within the primary health care team. This would support the full/part-time employment of pharmacists to undertake QUM related services and training.

d. *QUM Budgets* to ACCHSs could be used to supplement the employment of sessional pharmacists.

e. By expanding existing workforce related schemes, funding provision could be made for more academic pharmacist employment within remote-area ACCHSs. Examples of schemes include the Rural Pharmacy Workforce Program under the 5th Community Pharmacy Agreement; and amendments to the Practice Nurse Incentive Program (by introducing pharmacists into the allied health professional category).

Reimburse RAAHSs for dispensing S100 medicines

9. Introduce a scheme for Medicare Australia to reimburse RAAHSs for *dispensing* S100 medicines to their clients. The labeling and dispensing activity of RAAHSs is currently not reimbursed. ACCHSs undertake and fund this activity from core service budgets. Funding received under such a scheme could be used towards QUM activity.

A coordinated and systematic approach to QUM support

10. Introduce a coordinated and systematic approach to QUM 'systems support' within remote-area ACCHSs by enabling service-specific initiatives through *QUM Budgets and* online QUM workplan development.

    a. *QUM budgets* (see above) could be used to subsidise the purchase of labeling equipment or provide QUM training of ACCHSs staff, or employ sessional pharmacists (or other uses of a service-specific QUM allocation-see Box 3).

    b. Regional or State/Territory 'QUM Pharmacists' could be employed within Affiliates or by the Guild (as per the QUMAX Program) to provide local support to remote area ACCHSs in developing service-specific QUM workplans and allocating their QUM budgets. Such an approach would need further consultation with NACCHO, taking into account the role of pharmacists employed locally by ACCHSs.

    c. A systematic and online approach to remote-area QUM workplan development would improve transparency, enhance workforce support, help ACCHSs to manage a service-specific QUM related budget, improve accountability and Departmental feedback to ACCHSs, and provide more tools to help guide services in the specification of the QUM services they need at a local level.

   d. The successes achieved with QUMAX may help inform the systematic application of improved administration and monitoring towards QUM within ACCHSs participating in the S100 program.

   e. The implementation of an improved administration and monitoring system towards QUM within ACCHSs would require a full time position to be funded within NACCHO to facilitate the establishment of the above quality assurance system.

Legislative amendments

11. NACCHO encourages the Senate Committee to recommend legislative amendments to:

    a. Overcome the current prohibition to dispensing/filling of Dose Administration Aids (DAA) by pharmacists outside a community pharmacy. (eg Registering remote health clinics as 'pharmacy outstations' was one suggestion, but the feasibility and acceptability of that would need investigation).

    b. Align, simplify and revise State Health Poisons Acts and Pharmacy Practice Acts legislation so that barriers in the provision of pharmacy/ist services faced by RAAHSs can be addressed.

12. RAAHSs are required (under S100 supply) to dispense and label PBS medicines, and this function should therefore be supported by a QUM-related service-specific budget (see TOR (c)).

13. Legislative reform and QUM-budgets would assist staff within ACCHSs to undertake their required responsibilities towards dispensing and quality use of medicines. (See TOR(c))

Aboriginal Health Worker education and better communication with RAAHSs

14. The employment of pharmacists within ACCHSs (see TOR(c)) would enhance educational opportunities for AHWs towards roles as Medication Assistants or the completion of Cert IV AHW Training.

15. NACCHO believes that the substantial communication gap that prevents remote area ACCHSs from learning of the outcome of S100 support allowance workplans, and prevents feedback to the Department of Health and Ageing regarding the S100 supply program, can be resolved by the adopting the recommendations pertaining to TOR(c).

PBS medicines listing for Aboriginal peoples and Torres Strait Islanders

16. NACCHO continues to support the evidence-based listing of medicines in the PBS specifically for the Aboriginal and Torres Strait Islander population. NACCHO encourages the Department to invite NACCHO to consult with ACCHSs regarding any additional medicines that might be added to the PBS for this specific population.

1.0 Introduction

Special arrangements exist for the supply of pharmaceutical benefits to clients of eligible Remote Area Aboriginal Health Services (RAAHS), primarily due to Aboriginal peoples and Torres Strait Islanders having by far the worst health outcomes and the clearest inequity in health care provision of any identifiable group in the Australian population. These special arrangements for access to Pharmaceutical Benefits Scheme (PBS) medicines – based on Section 100 of the National Health Act (1953) – aim to alleviate these disadvantages, and assist in 'Closing the Gap' (CTG) between Aboriginal and other Australians.

Currently 173 RAAHSs participate in the Section 100 program (Table 1) with the vast majority being State/Territory Government-run Aboriginal Health Services. Currently, only one third (34%) of participating RAAHSs are Aboriginal Community Controlled Health Services (ACCHSs).

There are over 150 ACCHSs across Australia that are members of the National Aboriginal Community Controlled Health Organisation (NACCHO). ACCHSs are distinct from State/Territory Government RAAHSs, and private general practices in that they are governed by an Aboriginal body which is elected by the local Aboriginal community and are not for profit services. By definition, ACCHSs deliver culturally appropriate and comprehensive primary health care to the community which controls it.

A total of 23 community pharmacists currently support the S100 supply program.

Table 1. Number of Remote Area Aboriginal Health Services (RAAHS) currently accessing medicines under Section 100 (National Health Act, 1953)[1]

State/Territory	Aboriginal Community Operated (ACCHSs)	State/Territory operated	Total
NSW	5	-	5
NT	25	54	79
Qld	5	39	44
SA	5	2	7
Tas	2	-	2
WA	17	19	36
Total	**59**	**114**	**173**

Source: Department of Health and Ageing. Athough approved, some services may elect not to participate, or may participate on an intermittent basis.

NACCHO has systematically responded to each of the Terms of Reference detailed in the inquiry. The Section 100 arrangements of the Act are referred to as the 'S100 Program' or 'S100 supply program' hereafter.

[1] Personal communication to Dr Couzos (May 2011).

2.0 NACCHO responses to the Terms of Reference

The Senate Inquiry examines the following terms of reference, which are followed by responses from NACCHO.

(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;

This submission refers to the S100 Program with respect to its effectiveness in improving medicines *supply* (through co-payment relief and bulk supply on site within RAAHSs) and *quality use of medicines* (through ancillary programs (see TOR (c)).

It is well established that the Section 100 arrangements of the National Health Act 1953 for RAAHSs which commenced in 1999 *significantly* address barriers to access *to all listed PBS medicines*, for all clients (Aboriginal and non-Aboriginal) of RAAHSs, by eliminating the known barrier of cost. PBS medicines listed under S100 are provided at no cost, and without the need of a script, to clients in remote locations, with 'remote locations' constituting RRMA locations 6 and 7 (remote and very remote). These locations denote a "very restricted accessibility of goods, services and opportunities for social interaction".[2]

These arrangements eliminate the need for a client to pay any 'co-payment' for medicines and bulk orders by RAAHSs mean that stocks of medicines are kept on site, eliminating the need for a prescription. The pharmacist is reimbursed for bulk orders by Medicare but this excludes branded products (as Medicare only pays the generic cost of the medicine). When a generic medicine is out of stock, a pharmacy may absorb the brand price premium or some arrangement is made with the RAAHS.

In non-remote areas, prescriptions presented to a pharmacy under section 85 of the National Health Act 1953 incur a co-payment of $34.20 for general patients and a co-payment of $5.60 for concession card holders (Table 2, 1st Jan 2011).

Two other programs have also provided co-payment relief for the Aboriginal and Torres Strait Islander population. A program known as QUMAX -*Quality Use of Medicines Maximised for the Aboriginal and Torres Strait Islander population-* has provided co-payment relief to 'needy' Aboriginal and Torres Strait Islander patients of non-remote ACCHSs since 2008 until July 2010, this relief was extended to similar patients of private general practices (regardless of geographic location- Table 2) known as the *PBS CTG Co-payment relief measure*.[3] (A description of the different sources of co-payment relief for the Aboriginal and Torres Strait Islander population and how they intersect with the S100 program is provided below).

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[2] Commonwealth Department of Health and Aged Care. Measuring Remoteness: Accessibility/Remoteness Index of Australia (ARIA). Canberra (ACT): Department of Health and Aged Care & the National Key Centre for Social Applications of Geographical Information Systems (GISCA) at the University of Adelaide; 2001 Oct. 21 p.

3 Couzos S, Sheedy V, Thiele D. Improving Aboriginal and Torres Strait Islander people's access to medicines — the QUMAX program. MJA Rapid online publication 21 June 2011. http://www.mja.com.au/public/issues/195_02_180711/cou10504_fm.html

S100 Program- Improved medicines access by PBS utilisation and expenditure

Strong evidence that the S100 scheme addresses barriers to medicines access can be found in the comprehensive Co-operative Research Centre for Aboriginal Health's 2004 Review, which found that the program:

> "resulted in increased access to medicine in all jurisdictions. There was increased access to oral hypoglycaemics, ACE inhibitors, asthma medicine and acute medicines. These medicines are all used to treat conditions that are particularly problematic in the Aboriginal and Torres Strait Islander community. … The program has fostered the development of stronger relationships between pharmacists and [RAAHSs], and this has had benefits in terms of improving QUM (Quality use of Medicines) and the ability of [RAAHS] to provide integrated care. Overall S100 has been a very successful program and all respondents supported its continued funding".[4]

Medicines utilisation data showed strong evidence of increased PBS claims with progressive increases in the total number of quantities (of medicines) claimed per person (between 2000-03). In the 2000/01 to 2001/02 financial year, growth in the utilisation of ACE Inhibitors (for blood pressure) under the S100 program was twice the growth seen in PBS utilisation overall. Survey of pharmacists and services further confirmed increased PBS utilisation. The Review concluded that increased use rather than increased wastage was largely responsible for increased utilisation findings.

Recent AIHW analysis confirms that PBS utilisation has significantly improved over the years for patients of RAAHSs. PBS per person expenditure over 2006-07 in remote/very remote regions of Australia was higher for Aboriginal peoples than non-Aboriginal ($223 compared with $200, ratio 1.12).

In comparison, Aboriginal peoples in *non-remote regions* have significantly less access to the PBS than the non-Aboriginal population. Over the 2006-07 financial year, for every dollar spent on medicines for a non-Aboriginal person, only 44 cents to 63 cents was spent on an Aboriginal person in these regions.

Moreover, Aboriginal peoples in *non-remote areas* also had less access to the PBS than Aboriginal peoples in remote Australia (ratio 0.71 in major cities compared with S100 regions).[5]

The higher rate of medicines utilisation in remote Australia by Aboriginal peoples (exceeding that of non-Aboriginal peoples in that region and that of Aboriginal peoples in

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[4] Kelaher M, Taylor-Thomson D, Harrison N, O'Donoghue L, Dunt D, Barnes T & Anderson I. Evaluation of PBS Medicine Supply Arrangements for Remote Area Aboriginal Health Services Under S100 of the National Health Act. Melbourne (VIC): Co-operative Research Centre for Aboriginal Health & Program Evaluation Unit, University of Melbourne; 2004. 26 p.

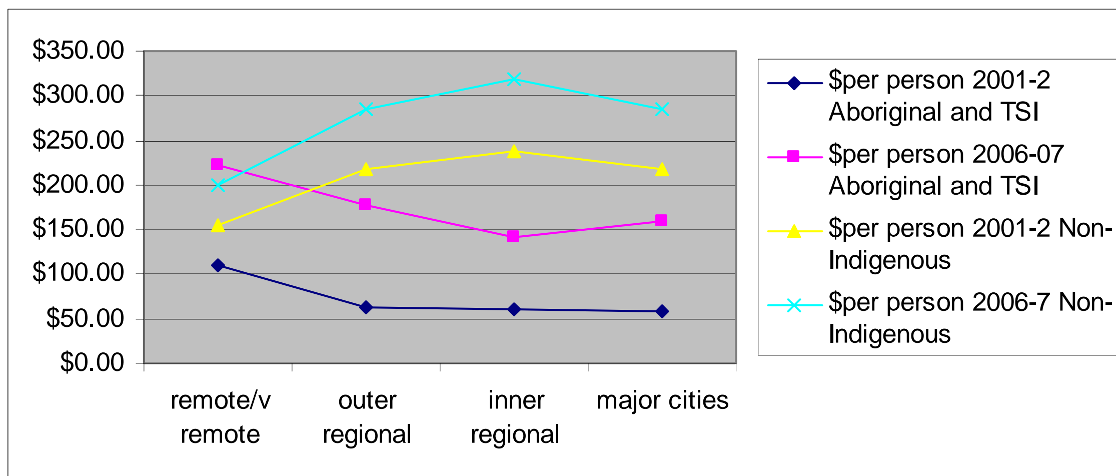
5 Australian Institute of Health and Welfare 2010. Expenditure on health for Aboriginal and Torres Strait Islander people 2006–07: an analysis by remoteness and disease. Health and welfare expenditure series no. 40. Cat. no. HWE 49. Canberra: AIHW

major cities), is the reverse of what is expected and can be attributed to the success of the S100 supply program.

Figure 1 outlines the five-year trend in PBS expenditure by geographical location and by Aboriginality. It demonstrates the above findings in S100 regions, but also shows that over 5 years to 2006-07, gains towards parity have been made especially in remote Australia.

In non-remote regions, disparities in access to PBS medicines between Aboriginal and non-Aboriginal Australians continue to exist. Geographically disaggregated data since 2007 have not yet been released by the AIHW, however, we expect to see improvements in PBS access as a result of QUMAX (see below).

Figure 1. Five year trend in PBS expenditure by Aboriginality and by geographical location (2001-2 to 2006-07).[6]



Note: S100 eligible locations are classified as 'remote/very remote'.

Despite the gains in PBS utilisation from the S100 program, NACCHO does not believe that current expenditure in the S100 program is sufficient to meet needs.

Achieving parity in PBS medicines utilisation alone will not lead to a closing of the gap in health disparity between the Aboriginal peoples and other Australians. Higher per person PBS expenditure is required to address the three times higher rate of chronic disease affecting Aboriginal peoples. Aboriginal peoples are three times more likely to die before the age of 65 years than non-Aboriginal Australians. (66% of Aboriginal and Torres Strait Islander deaths occurred before the age of 65 years compared with 20% of

[6] Extracted by Couzos S. Some caution in comparing PBS per capita AIHW with years preceding 2006-07. Different methodology in 2006-07, relying on the Voluntary Indigenous Identifier. (*Source:* Australian Institute of Health and Welfare 2010. Expenditure on health for Aboriginal and Torres Strait Islander people 2006–07: an analysis by remoteness and disease. Health and welfare expenditure series no. 40. Cat. no. HWE 49. Canberra: AIHW).

non-Indigenous deaths). Nearly 80% of the mortality gap (in terms of potential years of life lost) could be attributed to the higher burden of chronic diseases.[7]

Expenditure towards the S100 Program has increased from $4 million in 1999-00 to $32 million in 2007-08.[8] With 127,400 Aboriginal peoples living in remote and very remote regions (at June 2006), $32 million provides the same level of PBS utilisation if these patients used medicines to the same degree as other Australians.[9]

This indicates uptake of medicines (and expenditure) under the S100 program is still insufficient to meet the remote Aboriginal population's needs, given that medicine requirements are likely to be much higher than other Australian's.

Other Co-Payment Relief Schemes

Aboriginal and Torres Strait Islander patients in remote locations can now access medicines and receive co-payment relief in other ways, not just through S100 program. Aboriginal and Torres Strait Islander patients in remote areas can access co-payment relief not only from RAAHSs (S 100) but also from 'Indigenous PIP' registered private general practices (GPs) anywhere in Australia:

- Between November 2008 and 30 June 2010, some remote-area patients visiting non-remote ACCHSs could also access co-payment relief through the QUMAX Program.
- From 1st July 2010, private GPs in remote and non-remote locations can now offer co-payment relief (CTG scripts) if they are registered with the Indigenous Practice Incentive Payment (PIP).
- From 1st July 2010, ACCHSs (including other designated Indigenous Health Services) can offer co-payment relief (CTG scripts) but only in non-remote locations and do not need to be registered with the Indigenous PIP.

QUMAX

QUMAX was developed jointly by the Pharmacy Guild of Australia and the National Aboriginal Community Controlled Health Organisation under the 4th Community Pharmacy Agreement in 2006-07. It commenced a program of intensive QUM support, provision of dose-administration aids (DAA's), transport support and co-payment relief in 2008 until 30 June 2010, in non-remote ACCHSs. Thereafter, the co-payment relief function was transferred to the PBS co-payment relief measure (CTG scripts). QUMAX

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[7] AIHW. The health and welfare of Australia's Aboriginal and Torres Strait Islander people. 2011
[8] AHCA review

[9] With 170 RAAHSs in 2007-08, $32 million amounts to only $188,235 per service per year. Using the per capita expenditure on PBS medicines for non-Indigenous Australians at $290 (2006-07), this means that 649 persons per RAAHS (110,330 patients) may have benefited, which equates (roughly) to the Aboriginal population.

continues to provide DAA's and substantial QUM support to 2015 under the 5th Community Pharmacy Agreement.[10]

QUMAX has been highly successful at increasing medicines access for 'needy' and disadvantaged Aboriginal peoples[11] by eliminating co-payment across 70 ACCHSs in non-remote locations.

Between November 2009 and April 2010, the proportionate increase in the number of PBS medicines dispensed to patients of non-remote ACCHSs was nearly five times greater than the increase in medicines dispensed to all Australians, *and exceeded the increase seen in remote areas (S100)* by a factor of seven.

Greater access to medicines for chronic disease (lipid-lowering, antihypertensive and asthma medications) accounted for most of the increase. These outcomes were achieved despite QUMAX operating on a capped budget per ACCHSs.

Both the S100 program and QUMAX provide substantial evidence that co-payment relief has a significant impact in achieving equity in medicines access. Co-payment relief works, whether it's through S100 supply (remote areas), or through scripts that are annotated to waive the co-payment (non-remote areas).

QUMAX has also substantially increased medicines adherence and QUM within these ACCHSs according to an independent review.[12] These QUM support functions are continuing (see also (c)).

PBS Co-payment Relief Measure (CTG Scripts)

The PBS Co-payment relief measure under the Indigenous Chronic Disease Program is based on a patient's self-identified ethnicity; i.e. identifying as Aboriginal or Torres Strait Islander (but not requiring a three-tiered definition of Aboriginality).[13] Under this measure, patients identifying as Aboriginal or Torres Strait Islander can be registered

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[10]Couzos S, Sheedy V, Thiele D. Improving Aboriginal and Torres Strait Islander people's access to medicines — the QUMAX program. MJA Rapid online publication 21 June 2011. http://www.mja.com.au/public/issues/195_02_180711/cou10504_fm.html

[11] *Eligibility criteria:* [The prescriber must be of the view] that significant adverse health outcomes may result from the failure of the person to take the prescribed medicine, and the person is unlikely to comply with their medicines regime without assistance; and c) either: i. the person is currently holding a concessional entitlement card for PBS benefits, or is eligible to receive such benefits; Or ii. the person is not currently holding a concessional entitlement card for PBS benefits, and is not eligible to receive such benefits, but the clinical consultation with a prescriber indicates one of the following sub-criterion are met: − a history of evidence of foregoing medicines; − evidence that health is failing because of non-compliance with medicines; − social and/or legal obligations for a large family including guardianship of children; or − existence of co-morbidities and need for three or more prescribed medicines.

[12] Urbis Pty Ltd for the Australian Government Department of Health and Ageing. Evaluation of the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People (QUMAX) Program. April 2011. http://www.health.gov.au/internet/main/publishing.nsf/Content/5B1B138DA00BB9C7CA2578150083984E/$File/Final%20Report%20QUMAX%20Evaluation%20April%202011.pdf (accessed Jun 2011).

13 Couzos S, Thiele D. The new "Indigenous health" incentive payment: issues and challenges. MJA 2010; 192 (3) 154-157.

with Medicare Australia to participate in this program, through either: a private general practice registered with the Indigenous Practice Incentive Program (PIP) *and living anywhere in Australia;* or an 'Indigenous Health Service'[14], if the service is in a non-remote area.

Once PIP registered, the general practice receives an incentive payment from Medicare Australia, and if the patient is deemed eligible,[15] they can have their PBS scripts annotated 'CTG' (Close the Gap), to receive either free medicines or significantly reduced co-payments for medicines (for the life of the Program, Table 2).

Table 2. Summary of the medicinal concessions available to Aboriginal peoples and Torres Strait Islanders under the PBS co-payment measure (CTG scripts):

Patients	Concession Status	Patient co-payment per PBS medicine
Aboriginal & Torres Strait Islander (*any age, who are at risk of chronic disease or have a chronic disease*)	Concession card holder	Nil (free)
	General	$5.60 (free after SN threshold reached) *
All other Australians	Concession card holder	$5.60
	General	$34.20

*Aboriginal/Torres Strait Islander co-payment contributions are counted towards the Safety-Net (SN) as if they were general contributions (ie $34.20). Once the SN threshold is reached ($1317.20, equivalent to around 38 single item scripts per annum), Aboriginal and Torres Strait Islander general recipients receive free medicines for the remainder of the year as if they were concessional card holders.

Difference between S100 supply program and CTG Scripts

There are substantial differences between schemes in terms of policy and operational aspects, as well as differences in the way S100 program operates between jurisdictions.[16]

The main difference is that CTG scripts are merely annotated prescriptions that provide financial concessions for Aboriginal clients, but not linked to QUM programs. The S100

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[14]'Indigenous Health Service' is the terminology adopted by COAG. It pertains to ACCHSs, other OATSIH funded and State/Terr funded AHS's as well as private general practices that may be identified as such.

[15] **Eligibility criteria:** Self- identify as Aboriginal/Torres Strait Islander; "have an existing chronic disease or are at risk of chronic disease, and in the opinion of the prescriber would experience setbacks in the prevention or ongoing management of chronic disease if they did not take the prescribed medicine and are unlikely to adhere to their medicines regimen without assistance through the Measure".

16 Kelaher M, Dunt D, Taylor-Thomson D, Harrison N, O'Donoghue L, Barnes T, Anderson I. Improving access to medicines among clients of remote area Aboriginal and Torres Strait Islander Health Services. Aust N Z J Public Health. 2006 Apr;30(2):177-83

program (and QUMAX) on the other hand, are integrated with other programs providing QUM support and in the case of QUMAX- dose administration aids (see TOR (b)).

Another difference between CTG scripts and the S100 supply program is that co-payment relief provided under S100 is not based on a patient's *ethnicity*. Program eligibility for S100 is defined by the nature of the service (ie clients attending RAAHSs (which include ACCHSs).

In this way, the S100 program simplifies the provision of PBS medicines, as the vast bulk of patients attending RAAHSs are Aboriginal or Torres Strait Islander. There is no limit to the amount of bulk supplied medicines which can be ordered from community pharmacies under S100.

There is also no limit to the number of CTG scripts private general practices throughout Australia can provide to Australians who self-identify as Aboriginal or Torres Strait Islander. The eligibility criteria are flexible to account for a wide range of patient circumstances and co-payment relief can be provided for any PBS-listed medicine. For example, patients who are deemed to be 'at risk of' a chronic disease include those with family history and other environmental and socially determined factors including smokers, and those with low levels of physical activity.

This means that any remote area patient identifying as Aboriginal or Torres Strait Islander can access co-payment relief for PBS medicines from one of two schemes – the S100 supply program (from RAAHSs) or through CTG scripts (from private general practices registered with the Indigenous PIP).

At present, ACCHSs in remote locations cannot provide both CTG scripts and medicines under S100 (Table 3), nor have they been offered a choice. For remote Australia, there are obvious limitations to CTG scripts, in that there are few community pharmacies to offer these services. However, where a community pharmacy and private general practice are located in RRMA 6-7 regions, such services should be eligible to annotate CTG scripts.

As a result of the CTG measure, Aboriginal patients no longer need to attend a RAAHS or ACCHS to receive affordable medicines. Increased affordability is important, but as vehicles for improving patient's medication adherence and QUM, ACCHSs provide significant advantages over private general practices. This is an important point and is referred to in response to TOR (b) and (c).

Several ACCHSs in RRMA 6-7 locations consulted by NACCHO indicated that *they would definitely seek to annotate CTG scripts if they were given the option.* The reasons given included:

- Many clients travelling from remote to RRMA 4-5 locations and the need for these patients to access subsidised medicines through the CTG measure;
- One ACCHS reported being "tied to S100" as there is no access to any other co-payment subsidy program;
- stock control responsibilities being a burden versus the simplicity of CTG scripts.

Table 3: Relationship between S100 and PBS Co-pay Relief Program according to type and location of practice.

Category of services	Location	Invited to participate in Indigenous PIP?	Need Indigenous PIP participation to annotate scripts 'CTG'?	Can write CTG script?	Can access QUMAX?	Can access S100?
Private general practices	Australia-wide	Yes	Yes	Yes	No	No
ACCHS (plus other IHSs)	Non-remote	Yes	No	Yes	Yes (only ACCHSs)	No
ACCHS (plus other IHSs) **(ie RAAHS)**	Remote	Yes	No	No	No	Yes

ACCHSs: Aboriginal Community Controlled Health Services, IHS: Indigenous Health Service, RAAHS: Remote Area Aboriginal Health Services, QUMAX: Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples, PIP: Practice Incentives Program, CTG: Close the Gap.

RECOMMENDATIONS

- The supply of PBS medicines to RAAHS through S100 has substantially increased medicines access to the Aboriginal and Torres Strait Islander population in RRMA 6-7 regions, and should continue to be the predominant form of medicines supply to these services.
- Despite the gains in PBS utilisation from the S100 program, NACCHO does not believe that current expenditure in the S100 program is sufficient to meet Aboriginal people's health needs. PBS utilisation may need to increase substantially (and exceed that for the non-Aboriginal population) to address the three times higher rate of death before age 65 years.
- At present, remote area ACCHSs cannot offer clients both CTG scripts and PBS medicines under S100 (Table 3). Where a community pharmacy and private general practice are located in RRMA 6-7 regions, Aboriginal patients no longer need to attend a RAAHS or ACCHS to receive affordable medicines. Increased affordability is important, but as vehicles for improving patient's medication adherence and QUM, ACCHSs provide significant advantages over private general practices (see TOR(c)). It is preferable for Aboriginal patients to have access to QUM supports.
- ACCHSs in RRMA 6-7 locations should therefore be given the option of also providing CTG scripts to clients as well as the option to stock medicines on site through the S100 program.

(b) the clinical outcomes achieved from the (s100) measure, in particular to improvements in patient understanding of, and adherence to, prescribed treatment as a result of the improved access to PBS medicines;

The response to TOR(a) has established that affordability is a major factor in Aboriginal peoples equitable access to medicines and by addressing that, the S100 supply program has accomplished significant gains towards equity.

However, patient's adherence to medicines is mitigated by a variety of factors and not just cost- including demographic (age, sex, etc), psychosocial (beliefs, motivation, cultural), social disadvantage, health literacy, health system factors (type of service, social supports etc), and aspects related to the medicine itself.[17] Many of these factors are addressed in QUM initiatives (see TOR (c)).

Part of the success in the S100 program is related to the provision of medicines within the context of comprehensive culturally appropriate primary health care (especially through ACCHSs). The CRC Review (2004) confirmed that cultural appropriateness in the S100 program (accessing medicines from an Aboriginal health service, and having Aboriginal people involved in dispensing) was a significant factor that improved medication adherence for Aboriginal clients.[18]

The S100 program however, does not provide funding for Dose Administration Aids (DAA) nor their weekly refill. DAAs are commonly used medication management devices that lead to improved quality of life and better health outcomes for patients through improved quality use of medicines. Along with regular pharmacy interaction, DAAs can reduce adverse drug events and improve the patient's ability to manage their medicines.[2]

In the absence of a DAA funding scheme, at great expense, these costs have usually been borne by the ACCHSs themselves. The CRC Review (2004), recommended funding for DAA's so that RAAHSs can use them in the S100 program.[19]

More recently, the QUMAX program for non-remote ACCHSs has supported the cost borne by ACCHSs and delivered considerably more DAA's to Aboriginal clients. Within 12 months, 74,122 DAA's had been dispensed through ACCHSs in non-remote areas to Aboriginal patients (2009-10)[20] with substantial benefits in patient's medication adherence:

> "Amongst the services and pharmacists that had been 'operational' for some time, there was a very consistent view that medication compliance had improved drastically. One person said

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[17] Jin J, Sklar GE, Min Sen Oh V, Chuen Li S. Factors affecting therapeutic compliance: A review from the patient's perspective. Ther Clin Risk Manag. 2008 Feb;4(1):269-86 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2503662/

[18] Kelaher M, Taylor-Thomson D, Harrison N, O'Donoghue L, Dunt D, Barnes T & Anderson I. Evaluation of PBS Medicine Supply Arrangements for Remote Area Aboriginal Health Services Under S100 of the National Health Act. Melbourne (VIC): Co-operative Research Centre for Aboriginal Health & Program Evaluation Unit, University of Melbourne; 2004. page 96.

[19] Ibid. Page 18.

[20] Urbis Pty Ltd for the Australian Government Department of Health and Ageing. Evaluation of the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People (QUMAX) Program. April 2011. page 56

> '…compliance like we have never seen before.' One pharmacist estimated that the rate of 'pick up' for repeat prescriptions had improved by 90%. ACCHSs claimed that they had noticed a strong improvement in people's propensity to return to the service when they needed a new prescription for medications. Particular note was made of the impact of DAAs. For some services, QUMAX had allowed far greater use of Webster Packs etc without placing a financial burden on patients, pharmacies or ACCHSs. It was this increase in DAA use that was thought to lay behind the increased compliance that was being observed."[21]

An equally positive impact on medication adherence could be achieved through ACCHSs in remote areas if funding for DAA's was provided to supplement the S100 Program.

However, incorporating DAA fees into pharmacist handling fees in the provision of bulk medicines supply to RAAHSs may be difficult. A bulk order is not linked to individual patient's prescriptions.

RECOMMENDATIONS:

- Affordability is a major factor influencing Aboriginal peoples equitable access to medicines and by addressing that, the S100 supply program has accomplished significant gains towards equity. Medication adherence is also influenced by a range of other factors and can be enhanced through QUM strategies (see TOR (c)) including dose administration aids (DAA's). The S100 Program does not provide funding support for DAA's and many ACCHSs pay for these through their core budgets.
- NACCHO believes it is vital that financing for DAA's to Aboriginal clients of remote area ACCHSs be supported in order to improve Aboriginal people's medication adherence.
- DAAs for remote area ACCHSs may be financed through:
    - a program such as QUMAX extended nationally, and/or other DAA program financed by extension to the 5th Community Pharmacy Agreement.
    - a DAA service similar to that provided by the Department of Veterans Affairs (DVA) for eligible clients funded by the Australian Government.
    - specific QUM related grants (a service-specific *QUM budget* including for DAAs) to ACCHSs. See TOR (c).

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[21] NACCHO Annual Report 2008-09. Page 34.

(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;

Quality Use of Medicines means ensuring that "medicines are used wisely, safely and effectively", while also ensuring the "safe storage and appropriate stock control of medicines."[22] The National Prescribing Service defines QUM as shown in Box 1.

Box 1. Definition of the Quality Use of Medicine (NPS)

Quality use of Medicines defined:
For an individual, it means using (or not using) medicines appropriately, safely and effectively and having the knowledge and tools to do so
For health professionals, it means:

- choosing the most appropriate and cost effective treatment; and
- giving people the knowledge and skills to use medicines to their best effect

For providers of health services and products, it means contributing to best practice through appropriate information, education and promotional activities
For governments, it means developing public policy, health systems, regulation and education that support best medicines use.[23]

There is no doubt that the S100 Program has enhanced Aboriginal people's access to medicines through bulk supply and co-payment relief, but through a range of ancillary programs, QUM within ACCHSs and other RAAHSs has also improved.

There are several ways in which QUM support to ACCHSs and other RAAHSs accessing the S100 Program has evolved. The following is an incomplete list of QUM programs linked in some way to the S100 program. Reference is also made to the QUM program being delivered to non-remote ACCHSs (QUMAX) which has been found to be highly successful.

1. S100 Support Allowance (Pharmacy Guild- Australian Government Community Pharmacy Agreement)
2. Rural and Remote Workforce Program (Pharmacy Guild- Australian Government Community Pharmacy Agreement)
3. Outreach Pharmacists for Remote Aboriginal Health Services (OPRAH- National Prescribing Service)
4. Training of AHWs in QUM (Good Medicines Better Health Program)
5. QUM Support under QUMAX

Section 100 Support Allowance

[22] National Aboriginal Community Controlled Health Organisation. Section 100 Pharmacy Support Program. Australian Government Department of Health and Ageing. 2 p.
[23] http://www.nps.org.au/about_us/what_we_do/about_quality_use_of_medicines

The Support Allowance was developed after the success of a joint pilot program undertaken by the Pharmacy Guild, NACCHO and Charles Sturt University which commenced in 1999 and was designed to enhance the QUM within ACCHSs.[24]

Between 2005-10, the S100 Support Allowance Program ($13.4 million) under the 4th Community Pharmacy Agreement (CPA) provided an allowance of between $6000 and $10,500 per annum to community pharmacies for a range of QUM related services to support RAAHSs in 'the implementation or continuation of S100 supply arrangements'.[25] [26]

Under the 4th Agreement, the Business Rules were revised in collaboration with NACCHO so as to increase the collaborative relationship between ACCHSs (and other RAAHS) and community pharmacy.

According to the revised Business Rules for this program, community pharmacy services to RAAHSs should include:

- Developing and implementing an annual workplan in agreement with the CEO of the RAAHS formed after conducting an onsite needs assessment (templates available);
- 6-monthly progress reports against the workplan (discussed with the CEO of the RAAHS and co-signing a "Continued Support Service Form") provided to the Department of Health and Ageing (DOHA);
- Providing assistance in the implementation of appropriate procedures and protocols for managing S100 supply arrangements, including the establishment of a medicine store;
- Developing a range of other appropriate measures to enhance QUM (which may include assistance with dose administration aids, participation in regular meetings with health staff, and review of patient medication);
- Implementing agreed measures which aim to enhance the QUM; and
- Providing a range of education services to RAAHS clinical and support staff relating to medicines and their management.

As part of the contractual agreement, the pharmacist is expected to consult with clinic staff to provide assistance in the following QUM areas:

- Supply of medicines and maintaining adequate stock levels
- Education of health service staff

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[24] Emerson, L., Bell, K., Croucher, K. *Quality Use of Medicines in Aboriginal Communities Project: Final Report.* Canberra: Pharmacy Guild of Australia. (2001).
[25] The Australian Government Department of Health and Ageing & The Pharmacy Guild of Australia. Pharmacy Information Kit: Section 100 Pharmacy Support Allowance Program (Section 1). Canberra (ACT): Commonwealth of Australia; 2008. 10 p.
[26] The Pharmacy Guild of Australia. Review of the Existing Supply and Remunerations Arrangements for Drugs Listed Under Section 100 of the *National Health Act 1953*: Aboriginal Health Services Remote Access Program. Australian Healthcare Associates; 2010 Feb. 31 p.

- Drug information services
- Management of DAA's (e.g. Dosette boxes and Webster Paks)
- Review of medication charts
- Home Medication Reviews
- Client counseling.

The current allowance is based on the volume of PBS medicines supplied under the S100 Program to the RAAHS in the preceding year, plus an additional travel loading.

Two reviews recently appraised this program with the findings summarized below. A separate review examined the delivery of pharmacy services to RAAHSs, and is also referred to below.

1. ***Australian Healthcare Associates Review[27]***

The Review found that:

- the current *Allowance* does not reflect the level of effort required by the pharmacist, with these medical professionals often undertaking lengthy visits to AHSs to see patients;
- the scheme poses a financial burden on some pharmacies;
- there is difficulty in enlisting a locum to cover their absence at the pharmacy, have led in some instances to fewer visits than they consider necessary to provide an adequate service;
- there is little use of new technology such as tele-pharmacy (using web cameras or videoconferencing);
- However, many RAAHSs were requesting and receiving more than two visits per year (some received daily, weekly, fortnightly visits whilst others received one annual visit).

The Review recommended that:

- The support allowance funding might be better integrated with S100 medicines supply arrangements and that this be managed by a committee that was responsible for both areas.
- They also recommended increased handling fees (this was increased from $1.55 to $2.69 per item in 2009, and again to $2.79 in 2011), plus separate fees for transporting and cold chain costs, which might be reimbursed based on receipts.
- The 5th CPA to provide for additional fees for DAA provision to RAAHSs.
- The 5th CPA provide set-up funds to RAAHSs if they require additional software programs to allow for electronic ordering.

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[27] Australian Healthcare Associates. Review of the existing supply and remuneration arrangements for drugs listed under Section 100 of the National Health Act 1953. Feb 2010.

- RAAHSs should be allowed to employ pharmacists with possible reimbursement through Medicare Australia; and
- Allow pharmacists to be employed by RAAHSs and exempt RAAHSs from pharmacy location rules[28] if these were to apply.

Legislation inhibits pharmacists in most States from dispensing outside a registered pharmacy. Thus, career/academic pharmacists employed by the RAAHS, who do not want to own a pharmacy, are legally unable to label/dispense medicines or pack a DAA, or receive remuneration for this service through regular channels. An exception to this exists in the NT. [29]

As a result, the Review reported that RAAHSs "currently perform the labeling and dispensing services but do not receive reimbursement for this service. If funding was provided to [RA]AHS, this could be used by each [RA]AHS to improve their medicine storage facilities and increase members skills in performing these duties."[30] However, no recommendation was made in the report on this matter.

The Review noted the difference between the S100 program handling fee ($2.69) and the PBS dispensing fee ($6.42) per item, and elicited a range of views regarding allocation of the underspend (if it was to be made available). These ranged from allocating this to the S100 Support Allowance to increase QUM support to RAAHSs, or funding other activities and initiatives for QUM.

It is very clear that the S100 Program "has moved the responsibility for the management of the medicines storeroom, distribution of medicines and the provision of ongoing client information from pharmacists to [RA]AHS workers"[31] and this has been welcomed by many services whilst also a burden for others.

This situation has led to a range of strategies by ACCHSs such as employment of contractual pharmacists (see later), training of Aboriginal Health Workers as medicine assistants (see TOR (f)) and calls by RAAHSs to be eligible for access to the CTG scripts measure (see TOR (b)).

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[28] Pharmacy Location Rules have been a feature of all five Community Pharmacy Agreements and have been in place in one form or another since 1991. The Rules are given their effect by means of a Ministerial Determination under section 99L of the National Health Act. This Determination, entitled National Health (Australian Community Pharmacy Authority Rules) Determination 2006 , is commonly referred to as the Pharmacy Location Rules (the Rules). The Rules are administered by the Australian Community Pharmacy Authority (ACPA)… The Minister for Health and Ageing has a discretionary power to approve pharmacies in unique circumstances where the application of the location rules results in a community being left without reasonable access to the supply of pharmaceutical benefits by an approved pharmacist, and approval of the pharmacy is in the public interest.
http://www.guild.org.au/5CPA/Initiatives/Location_Rules/Location+Rules.page

[29] Swain L. Remote Rural Pharmacists Project. Australian Pharmacy Council, June 2009.
[30] Australian Healthcare Associates Page 36.
[31] Australian Healthcare Associates Page 42.

2. *Nova Review*[32]

This Review surveyed 25 RAAHSs and found that they valued the S100 Support Allowance program as it addressed several QUM issues, especially with regard to safe storage, handling, dispensing and improved labeling of medicines. Pharmacists also generally concurred with these benefits. However, the program fails to provide sufficient pharmacist involvement in clinical activity such as medication chart reviews, and home medicines review.

Importantly, the new Business Rules and workplan process were valued by almost all RAAHS, with support for "improving the efficiency of this process through online reporting."[33]

Recommendations for improvements to the program included:

- Better sharing of information between participants utilizing the S100 Support Allowance (an action to be shared between the Pharmacy Guild and NACCHO)
- Establish a governance mechanism to coordinate the program through the DOHA, Pharmacy Guild and NACCHO (including a complaints process).
- More guidance for pharmacists in the provision of support to RAAHSs
- Transferring responsibility for payment of pharmacy services to RAAHSs might enhance pharmacists accountability (eg cashing out existing subsidies for direct employment of pharmacists by RAAHSs)
- Improvements to workplan reporting mechanisms (eg online submission etc)
- Subsidies for RAAHSs for purchase of labeling equipment (The Review found many RAAHSs lacked labeling equipment).
- Funding pool for QUM training of RAAHSs staff,
- Subsidies for Dose Administration Aids.

Some RAAHSs directly employed pharmacists (see Rural Workforce Pharmacy Program below). Direct employment significantly advantaged primary care delivery.

The review referred to the potential for improved administration of the program such that it aligned with QUMAX. Moreover, the Pharmacy Guild recommended a full time position within NACCHO could be established to promote the program and its quality assurance to RAAHSs.[34]

3. *Australian Pharmacy Council Review*[35]

This review examined the legislative and remuneration barriers facing the delivery of a full range of pharmacist services in rural and remote regions but also through the S100 supply program involving RAAHSs.

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[32] Nova Public Policy Pty Ltd. Evaluation of Indigenous Pharmacy Programs. Final Report. 28 June 2010.
[33] Nova Review. Page 3
[34] Nova Review. Page 30.
[35] Swain L. Remote Rural Pharmacists Project. Australian Pharmacy Council, June 2009.

The review recommended:

- Registering remote health clinics as 'pharmacy outstations' so that pharmacists may dispense in these locations. (*Including also the labeling, packing of DAAs, provision of medication counseling and other pharmacy services). This would require legislation amendments, and there is a precedent in the NT*.[36]
- Remunerating remote pharmacists for services though the Medicare Benefits Schedule (MBS). S*ervices to be considered include: medication counseling, patient case conferences with Medical Practitioners, (face to face or by phone), Home Medicines Review (already existing), Nurse and Aboriginal Health Worker medication education*.
- Exempting RAAHSs from pharmacy ownership laws if a pharmacist is employed full time to oversee and establish QUM observance.
- For the Federal Government to employ and suitably remunerate a pharmacist for each [RA]AHS.
- Aligning, simplifying and revising State Health Poisons Acts and Pharmacy Practice Acts legislation.

Rural Pharmacy Workforce Program (RPWP)

This 4th Community Pharmacy Agreement program is managed by the Pharmacy Guild and one function is to provide pharmacy academics at 11 University Departments of Rural Health ($3.2m).[37] As well as managing rural clinical placements for pharmacy students (including within ACCHSs), these academic pharmacists also deliver OPRAH (see below) and can be employed also within ACCHSs for S100 QUM support.

For example, in the Kimberley region of WA, the S100 Support Allowance is redirected (by contract with the pharmacist) to the Kimberley Aboriginal Medical Services Council (KAMSC), which then employs their own pharmacist to deliver these QUM services according to the business rules of the Allowance. Funding for an academic pharmacist from the University Departments of Rural Health provides additional funds to supplement the cost of this QUM provision.

According to the Australian Healthcare Associates Review: "there is also nothing to preclude a community pharmacist from engaging a consultant/academic pharmacist through a local agreement to undertake the RAAHS [S100 support allowance services]… Nevertheless some consultant pharmacists would like to be able to access the Allowance in their own right, and not be contracted by a community pharmacy."[38]

A recent review of the RPWP did not explore this role further.[39]

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[36] Dispensing by pharmacists permitted in NT RAAHSs under Health Minister approved exemption of Section 94 of the Health Act. [Source: Swain review].
[37] Note that funding for the pharmacy academics is provided to the Universities, not direct to the UDRH.
[38] Australian Healthcare Associates Review. Page 38.
[39] KPMG. Evaluation of the Rural Pharmacy Programs Final Report. Department of Health and Ageing. Nov 2010.

There is also a number of small projects underway funded under the RWPP that aim to develop career pathways for Aboriginal people to provide medication support services in remote AHS settings, or to pilot the role of *Aboriginal adherence workers*.[40] (see also TOR (f)).

Outreach Pharmacists for Remote Aboriginal Health Services (OPRAH)

This program is funded by the National Prescribing Service (NPS) and aims to enhance QUM by training those pharmacists who provide support to RAAHSs to deliver QUM education to clinic staff (nurses and Aboriginal Health Workers- AHWs). Training sessions are conducted twice yearly, and educational sessions to RAAHSs are offered on two topics annually.

Pharmacists can report on this activity in the workplans developed under the S100 pharmacy support allowance, minimising any additional burden to participants. Moreover, it permits networking of pharmacists supplying S100 bulk supply to RAAHSs.[41]

In 2009, 29 outreach pharmacists were trained who in turn delivered QUM training for ‘chronic obstructive pulmonary disease’ at 33 RAAHSs to 106 staff including 38 AHWs and 52 nurses.[42]

Training of AHWs in QUM (Good Medicines Better Health Program- GMBH)

Funded by the National Prescribing Service (NPS), this program is a national joint initiative between NACCHO, the State Affiliates associated with the rollout of GMBH, and various training organisations. The program’s goal is to enhance *Aboriginal Health Workers* (AHWs) capacity to provide QUM support to clients of ACCHSs across Australia.

Affiliates or training organisations provide modular training to AHWs who then train other workers within their services including RAAHSs. Training is accredited towards AHW Certification (IV). Approximately 60 AHWs are expected to complete training as ‘trainers’ over three years to 2013-14.

QUM Support under QUMAX

The QUMAX program for ACCHSs has successfully embedded QUM within non-remote services, in conjunction with the CTG scripts measure. An independent review confirmed

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[40] KPMG. Evaluation of the Rural Pharmacy Programs Final Report. Department of Health and Ageing. Nov 2010.

[41]http://www.nps.org.au/news_and_media/media_releases/repository/Supporting_outreach_pharmacists_across_Australia

[42] Pippa Travers-Mason, et al. Getting QUM messages on COPD into remote Aboriginal Health Services- how OPRAH did it? NPS 2010.

that QUMAX has substantially improved the capacity of ACCHSs to deliver QUM.[43] Box 2 and 3 summarise the features of the program.

The successes achieved with QUMAX may help inform the systematic application of QUM within RAAHSs participating in the S100 program. A joint QUMAX and S100 Support program workshop involving pharmacists and ACCHSs (plus other RAAHSs) is proposed to be held later this year to share learning's on QUM and consider possible improvements to the S100 program.

Box 2. Summary of how Quality Use of Medicines Workplans are developed through the QUMAX Program

How QUMAX Works

ACCHSs are enabled and supported to deliver QUM through an electronic and coordinated workplan – based system. ACCHSs agree to an annual joint workplan with a range of community pharmacies. The activities are costed and agreed upon, based on a financial grant allocated to each participating service. Grants depend on the size of the clinics (number of registered clients in the ACCHS) and range from $10,000 to $87,000 per annum. Workplans are then jointly approved by the Guild and NACCHO Program Managers as well as Department of Health & Aging representative. ACCHSs are funded by the Guild through contracts containing the workplans. At the same time, the Pharmacy Guild provides pharmacists up-front quarterly funding for the DAA costs based on the agreed workplan.

There is 100% participation by all ACCHSs in non-remote locations throughout Australia (73 ACCHSs).

Support for QUM is sourced by ACCHSs from their local nominated community pharmacists as well as a funded State-based QUM Support Pharmacist/s employed by the Pharmacy Guild. NACCHO State Affiliates also receive funding from NACCHO to provide support to ACCHSs in their own jurisdiction for QUM related activities.

Individual ACCHSs can also appoint sessional pharmacists (by allocating their 'QUM pharmacy support' option accordingly) to undertake QUM activity. Pharmacists from community pharmacies can agree to undertake this work, or the ACCHSs may make alternate arrangements if the community pharmacist is unavailable. These appointments will be approved by the Department of Health and Ageing on a case by case basis.

Box 3. Summary of the range of customized and service-specific QUM related activities that can be undertaken through the QUMAX Program

The QUM activities funded through QUMAX include:

- DAA provision.
- QUM pharmacy support *(eg safety net education, QUM training for staff/clients, brokering access to NPS or other QUM programs, promoting Home Medicine Reviews to clients such as elders, advice on medicine stock control, sessional employment of a pharmacists, etc)*
- HMR models of support (*eg establishing specific MHR protocols for the ACCHSs, reimbursement for service orientation provided to the HMR pharmacist, health promotion clinics, reminders for HMR visits, accompanying AHWs to HMR visits)*
- QUM devices to improve medication delivery (*eg asthma spacers,[44] point of care testing etc)*

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[43] Urbis Pty Ltd, Review, 2011.
[44] In conjunction with the Asthma Spacers Ordering Scheme.

- QUM education
- Cultural awareness (eg reimbursement to ACCHSs for cultural training to pharmacies)
- Transport support (eg to assist patients getting to a pharmacy for filling of scripts) or for delivery of scripts or medicines).

Many of the aforementioned reviews have highlighted the need to enhance the provision of pharmacist services to RAAHSs and a role for an academic or career pharmacist.

Recently, the new 'Pharmacist Coalition for Health Reform' expressed concern their services were being underutilized and will push for a role in different models of care.[45] Such models include salaried and sessional positions for pharmacists alongside other primary care staff.[46]

The National Health and Hospitals Reform Commission (NHHRC, 2009) report,[47] signaled some future reforms "within GP-led medical centres which could function as 'one-stop shops' and include, not only general practitioner and nursing care but also access to a range of additional services including pharmacies."[48] However, reforms to the role of pharmacists were not specifically addressed.

These developments are consistent with the views of RAAHSs which recommend pharmacists to be employed within RAAHSs.

A possible enabling strategy for such a role is through the new *Practice Nurse Incentive Program (PNIP)*. The program was announced in May 2010, and aims to contribute $390.3 million to general practices and ACCHSs to employ practice nurses and/or Aboriginal Health Workers per full time equivalent GP. This measure will support Aboriginal Community Controlled Health Services *throughout Australia,* and general practices in urban areas where there are workforce shortages.

Funding will allow ACCHSs to employ a part-time allied health professional, such as a physiotherapist, dietician and occupational therapist, instead of, or in addition to, a practice nurse and/or Aboriginal Health Worker. The DOHA has listed the types of allied health professional eligible under this measure; however, NACCHO noted that *'pharmacists' and 'dentists/ assistants' were not listed.*[49]

NACCHO strongly recommended that the program rules be amended to permit the inclusion of pharmacists for when the PNIP starts on 1st July 2011, but the rules have not

[45] Kelly J. Pharmacists want reform role. The Australian 20 June 2011. Page 7.
[46] Pharmacist Coalition for Health Reform Media release: National pharmacist organisations work together to input to health reform agenda, 17 Nov 2010.
http://www.napsa.org.au/documents/PCHR_media_release_17_Nov_2010.pdf
[47] A healthier future for all Australians,
[48] RPWP report
[49] National Aboriginal Community Controlled Health Organisation. Meeting of the Practice Nurse Incentive Program Technical Working Group. National Aboriginal Community Controlled Health Organisation; 2010 Dec. 3 p.

changed. It is vital this measure be amended to include pharmacists as part of the expanding primary care team.

RECOMMENDATIONS:

- The S100 supply of medicines to ACCHSs has evolved to encompass a range of ancillary programs that support the quality use of medicines (QUM). The often unconnected nature of these programs adds to their complexity for primary health care services. These programs need better integration within primary health care. This can be achieved by the introduction of a scheme to allocate *QUM budgets* to ACCHSs from which services can draw from, and negotiate service-specific activities with community pharmacy or academic pharmacists. The difference between the S100 program handling fee ($2.79) and the PBS dispensing fee ($6.42) per item comprises a PBS underspend that could be used to fund a range of service specific QUM initiatives within remote area ACCHSs.
- Governance for the broad range of QUM programs established to support RAAHSs in the S100 program needs to be improved.
    - This will require the establishment of a broader and multidisciplinary steering committee structure that has significant NACCHO membership, but also includes the involvement of a range of pharmacy groups.
    - In addition, consideration should be given to integrating or creating cross membership between remote-area QUM governance structures with governance committees responsible for QUMAX and the CTG PBS co-payment relief measure (CTG scripts).
    - NACCHO should be invited to be a member of a governance structure to monitor the implementation, uptake and evaluation of the CTG scripts measure, especially in the disaggregation of data between ACCHSs and private general practices.
- Multiple independent reviews have confirmed that a greater level of pharmacist involvement in RAAHSs is needed. RAAHSs should be supported to employ salaried and sessional positions for pharmacists alongside other primary care staff. This can be achieved by transferring responsibility for the payment of QUM related pharmacist services to RAAHSs, as they move towards adopting pharmacists as core members of the primary health care team. Funding sources for these positions needs to be agreed and a range of options considered.
- NACCHO recommends that ‘pharmacists’ be added as additional allied health professionals under the Practice Nurse Incentive Program (PNIP). This will provide the option for ACCHSs to (partly) fund a pharmacist (in any location across Australia).
- Introduce Medicare Rebates for the delivery of pharmacist services within ACCHSs (remote and non-remote) in recognition of their role within the primary health care team. This would support the full/part-time employment of pharmacists to undertake QUM related services and training.

- By expanding existing workforce related schemes, funding provision could be made for more academic pharmacist employment within remote-area ACCHSs. Examples of schemes include the Rural Pharmacy Workforce Program under the 5th Community Pharmacy Agreement; and amendments to the Practice Nurse Incentive Program (by introducing pharmacists in the allied health professional category).
- Introduce a scheme for Medicare Australia to reimburse RAAHSs for dispensing S100 medicines to their clients. The labeling and dispensing activity of RAAHSs is currently not reimbursed. ACCHSs undertake and fund this activity from core service budgets. Funding received under such a scheme could be used towards QUM activity.
- Introduce a coordinated and systematic approach to QUM 'systems support' within remote area ACCHSs by enabling service-specific initiatives through *QUM Budgets and* online QUM workplan development. *QUM budgets* (see above) could be used to subsidise the purchase of labeling equipment or provide QUM training of ACCHSs staff, or the employment of sessional pharmacists (or other uses of a service-specific QUM allocation- see Box 3).
- Regional or State/Territory 'QUM Pharmacists' could be employed within Affiliates or by the Guild (as per the QUMAX Program) to provide local support to remote area ACCHSs in developing service-specific QUM workplans and allocating their QUM budgets. Such an approach would need further consultation with NACCHO, taking into account the role of pharmacists employed locally by ACCHSs.
- A systematic and online approach to remote-area QUM workplan development would improve transparency, enhance workforce support, help ACCHSs to manage a service-specific QUM related budget, improve accountability and Departmental feedback to ACCHSs, and provide more tools to help guide services in the specification of the QUM services they need at a local level. The successes achieved with QUMAX may help inform the systematic application of improved administration and monitoring towards QUM within ACCHSs participating in the S100 program.
- The implementation of an improved administration and monitoring system towards QUM within ACCHSs would require a full time position to be funded within NACCHO to facilitate the establishment of the above quality assurance system.
- NACCHO encourages the Senate Committee to recommend legislative amendments to:
    - overcome the current prohibition to dispensing/filling of Dose Administration Aids (DAA) by pharmacists outside a community pharmacy. (eg Registering remote health clinics as 'pharmacy outstations' was one suggestion, but the feasibility and acceptability of that would need investigation).
    - Align, simplify and revise State Health Poisons Acts and Pharmacy Practice Acts legislation so that barriers in the provision of pharmacy/ist services faced by RAAHSs can be addressed.

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

There are statutory requirements for the labeling of prescription medicines being dispensed.[50] Australian Guidelines for the content of labels on dispensed medicines is shown in Box 4.

Box 4. Guidelines for labeling dispensed medicines. [51]

Guidelines for labeling dispensed medicines

- The label should be clearly and legibly printed in unambiguous and understandable English;
- The brand and generic names of the medicine, the strength, the dose form and the quantity supplied (for extemporaneously prepared medicines and medicines not dispensed by count, the name and strength of each active ingredient, and the name and strength of any added preservatives or the name of the formula as described in a standard reference book);
- Specific directions for use, including frequency and dose
- The patient's name
- The date of dispensing or supply the dispenser's (and if different, the checking pharmacist's) initials
- A unique identifying code
- The name, address and telephone number of the pharmacy or pharmacy department at which the prescription was dispensed
- Storage directions (where important) and expiry date (where applicable)
- The words 'Keep out of reach of children'.

The Nova Review recommended subsidies for RAAHSs for the purchase of labeling equipment, as the Review found many RAAHSs lacked labeling equipment.

However, some ACCHSs (eg in the Kimberley region of WA) have no problems with labeling and monitoring of PBS medicines.

The Kimberley Aboriginal Medical Services Council (KAMSC) operate a regional system of bulk medicine order and supply, with thermal labels generated through the electronic information management system MMEX (web-based e-health record). MMEX assists the pharmacist on site (employed as academic pharmacist and subcontracted through the S100 support allowance) to control stock and check on orders based on a Standard drugs list. Occasions of dispensing are recorded in MMEX, and accessed by doctors anywhere across Kimberley ACCHSs.

RECOMMENDATION:

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[50] The general requirements for medicinal labels are detailed in the Therapeutic Goods Order No. 69, which falls under section 10 of the Therapeutic Goods Act 1989. Source: Commonwealth of Australia. Therapeutic Goods Order No. 69 – General Requirements for Labels for Medicines. Canberra (ACT): Office of Legislative Drafting and Publishing, Attorney-General's Department; 2009 Apr.

[51] Pharmacy Board of Australia. Guidelines for dispensing of Medicines [undated]. www.pharmacyboard.gov.au

- RAAHSs are required (under S100 supply) to dispense and label PBS medicines, and this function should therefore be supported by a QUM-related service-specific budget (see TOR (c)).

(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 its patients;

Previous sections of this submission have described the S100 supply program and ancillary QUM program funding. The distribution of funding through S100 supply program is a function of client demand from RAAHSs and is an uncapped Australian Government provision. Pharmacists and RAAHSs also benefit from other QUM related funding (such as the S100 Support Allowance, amongst other programs - see TOR(c)).

Most of these QUM-related programs supporting S100 medicines supply are funded under the Community Pharmacy Agreement between the Australian Government and the Pharmacy Guild of Australia. Few QUM related programs have a direct funding relationship between the Australian Government and the ACCHSs sector.

Because community pharmacies don’t dispense medicines directly to patients attending S100 sites (GPs, nurses and AHWs dispense within RAAHSs), they receive a lower dispensing fee per medicine from the PBS.

The difference between the S100 program handling fee ($2.79) and the PBS dispensing fee ($6.42) per item comprises a PBS underspend that could be used to fund a range of service specific QUM initiatives within ACCHSs.

This can be achieved by the introduction of a scheme to allocate *QUM budgets* to ACCHSs from which services can draw from, and negotiate service-specific activities with community pharmacy or academic pharmacists.

RECOMMENDATION:

See recommendations pertaining to TOR(c).

(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;

Aboriginal Health Workers (AHWs) do not prescribe medications. With regard to dispensing activity, Certificate IV level trained AHWs are trained to interpret medicine order's accurately, administer medicines safely (including injections), understand and work within the legal framework for medicines use, support client's use of medicines, and dispense medicines under standing orders as required amongst other QUM activity.

All Registered Training Organisations (RTO) that offer the 'Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health care (practice)' must deliver the HLTAHW406A Unit 'Work with Medicines' as it is a compulsory component of this training.

The completion of Cert IV AHW training across Australia is now standardised and provides the skills set necessary for AHWs working with medicines in RAAHSs under the S100 supply program. Cert IV training provides 9 months of exposure to working with medicines within the clinic environment under supervision, and the completion of a 3 week face to face unit in medicines theory including QUM. AHWs are also trained to fill DAA's and label medicines.

In the NT completion of the medicines module is a requirement of AHW CertIV Registration.

The elements of training that will deliver essential outcomes of this Unit of competency include:[52]

- Determining client medication requirements *(contraindications of commonly used medication, maintain medication records, etc)*
- Interpreting orders and instructions for medication, and referring queries appropriately *(including checking written and verbal medication instructions against published medicines information resources)*
- Supporting clients in their use of traditional and western medicines (*identifying generic and brand names of medicines commonly used in Aboriginal health services, providing consumer medicines information, including dosing and side-effects, support clients in obtaining PBS medicines, etc).*
- Administer medicines safely *(identifying dosages, giving injections, identifying adverse events, filling DAAs and labelling medicines in line with statutory requirements, maintain medicines records in line with legal requirements, etc).*
- Transport, store and dispose of medicines *(storage and disposal according to legislative requirements and manufacturers, cold chain transport etc).*

Modules in the Good Medicines Better Health Program (joint NACCHO and the National Prescribing Service (NPS)) provide some of the modules used by AHWs in the Cert IV training delivered by RTOs.

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[52] Source: J Poelina. KAMSC School of Health Studies. Broome WA. [Accessed June 2011].

A number of jurisdictions struggle to meet all the requirements of the Unit because of 'Poisons Acts' regulations often restrict AHWs from administering medicines including paracetamol. However, expert consensus is that most AHWs in RAAHS utilising S100 program would have the requisite skills and knowledge required to undertake these tasks.

Work is also underway in the KAMSC School of Health Studies to develop accredited training towards 'Medication Assistants' whose role would be to undertake supervised dispensing activity and stock control.[53]

But not all ACCHSs have adequately trained staff to undertake stock control, medicines labelling, and dispensing. One ACCHS reported that they had labelling equipment but no trained staff to use it. Another ACCHS reported having labelling equipment but the machine was unreliable, which meant labelling by hand.

Such situations underscore the need for systematic and coordinated programs for supporting remote area ACCHSs, and their workforce, in QUM.

RECOMMENDATIONS:

- Legislative reform and QUM-budgets would assist staff within ACCHSs to undertake their required responsibilities towards dispensing and quality use of medicines. (See TOR(c))
- The employment of pharmacists within ACCHSs (see TOR(c)) would enhance educational opportunities for AHWs towards roles as Medication Assistants or the completion of Cert IV AHW Training.

[53] Personal communication: Sabina Wakerman, KAMSC.

(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;

There has been limited consultation with the ACCHS sector regarding any reforms to the S100 supply program or in negotiations arising for the 5th Community Pharmacy Agreement (for S100 Support Allowance or rural workforce measures).

The new business rules for the S100 support allowance under the 4th Community Pharmacy Agreement were developed in consultation with NACCHO and its State/Territory Affiliates, but there has been no further program consultation.

NACCHO has had an excellent and long-term association with the Pharmacy Guild of Australia and the Department of Health and Ageing (DOHA)- both have partnered with NACCHO in the development and implementation of the S100 supply program, the Support Allowance, and the QUMAX program.

However, there have not been any recent moves by the Pharmacy Guild or the Australian Government to substantially reform any of the S100 related programs. As described previously, over the years, the S100 supply of medicines to ACCHSs has evolved to encompass a range of ancillary programs that support the quality use of medicines (QUM) as well as their supply. The often unconnected nature of these programs adds to their complexity for primary health care services. These programs need better integration within primary health care and this can be achieved by the introduction of a scheme to allocate *QUM budgets* to ACCHSs from which services can draw from, and negotiate service-specific activities with community pharmacy or academic pharmacists (see TOR (c)).

Most of the ACCHSs contacted by NACCHO in the preparation of this submission stated that they received little feedback from community pharmacies regarding progress with S100 (supply or support). ACCHSs reported to NACCHO that they almost never received a response from the DOHA regarding their workplans and that they had to actively seek an opportunity to give the DOHA some feedback.

Through the Community Pharmacy Agreements process, pharmacies are the primary and often sole contact point with DOHA regarding the completion of S100 workplans with RAAHSs. This structure has created a large communication gap in that ACCHSs in remote areas are often disengaged from being active participants in reforming the program. There is a lost of scope for improved communication with ACCHSs in this program.

RECOMMENDATION:

- NACCHO believes that the substantial communication gap that prevents remote area ACCHSs from learning of the outcome of S100 support allowance workplans, and prevents feedback to the Department of Health and Ageing regarding the S100 supply program, can be resolved by the adopting the recommendations pertaining to TOR(c).

(h) access to PBS generally in remote communities;

NACCHO makes the following additional recommendation:

- NACCHO continues to support the evidence-based listing of medicines in the PBS specifically for the Aboriginal and Torres Strait Islander population. NACCHO encourages the Department to invite NACCHO to consult with ACCHSs regarding any additional medicines that might be added to the PBS for this specific population.

(i) any other related matters.

N/A. See above.

3.0 Appendix

Call for Submissions

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

Information about the Inquiry

On 24 March 2011 the Senate referred the following matter to the Senate Community Affairs Committees for inquiry and report.

Submissions should be received by **30 June 2011**. The reporting date is **18 August 2011**.

The Committee is seeking written submissions from interested individuals and organisations **preferably in electronic form submitted online** or sent by email to community.affairs.sen@aph.gov.au as an attached Adobe PDF or MS Word format document. The email must include full postal address and contact details.

Alternatively, written submissions may be sent to:

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Terms of Reference

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

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:

(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;

(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;

(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;

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

(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;

(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;

(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) any other related matters.