Submission

Senate

Community Affairs Committee

in response to the

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

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The single greatest clinical intervention in primary health care in this country is the taking of medication.

The Australian Government introduced the Section 100 Remote Aboriginal Health Services Program (S100 RAHSP) for remote area Aboriginal Health Services (AHS's) in 1999. This has proved to be an outstanding success in addressing the issue of supply of medications to Aboriginal and Torres Strait Islanders. Whilst access to medications on the Pharmaceutical Benefit Scheme has been greatly improved, there is still a substantial deficit in the level of other services to the recipients of these medications. The primary reason for this has been the lack of access to professional pharmacy services as a direct result of poor funding models that do not promote the essential services and advice that every Australian deserves and expects from their pharmacist.

These services are generally described in the various standards provided for by the legislation that exists on a State and Federal level and the professional standards set by the National Pharmacy organisations. For the vast majority of Australians their medication is provided to them after a pharmacist has examined their prescription, checked a large number of relevant facts and then dispensed the medication, including recording the patient's name, address and date of birth; the date and origin of the script including the details of the prescriber; labelling the medication with the drug name, strength and quantity, the directions and specific detail for the correct administration the medication and any relevant cautionary and advisory labels; provision of consumer product information in a written form; direct counselling of the patient to check for allergies, interactions and other issues; advice on the importance of compliance; checking past compliance; and advice on lifestyle issues that affect the patient's treatment such as diet, alcohol consumption, smoking and exercise.

When a patient is the recipient of a medication under the S100 RAHSP arrangements, some or all of this advice or service is not provided. Moreover, the burden of advice in these critical areas is passed over to another health worker, be they clinician, nurse, aboriginal health worker or other allied health workers, who are already overloaded with their own important functions.

Over the years there have been a number of reviews that have made recommendations (often repeated) as to how aspects of these services may be improved. Sadly, none have resulted in any meaningful action. One of the few stimulants for improvement has come from the pharmacies that provide these services and the AMSs that receive them, raising the level of service provision at their own cost.

Suggestions for change

1. Clinics with high need for chronic disease underfunded by current funding models

- Funding is based on a handling fee related to the volume of PBS items supplied and does not take into account the increased chronic disease burden that exists from clinic to clinic
- In addition to this, the Pharmacy Support Allowance is also paid to assist in the cost of visiting clinics
- The expectation of the service level provided to clinics has dramatically increased
- The time involved in providing support to clinics with complex chronic disease clients is much greater than in communities with less complex clients
- The greatest potential for patient outcome is by addressing these needs with expert pharmacy advice and service
- These services include, but are not limited to:
    i. Provision of Drug Administration Aids, where medications require repacking to aid patient compliance
    ii. Labelling of original packs with pharmacy labels and cautionary and advisory labels to aid compliance and improve the quality use of medicines
    iii. Patient education by direct advice to clients during clinic visits about their medications and their side effects; interactions with other drugs, alcohol and foods; when they should be taken; how they should be taken
    iv. Medication reviews of chronic disease patients
    v. Clinical interventions
    vi. Patient education to improve chronic disease management through lifestyle
    vii. Regular clinical script audits
    viii. Stock management and Poison Regulation compliance
    ix. Auditing clients with medication changes
    x. Client recalls for script updates
    xi. On call clinical support for medical and clinic staff
- Many of these services need to be available at time that the patient is collecting their medication.
- This will only be achieved by a greater availability of pharmacists in clinics. The first measure to address this is to increase the frequency of visits to these communities,
- Another measure is the use of the Government's new Telehealth initiative to allow connections between clinics and pharmacies and so enable access to a pharmacist for any patient at any clinic.

Suggestion

Funding should be based on the needs of the clients in the community and calculated by the number of patients receiving regular chronic disease medications and the resulting agreed services from the needs assessment and work plan.

Current funding from the S100 arrangements and the Pharmacy Support Allowance are inadequate.

Additional funding should be calculated on the needs of the community independent from the number of PBS items supplied, as this not a reflection of the time, resources, number of visits or level of support provided.

Funding should also be made available for the use of Telehealth facilities for pharmacist consultations, allowing for access to electronic portals in all clinics and outposts connected with their pharmacy service provider.

2. Costs of transport not covered

- The additional $1000 per clinic per year, provided by the Pharmacy Support Allowance if you are required to fly does not even cover the cost of one trip
- The more remote the area, the less access clients have to hospitals, medical officers, specialist staff and pharmacists therefore a **greater** amount of service should be provided from pharmacists around medications, chronic disease, compliance etc
- Currently we rely on free transport from other agencies and private businesses to fly in and out of communities where my only access is air. This is done so that we can visit these especially remote areas which have a very high level of need 8-10 times a year. With the current funding received, we would only be able to go twice a year.
- By using other charters, we have limited input into when these charters fly, therefore frequently having to change schedules, cut visits short, stay longer is some places or leave before we have completed all we wish to as we cannot afford to pay to fly out separately.

Suggestion

In addition to the funding received to provide the service, a separate arrangement should be in place allowing pharmacies to provide receipts and be reimbursed for the cost of transport and accommodation in providing these invaluable services.

3. Poor accountability of service providers

- The impact of remote area pharmacists is significant and at this stage largely unrecognised
- By enforcing documentation of outcomes of services provided as part of the agreed funding arrangement, the impact on clients health outcomes, compliance and overall medication management at a clinic level will be demonstrated
- This accountability will also act to lift the bar on services provided and greatly improve the standard all over the country
- A base standard should be set that is applied regardless of supply pharmacy where all clinics and clients receive the same basic level of service regardless of where there medications come from.

<u>Suggestion</u>

Development of minimum service standards is a must. For each clinic visit, a work plan must be completed and should be submitted with a progress report looking at:

1. **Medication reviews**
2. **Clients engaged**
3. **Compliance survey**
4. **Education provided to health providers and community members**
5. **Interventions conducted**
6. **Feedback from clients and clinic staff**

There is a need to develop Key Performance Indicators for the Pharmacy services provided, and these should form part of the work plan evaluation.

4. Services provided will vary – One size fits all for funding is not appropriate

- The needs assessment is a great tool but could use improvement and be more greatly incorporated into the work plan
- The work plan should be a health service and pharmacy document that is designed with maximum clinic and client input into services provided to ensure these are appropriate, worthwhile and engaging of all stakeholders
- Outcomes from the services should be decided and goals set for clinic and pharmacy staff around medication management, compliance, wastage etc
- The number of visits is then decided and the level of time committed by the pharmacy agreed upon by all stakeholders

Suggestion

These aspects of the work plan – the number of visits, time committed, outcomes required to be reached and complexity of services provided need to be considered in the funding model.

5. Remuneration currently based on the number of PBS items may lead to wastage

- The amount of items supplied is not directly correlated to the level of service provided.
- A large contributor to the wastage of mediations in clinics is due the over ordering of imprest items and the number of imprest items kept in remote areas unnecessarily.
- Significant role of the servicing pharmacist is stock control and imprest management
- This is done by reducing and managing stock levels, monitoring orders and regular review of what items are kept in clinics by using a standard list (e.g. Kimberley Standard Drug List in use in the Kimberley region).
- The outcome of this is less wastage, less expiring medications and less PBS items claimed.
- This results in the funding received for providing S100 support service to be decreased when this role is a significant one in saving money for the PBS.

Suggestion

The current funding model may continue to apply as a suitable model for the supply function, but additional funding should be on a needs basis as described above.

SUMMARY

When not even the travel costs or time costs are covered under the current funding arrangements this significantly limits the services provided and the time available to be committed to this program. The outcome of this situation means:

- Less education around medications,
- Less compliance,
- Poor medication management,
- Reduced health outcomes and
- More PBS items expiring and being underutilised.

The impact in the long term of these services not being funded will be:

- More chronic disease,
- More medications needing to be provided,
- More clients requiring costly medical intervention due to poor compliance in early stages of treatment
- Shorter life expectancies and
- Poor future outcomes for communities as a whole

The trained pharmacist workforce to deliver these services is readily available and would be able to be deployed within a short time frame. All that is required is a very small financial investment to achieve this.

Pharmacists in remote areas are in a unique position to address all of these issues and would have a large impact on:

  - patient outcomes
  - make huge advancements in closing the gap for health
  - improve knowledge around health issues and chronic disease in communities
  - educate other allied health workers on medication management

And all of this is achievable with very little more than time and energy and a comparatively small sum of money.

The residents of these communities throughout remote and regional areas have every right to the same level of service provided to the majority of Australians. Their health and wellbeing is compromised by these omissions.