Kimberley Aboriginal Medical Services Council Submission to the

Senate Community Affairs Reference Committee inquiry Into the effectiveness of the special arrangements for the supply of Pharmaceutical Benefits Scheme (PBS) medicines to remote area Aboriginal Health Services

July 2011

Glossary of Terms

ACCHS	Aboriginal Community Controlled Health Services
KSDL	Kimberley Standard Drug List
KAMSC	Kimberley Aboriginal Medical Services Council
PBS	Pharmaceutical Benefits Scheme
NPS	National Prescribing Service
QUM	Quality Use of Medicines
KSDL	Kimberley Standard Drug List
CAPTER	(KAMSC) Centre for Aboriginal Primary Health Care Training Education and Research

Introduction

The Kimberley region

The Kimberley region covers over 440,000sqkm of varied landscape in the northwest corner of Western Australia, and includes 3 major towns, 2 smaller townships, and a vast number of remote Aboriginal communities of varying sizes with the largest supporting around 850 people. The climate is tropical with wet and dry seasons, the former increasing the challenges of remoteness and access with roads and airstrips often cut for varying lengths of time during periods of heavier rain and flooding. Aboriginal people comprise almost half the total Kimberley population, but outside of the towns of Broome, Derby and Kununurra, contribute well over 80% of the more remote population.

The Kimberley Aboriginal Medical Services Council (KAMSC)

KAMSC is a regional Aboriginal Community Controlled Health Service (ACCHS) which provides a collective voice for a network of member ACCHS from towns and remote communities across the Kimberley.

A major role is in advocacy and support for independently incorporated member ACCHS services, namely:

1. Ord Valley Aboriginal Health Service (OVAHS) in Kununurra (also servicing the remote communities of Glen Hill, Doon Doon and other communities along and just across the NT border)
2. Yura Yungi Medical Service (YYMS) in Halls Creek (who also operate clinical services in the remote community of Kundat Djaru / Ringer Soak)
3. Derby Aboriginal Health Service (DAHS) in Derby (servicing remote communities of Jarlmadangah, Pandanas Park, and 6 communities along the Gibb River Road)
4. Broome Regional Aboriginal Medical Service (BRAMS) in Broome

KAMSC's regional support for members includes:

- Population Health – data collection, quality improvement support, development of regional best practice protocols and guidelines, and specific program support
- Social and Emotional Well Being workforce support and training
- Health Promotion
- Information Technology
- Pharmacy Support and Training
- Corporate and Financial Services

In addition, KAMSC itself is a direct clinical service provider, responsible for the provision of comprehensive primary health care services in the remote communities of Balgo, Billiluna, Mulan, Beagle Bay and Bidyadanga. KAMSC also hosts all Renal Services for the Kimberley, including 3 satellite dialysis units in the region, and is the lead agency for youth mental health service Headspace Kimberley.

Finally, KAMSC is a major provider of regional health training and education, hosting the KAMSC Centre for Aboriginal Primary Health Care Training Education and Research (CAPTER), bringing together vertically and horizontally integrated health training including:

- Undergraduate medical training in conjunction with the UWA and Notre Dame Universities Rural Clinical School;
- Postgraduate medical training with partner WA GP Education and Training (WAGPET);
- the KAMSC School of Health, a Registered Training Organisation providing VET level training for Aboriginal Health Workers up to Advanced Diploma level, Medication Assistant training (see below), recently introduced Diploma and Graduate Diploma of Counselling, and Advanced Renal Skills Training
- Research – with a full-time UWA Rural Clinical School funded Research Fellow and a multitude of current research grants and projects focused on health and health services based research and regional Aboriginal research capacity building

KAMSC Pharmacy Support Services

In 2003, KAMSC negotiated with the Combined Universities Centre for Rural Health (CUCRH) to secure funding through the Commonwealth's Pharmacy Academic University Departments of Rural Health (PAUDRH) funding stream. This was inadequate to support a Pharmacist in the region, but negotiation with the local retail pharmacy provided access to KAMSC to the section 100 support payments to which KAMSC and its member ACCHS clinics are entitled, and together these two funding sources contributed the opportunity to engage a full-time pharmacist based at KAMSC.

In 2010 the PAUDRH funding to KAMSC was ceased, but the position of KAMSC Pharmacist had already demonstrated its worth many times over, with the contribution to quality use of medicines and regional pharmacy training and support recognised not only within our own services, but by other agencies both inside and outside the Kimberley region.

With this role firmly established as a major KAMSC priority, we were able to maintain the role utilising the ongoing transfer of section 100 support payments to KAMSC from now two retail pharmacies, and patching this together with KAMSC funding from a variety of alternative sources, including a contribution from KAMSC renal support services funding.

Under the contractual agreement with two Kimberley community pharmacies, the solo KAMSC pharmacist delivers Section 100 pharmacy support to 14 remote ACCHSs throughout the region. In addition to standard support elements of the section 100 service, functions also covered through this position include:

- Major contribution to the development, review and maintenance of the regional Kimberley Standard Drug List, referred to later in this document
- Contribution to the development and revision of regional Chronic Disease and Maternal and Child health therapeutic protocols
- Revision and maintenance of KAMSC Standing Orders for AHWs and RNs, including immunisation standing orders
- Ongoing audit and quality improvement activities as well as formal research activities

- Training for new staff and refresher / maintenance of skills for existing staff in the use of the pharmacy management component of the electronic health information system (MMEX)
- Aboriginal health worker training at basic level, and at Advanced Diploma level
- Medication Assistant training and support – KAMSC has now trained through its regional RTO a number of local Aboriginal people to work safely and effectively in KAMSC and member ACCHS dispensaries. Originally KAMSC delivered the national Pharmacy Assistant Cert I-III training packages but found the effort needed to adapt the package for the specific environment in which trainees were working was immense. We have therefore re-developed this package as a Medication Assistant course, designed specifically for work in Aboriginal health service dispensaries, with tailor-made learning resources and progress towards formal course accreditation

Provision of this variety of services across 14 clinics and 440,000sqkm with somewhat tenuous funding clearly poses some challenges.

Response to the specific areas of Reference Committee Inquiry

A. Barriers in accessing essential PBS medicines

KAMSC and affiliated clinics stock a range of PBS medications largely dictated by the Kimberley Standard Drug List. The KSDL is a list of both PBS and non PBS medicines considered essential for the optimum management of patients with both chronic and non chronic conditions. The KSDL was established in 2004 through a collaboration between the KAMSC, the WA Country Health Service (WACHS) and the Kimberley Division of general Practice (KDGP), defining a regionally agreed list of medicines which are either essential for every clinic across the region to keep in stock (essential list), or may be selected through a local decision-making process to stock in response to specific patient population needs (supplementary list).

The KSDL is overseen by a regional committee who undertakes regular reviews, additions and deletions of medicines in response to regional modification requests and evidence of benefit for new medicines to either replace or add to those already listed. A number of the medicines on the KSDL are non PBS listed or non S100 but have been considered efficacious for Kimberley patients and the cost for supply of these is met by the local clinic / health organisation. Clinics have access to PBS medicines from 3 community pharmacies, one in the east and two based in the west Kimberley.

The only barriers we are aware of in accessing essential PBS medicines are that Schedule 8 medicines and Repat schedule items are not accessible through the section 100 scheme and are therefore required to be supplied to patients at a cost to the clinic or to the patient (In Kimberley ACCHS clinics, usually the former)

While there are few barriers to accessing PBS listed medicines, cost is an issue in the supply of non-PBS medicines (and therefore non-section 100 listed medicines) to Aboriginal people in the Kimberley, with the cost currently worn by clinics rather than passing the cost on to the client.

Suggestions:

- That listing on the PBS for Aboriginal and Torres Strait Islander people be expanded with special consideration being given to non S100 medications included in formularies or standard drug lists in remote areas

- that S8 and REPAT items be considered for inclusion in S100

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;

There is no doubt that there has been an increase in access to medications by Aboriginal people in the Kimberley region since the advent of the section 100 supply scheme.

Prior to the introduction of the scheme, ACCHS in this region provided access to medications for Aboriginal people who could not afford to pay for scripts and / or for whom the additional steps required in accessing medications through a retail pharmacy otherwise posed a prohibitive barrier. Medications required for treating acute conditions were generally purchased and stocked on shelves, at significant cost to the local ACCHS who were not funded for this and therefore needed to shift funds from other areas of core business; and / or the cost of a script filled through the local retail pharmacy was billed back to the local ACCHS under an arrangement between services, particularly for e.g. ongoing chronic disease medications.

The advent of the section 100 scheme provided immediate cost sparing for the ACCHS, and clinic managers and staff universally reported relief at being able to support patients to access medications at the point of care, without the burden of having to decide whether or not an individual patient could or should be paying.

Anecdotally patients also expressed relief at being able to avoid the financial burden of medications, particularly for those on multiple chronic / ongoing medications, as well as avoiding the significant inconvenience of having to procure medications from an outlet which in many cases may be some hundreds of kilometres away.

It is difficult to assess exactly what the level of compliance is with medications supplied through the section 100 scheme. We have not yet undertaken a formal investigation of the level of compliance with medications in the region, but we are aware that many clinics handle a large number of unused Websterpaks, and a much smaller number of returned, unused / expired medicines. (Records in the electronic health record (MMEX) dispensed medication history).

Nevertheless, chronic disease prevalence in the region is high, a large proportion of the adult Kimberley Aboriginal population are on regular chronic disease medications, and anecdotally there are many who take the vast majority of doses of their prescribed medications. In some areas of the Kimberley, proxy measures - such as short and medium term chronic disease outcomes including control of blood sugars and blood pressure in people with diabetes – suggest that compliance may actually be reasonably high.

For example, we have recently concluded the data collection and cleaning for an audit of diabetes care in one large ACCHS, following a 10 year cohort. Results suggest that on almost all outcome measures, there have been steady improvements over the last decade, with a high proportion of clients with diabetes now having average to excellent control of blood sugars and similarly good results for BP control. These results are not coupled with a concomitant trend towards lower weight / BMI, suggesting medication plays an important role.

KAMSC is a RTO providing training to Aboriginal Health Workers up to Advanced Diploma. The students cover a specialised Work with Medicines block in cert IV and Manage Medicines at Diploma level. The training results in AHW graduates having an understanding of the role of medications in treating chronic and other conditions together with medication management, the legal requirements and knowledge for safe supply and quality use of medicines (QUM). Trained AHWs are best placed to communicate with, counsel and help clients understand their medications, though in reality time constraints in the clinic can thwart AHWs from satisfactorily counselling patients.

Beyond their formalised training blocks AHWs are provided with continuing education by the pharmacist during support visits. Pharmacists are extensively trained in ordering, dispensing, counselling as well as their legal and professional obligations in relation to medicines, and access for generalist clinic staff including AHWs to this resource for primary training, as well as for continuing support and skills development, is seen as essential and is highly valued by ACCHS in this region.

However, the extent of continuing education is not adequate under the current funding of the S100 pharmacy support program which allows for 2 visits per year. Limited contact during pharmacist support visits to clinics determines the often inadequate extent of additional education provided to clinical staff. The current situation is frustrating for the pharmacist and staff.

Continuing education is recognised by professional registration boards but is not adequately delivered in remote areas of Australia. There is no formalised continuing professional education program for AHWs in Western Australia, although in 2011 KAMSC has been provided with one-off funding to conduct post-graduate professional development for AHWs.

Under the current model the support pharmacist provides an orientation to newly employed RNs and GPs which includes the management of medications in Kimberley ACCHSs. The orientation includes S100, KSDL, MMEx, Standing orders, Chronic Disease Protocols and legal requirements for supply of medications in remote clinics. The orientation can be constrained by time and the capacity of individuals to absorb new information.

Current funding of the S100 pharmacy support program is based on the number of PBS items supplied by a clinic per year. Smaller clinics (< 5000 scripts/year) are therefore not funded to the same extent as those which supply > 5000/year yet the needs of the chronic disease patients are the same, support and education of staff require the same time yet travel to the smaller and often more distant clinics is more time and resource demanding. The S100 support allowance funds the equivalent of 2 annual visits to an AHS. The allowance is grossly inadequate to fund maintaining current standards let alone attempts to improve practice. (The KAMSC pharmacist provides 4 annual visits to clinics, some of which are at KAMSC's cost)

With sufficient funding an ACCHS employed pharmacist could contribute to a decrease in wastage by improving medication management and the consequent saving to the PBS. As part of the primary health team the pharmacist would have direct engagement with clients, educating, counselling and regularly reviewing medications. The pharmacist would also educate clinic staff and the community to help improve health outcomes for Aboriginal people living in remote Australia.

When employing a pharmacist is not economically viable in some clinics then more funding should be made available for a support pharmacist to respond to clinic's needs and visit more regularly. The visits could be used to more comprehensively train clinic staff in medication management, improving staff, community and client's knowledge of chronic diseases and their pharmacological treatment. Pharmacist intervention could contribute to less medical interventions and hospitalisations as well as helping to improve life expectancy for remote Aboriginal people.

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

It is clear in this region that there have been immense benefits in having a full time pharmacist employed through KAMSC, made possible because of the collective bargaining power of ACCHS in this model and the capacity to combine section 100 payments for each site, as well as other sources of funding, in order to do so. We have described to some extent already the role of the KAMSC regional pharmacist in QUM, including driving and supporting the maintenance and revision of the Kimberley Standard Drug List, regional workforce training and support, and specific audit and support activities provided during section 100 site visits.

Many generalist staff working in remote areas are transient. High staff turnover together with inadequate training and support contributes to a less effective QUM. Poor quality of internet service to remote clinics can contribute to the excessive time taken to perform any medication supply or management, placing more time constraints on staff and less time to address QUM.

QUM is incorporated into the course for Aboriginal Health Workers trained at KAMSC. Time permitting the KAMSC pharmacist reinforces QUM principles to AHWs and RNs during S100 support visits. Inadequate resourcing and limited time at clinics means that clinical staff do not have the time nor are they trained thoroughly enough to encourage patient compliance with each patient contact.

The National Prescribing Service (NPS) has created QUM resources as part of their Good Medicines Better Health program. KAMSC provided intellectual property during the development of the resources. Flipcharts, pamphlets, posters and Medicines Lists have been circulated to clinics but it is difficult to quantify the degree of QUM achieved in remote communities.

Nevertheless, this resource is severely restricted in its scope to cover 14 clinics across a vast remote area. There are no locally employed pharmacists in any Kimberley clinic, hence Aboriginal people living in communities outside of Broome, Derby and Kununurra have no direct contact with a pharmacist. In urban Australia there are opportunities for direct one-to-one access to community pharmacists. Community pharmacist provide a substantial number of primary health consultations each year to patients who have scripts filled, buying over-the-counter medications or merely requesting health or medication information. There are a variety of different barriers for urban Aboriginal populations in accessing this resource, but for Aboriginal and Torres Strait Islander people living in remote communities there is virtually no opportunity for contact with a pharmacist at their clinics and consequently no opportunity for the pharmacist to contribute to education and support for patients at an individual or family level.

The burden of chronic diseases is very high in remote Aboriginal communities. Clinics need support and particularly pharmacist services and advice to assist in the care of patients with complex chronic diseases who are often on a myriad of different regular medications. While front-line generalist health providers, particularly Aboriginal Health Workers and now Medication Assistants, have a critical role to play in supporting access and quality use of medicines, their training and experience complements but is not a substitute for the depth of knowledge and expertise which can be provided by a pharmacist, particularly for the vast majority of our service population who experience a heavy burden of chronic illness with onset decades earlier than in non-Aboriginal populations.

Suggestions:

- That there be adequate resourcing of dedicated positions for pharmacists as a component of the primary health care system throughout ACCHS. In regions such as the Kimberley, it has worked well to have a full time pharmacist as a shared position working across services, predominantly supporting local generalists to increase QUM knowledge and skills. But this needs to be expanded to include sufficient resourcing for pharmacists to be able to provide one-to-one medicines review, assessment and counseling for those clients with more complex pharmacy needs;

- The modeling for resourcing of pharmacists in primary health care clinics such as ACCHS needs to take into account (1) throughput of medicines, including anticipated throughput if system efficiency was optimized; and (2) remoteness including distance from retail pharmacies. Even with the collective arrangement operating through KAMSC, the section 100 support payments passed on to KAMSC are not currently sufficient in themselves to support the breadth of activities and contact required across the region.
- Alternative funding models could be considered in the reimbursement process for section 100 implementation – see also next sections

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

All the KAMSC and KAMSC affiliated clinics in the Kimberley have been using an internet-based electronic health information system called MMEx for recording, labeling, stock management and monitoring of medications. MMEx is a comprehensive electronic system which maintains a record of all current, dispensed, archived medications, Websterpaks and their supply to patients. Adhesive medication labels which comply with WA Poisons Regulations are generated using MMEx.

Clinical staff are informed that " It is a legal requirement (*Poisons Regulation 1965 Reg 21*) that all medications which leave the clinic are labeled in accordance with State law" as stated in KAMSC Recommended Policies and Procedures for Use in Kimberley Aboriginal Community Controlled Health Service Dispensaries. In case of power failure clinics have access to pre-printed adhesive labels which also comply with WA regulations.

Adherence to the legislative requirements, as well as to regional dispensary policies and procedures, is monitored locally by clinic managers, with back-up from the regional pharmacist, though the latter is significantly stretched across multiple sites and close monitoring of implementation standards is made challenging.

Suggestion:

We are confident that current arrangements through section 100 supply throughout our clinics are compliant with legislative requirements, though additional resourcing for pharmacist support would enhance capacity to adequately monitor adherence as well as to provide education and support for local service managers and dispensary workers in this regard.

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;

A review of other models for the distribution of funds, particularly funds being made directly to ACCHSs for medication management would be very welcome and is in fact long overdue.

The community pharmacist receives a handling fee for each PBS item supplied to an AHS and a dispensing fee for each prescription processed in a pharmacy. In the AHS trained Aboriginal Health Workers, RNs and GPs devote a considerable proportion of their work time to prescribe, dispense and label medicines as well as counsel patients. Clinical staff do not attract any Medicare payments for doing so. QUM is inherent in the dispensing of PBS medications to patients.

Australian Government policy on QUM states "to achieve quality use of medicines, people must be provided with the most appropriate treatment and have the knowledge and skills to use medicines to their best effect". Pharmacists employed by a remote AHS would be best placed to ensure that remote Aboriginal and Torres Strait Islander people have the opportunity to benefit from the government QUM policy. Direct involvement of a pharmacist in primary patient care and the appropriate use of medicines has been shown to improve health outcomes, reduce health costs of further treatment and unnecessary hospitalisations. Low levels of compliance lead to higher mortality and morbidity.

As described previously, pharmacist support for QUM through education and upskilling of local providers is critical, but the role of pharmacist needs to be extended to include sufficient resourcing to support direct client involvement where medication needs are more complex and / or adherence is very poor.

Models of funding which recognise medication handling in AHS would be welcomed. For example, should remote AHSs receive adequate remuneration from Medicare in the form of a dispensing fee for each PBS item, S100 Support payments together with pharmacy incentive payment for clinical services, services would be well-placed position to enable employment of a pharmacist, whether on a full time basis, part-time basis, or under a shared arrangement across a number of contributing services.

Unfortunately current pharmacy ownership laws in WA preclude remote AHSs from being registered for the purpose of dispensing medicines. Similarly dispensing by pharmacist in unregisters premises i.e. remote clinics is prohibited in WA. It is a curious situation that enables e.g. GPs to dispense but pharmacists who are specialised in this role are prohibited.

Options are for a change to the regulations (section 94 Health Act) or for an exemption to be applied for ACCHS and remote AHSs to enable pharmacist to be permitted to dispense from remote clinics and outstations, as is the case in the Northern Territory.

An additional point regarding the funding of section 100 arrangements relates to the timeliness of payments. 50% of the payment is to be made at the commencement or anniversary of service. 25% to be paid at the end of the first 6 months and the balance of 25%

at the end of 12 months of support. We received the first payment at the beginning of May 2011 for support which has been provided to some clinics since the beginning of January 2011, and understand from the retail pharmacy with whom we have the current on-payment relationship that this was the result of delayed payment to them, and hence forward payment to us. It is not reasonable to expect either the Pharmacy or KAMSC to carry the salary and travel costs of the employed pharmacist for lengthy periods during which work is done but funds not forthcoming.

Suggestions:

- ACCHS and remote AHS clinics are given exemption from registration and ownership requirements for pharmacies so that pharmacists are able to be employed by and work in a pharmacy within these services
- Pharmacists would then be able to dispense, label medications, pack Dosage Administration Aids, counsel patients on their dispensed medications and offer other pharmacy services, at the same time as supporting the development of local dispensary support workers and clinic staff in QUM
- Remuneration for pharmacists employed by an AHS could be based on dispensing fees for PBS items, S100 pharmacy support program payments and pharmacy incentive payments for programs tailored for Aboriginal and Torres Strait Islander people
- The funding cycle needs to be more responsive and payments processed more promptly, and following on from this, reporting should be expected to follow payments

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;

CAPTER (the KAMSC Centre for Primary Health Training Education and Research) provides training for Aboriginal Health Workers in certificate III, IV, Diploma and Advanced Diploma. AHW students are trained in medication management at Certificate III, certificate IV and Advanced Diploma.

AHW graduates are aware of their scope of practice. They have adequate training to allow them to prescribe, dispense and supply S2, S3, S100 and non S100 medications according to the KAMSC Standing Orders or under the direction of a GP. They are able to dispense and supply medications which have been charted by a doctor and according to the policies and procedures established at KAMSC and affiliated clinics.

The Senate Inquiry will be well aware of the nature of Poisons legislation in most states and territories of Australia, which fail to adequately recognize the role of non-GP workforce in management of medicines particularly in remote communities, and this is worth mention though beyond the scope of this document to elaborate on further.

Beyond their formalised training AHWs have the opportunity to attend inservicing at their clinics either by visiting educators or the S100 support pharmacist. The S100 pharmacist is available by phone for advice and support.

While the AHW graduates are well trained during their formalised study and deemed competent to manage medication there is not an established program for refresher courses and continuing professional development, and as described previously, existing Pharmacist resourcing is not sufficient to meet the full breadth of support, training and professional development needs of health staff across the region.

Accredited Pharmacy Assistant has previously been provided through KAMSC, and this is being replaced with a tailor-made, Kimberley-developed Medication Assistant package designed specifically to meet the needs of ACCHS and remote AHS clinics.

Suggestions:

- Specific resourcing be provided to RTOs to provide continuing professional development generally, and in the area of medication management / QUM specifically, for AHWs
- Increasing the capacity for employment and support of Pharmacists in the primary health care setting as described already throughout this document, to enhance opportunities for training and supervision of the local PHC workforce, including AHWs and Medication Assistants
- Opportunities for the development of the model of Medication Assistants, including funding of trainees and positions in local clinic dispensaries, supported with an accredited training package such as that developed by KAMSC expressly for this purpose

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

"Review of the Existing Supply and Remuneration Arrangements for Drugs Listed Under Section 100 of the National Health Act 1953" was conducted by Australian Healthcare Associates in 2009 resulting in no change to the program.

Medicare Australia introduced changes in Section 100 Pharmacy Support program in January 2009. The writing of work plans based on a needs assessment, reporting and payment structure subsequently changed. Concerns regarding delays in payment and the reporting arrangement were discussed previously

H. access to PBS generally in remote communities

Access to PBS medications in the Kimberley is largely timely and comprehensive. Regular and cold chain medications are delivered promptly and securely (weather permitting – occasional extremes such as the widespread severe flooding experienced early this year clearly interrupt supply and pose significant challenges for all concerned). Other reasons for delay in obtaining particular medications arise, but those delays can be experienced in urban areas as well especially when wholesalers are out of stock of a particular medication.

The KAMSC and affiliated clinics have a well-established relationship with community pharmacies in both Broome and Kununurra, which service the east and west Kimberley. Collaboration between the pharmacies has allowed, for example, medicines to be delivered from Broome in the west Kimberley to a clinic normally supplied by the Kununurra pharmacy in the east Kimberley, at a time when the road between the clinic and the supply pharmacy in Kununurra was closed by floods. On occasion we were dependent on the RFDS plane to deliver medicines to clinics cut off by road.

Clinics likely to experience fluctuations in supply during the wet season increase their stock levels before the rains begin to buffer against any unforeseen circumstances.

I. any other related matters.

Section 100 Pharmacy Support Program payments are inadequate to meet the needs of remote clinics. At the current level the KAMSC pharmacist would be able to visit clinics only twice each year. Through ingenuity and close networks in the Kimberley the pharmacist is able to ‘ hitch’ rides to remote clinics to minimise transport costs, however extra accommodation & salary costs are carried by the organisation.

Patients in the remote communities have less access to GPs, hospitals, specialists, allied health and pharmacists. It is these patients with the higher burden of chronic disease who would benefit most from either a pharmacist employed by the AHS or more regular access to a visiting pharmacist.

The transport costs under the S100 Pharmacy Support program are based on the distance from the S100 approved pharmacy to the clinic. The inequity in our situation is that the contracted KAMSC pharmacist must travel for 10 hours by road (each way) to Kununurra to visit a clinic which is 2 kms from the S100 approved pharmacy. We receive no transport costs for those visits.

For example, the cost for a visit to the Tanami Desert and the clinics at Balgo, Billiluna and Mulan are as follows:

1. cost of chartering a plane		$4000
2. accommodation costs for 4 nights @ $150/night		$600
3. meals and allowances at approx $100/day		$400
estimated	TOTAL	$5000

The payments received (late) from Medicare for the above clinics total $13,500 per annum.

It is quickly obvious that the reality of pharmacist support visits to the clinics would not be possible more than twice per year. The support allowance funding is not adequate to raise the level of pharmacy services for Aboriginal people living in the remotes to the standard expected by urban Australians who receive their medicines under section 85 arrangements.

Access to clinics is largely dictated by the weather, particularly the wet season, necessitating travel by air rather than road. Travel to remote clinics is often curtailed by lack of accommodation.

Suggestions:

- A review be done of the real costs associated with remote travel for S100 support visits.
- Travel costs should be paid on the basis of distance and mode of travel from the support pharmacist not S100 approved pharmacy
- S100 support pharmacists be allowed to claim for extra costs of travel and accommodation associated with travel during difficult conditions e.g. seasonal demands for alternative travel arrangements and increased costs of accommodation.

Summary

Under the present S100 pharmacy support program a work plan is written based on a needs assessment for individual clinics i.e. security, medication storage, dispensing, cold chain etc. This is a basic level of service. Little of that relates directly to outcomes for patients. Many of the comments and suggestions made throughout this document emphasise the need for greater access for both clients and providers to high quality support for QUM, and are centred on the need for improved outcomes for patients and their families. A broader view of the nature and scope of pharmacy support services is needed.

Many KAMSC and member service staff have been working in the field long enough to remember the old days when scripts were sent hundreds of kilometres, turn-around time for receipt of medicines could be many days to weeks, patients refrained from trying to have scripts filled for these reasons as well as to avoid the significant cost, and clinics bore the burden of keeping local supplies of medicines likely to be needed for acute presentations. There is no doubt that the advent of the Section 100 scheme has provided significant benefits for our services and communities and has overcome many of these barriers for Aboriginal people in remote locations to accessing medications to education and support for use of medications.

Nevertheless there remains some room for improvement, most particularly in the resourcing and support for services to optimise quality use of medicines.