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Senate inquiry submission:

The effectiveness of the special arrangements established in 1999 under section 100 of the National Health Act 1953 for the supply of PBS medicines to remote area Aboriginal Health Services

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EXECUTIVE SUMMARY

This Senate enquiry seeks submissions on services to remote area Aboriginal Health Services and the use of medicines for the 25% or so of Indigenous Australians who live in remote Australia.

There is considerable evidence that although there has been improvement in the supply of medicines to Indigenous Australians in remote areas over past decade, the current programs and business rules do not achieve desired health or program outcomes. In addition they do not support innovation and largely restrict pharmacy services to the current community pharmacy service delivery model, under the Community Pharmacy Agreement (CPA).

Across Australia pharmacists are the most accessible of all health professionals. Consumers needing medicines or health related advice know where to find a pharmacy and know that a pharmacist will always be present to provide that advice – unless they are an Indigenous Australian living in a remote area.

The most disadvantaged Australians with a heavy chronic disease burden and limited health literacy have reduced access to primary health care and almost no access to a pharmacist. SHPA believes that Indigenous and non-Indigenous Australians should have equal access to a pharmacist irrespective of where they live.

Evidence suggests that the focus of current pharmacy programs remains on improving the distribution and supply of medicines (or stock supply and control) rather than improving the use of medicines for individuals. There is a need to move towards an integrated quality use of medicines (QUM) approach. Such an approach is now the norm in most pharmacy services in hospitals and health services.

In addition to addressing the terms of reference for this enquiry SHPA makes the following recommendations which are discussed in detail in this submission.

1. That Indigenous Australians should be able to have direct access to a pharmacist under separate arrangements and/or in addition to the supply of their medicines.

2. That remote area Aboriginal Health Services should have permanent salaried pharmacist positions to ensure access to a pharmacist, designed to meet the needs of its community.

3. That remote Aboriginal Health Services should receive additional monies so that they can fund permanent salaried pharmacist positions.

4. That remote Aboriginal Health Services should have the option of cashing out existing subsidies to partially fund the direct employment of pharmacists.

5. That remote Aboriginal Health Services should be empowered to directly employ individual pharmacists or contract for the services of pharmacists through any existing pharmacy team or pharmacy practice setting.

6. That the Commonwealth should assist individual remote Aboriginal Health Services in identifying the services needed to support the use of medicines in their community.

7. That the plethora of current funding programs should be streamlined to maximise health outcomes and to improve equitable access, efficiency, consistency and to be inclusive of all healthcare settings.

ACCESS TO PHARMACISTS

Recommendation
1. That Indigenous Australians should be able to have direct access to a pharmacist under separate arrangements and/or in addition to the supply of their medicines.

Across Australia pharmacists are the most accessible of all health professionals. Consumers needing medicines or health related advice know where to find a pharmacy and know that a pharmacist will always be present to provide that advice – unless they are an Indigenous Australian living in a remote area.

The most disadvantaged Australians with a heavy chronic disease burden and limited health literacy have reduced access to primary health care and almost no access to a pharmacist.

As noted in the Campbell Research & Consulting report into Home Medicines Review (HMRs): *"The extremely high incidence of medication misadventure, non-adherence and resulting hospitalisation among Indigenous consumers as well as the flow-on effects such as organ damage and amputations were matters of grave concern to those respondents who work with Indigenous consumers. The co-morbidities because of the lack of adherence to medications were considered to be as high as three to four times that of non-Indigenous consumers."*

There is room for considerable improvement in the services that support the safe and effective use of medicines, delivered in a culturally appropriate manner and setting for Indigenous Australians.

Access to health services and therefore the health of Indigenous communities is influenced by many factors including:

- Indigenous Australians living in remote areas have a chronic disease load five times greater than non-Indigenous Australians.
- Literacy and numeracy skills are generally poor and health literacy is heavily influenced by belief systems.
- Approximately 25% of Indigenous Australians living in remote areas would be considered transient members of the community.
- By definition there is considerable distance to 'usual' primary care services such as community pharmacies.

In addition, **identified barriers to adherence and the effective use of medicines by Indigenous Australians include**:

- health literacy
- the concurrent use of and the replacement of traditional healing remedies (bush medicines)
- cultural issues around the concept of taking a medicines in the absence of any symptom, considerable problem given the wide use of medicines in chronic disease to prevent or reduce harm
- 'shame' involved in accessing medicines in a culturally alienating setting
- issues associated with extended families and multiple carers

- English literacy and the ability to understand instructions
- communication, cultural and behavioural elements and lack of shared knowledge and understanding that impact the success of consultations with mainstream health providers
- what constitutes a reasonable service for the provision of and management of medicines outside mainstream pharmacy services is poorly defined
- lack of appropriate stock control and stock housekeeping systems for medicines
- accessibility of health professionals
- high turnover rates of health professionals

All of the issues and barriers must be specifically addressed if medicines are to be used effectively by individuals. This requires an **ongoing dialogue** between individuals and a health care professional, ideally a pharmacist, about:

- the individual's belief system
- the individual's understanding of their condition and health literacy
- the use of Western style health care
- the use of medicines in general
- using medicines to prevent disease
- using medicines in acute diseases
- using medicines to manage chronic diseases
- ways to support the individual to improve their medication adherence

The inherent and specific barriers to the safe and effective use of medicines for each individual cannot be overcome in one or two conversations. What is needed is a ongoing dialogue between the pharmacist and individuals. A dialogue that encourages communication about the use of medicines, the use of specific medicines, barriers to the use of these medicines and how the health care professional can work with the individual to remove or address these barriers.

Addressing these issues requires multiple conversations initiated by both the individual and the pharmacist. Ready access to pharmacists is essential to overcoming barriers to improving the use of medicines in remote communities.

The Campbell Research & Consulting report acknowledged this need: *"The key request was for recognition of the importance of time to build rapport as part of an effective HMR and that multiple HMRs would enable gradual education and follow-up over time."*

An example that illustrates this point is the use of dose administration aids (DAAs). DAAs are used to assist individuals to remember to take their medicines and to take the correct medicine at the correct time. However a DAA is of no value if the individual does not see the need for these medicines (or indeed the use of any medicine), or if the individual does not have the physical ability to open the container or read the instructions on the container, or if the individual cannot afford to access the medicines that should be in the DAA, or if the medicines in the container differ from those required by that individual.

What is needed is a dialogue that encourages:

- communication about the use of medicines

- the use of specific medicines
- barriers to the use of these medicines and
- how the health care professional can work with the individual to remove or address these barriers

In addition there is a need to recognise that Indigenous Australians do not have access to primary care services offered through community pharmacies. Most remote Indigenous people in remote Australia never set foot in a community pharmacy as it is perhaps 1000kms away. Pharmacists can play an important role as part of the primary healthcare team (e.g. wound management, vaccination programs) but they must be accessible to deliver these services.

The role of pharmacists in hospitals is instructive about the contribution that could be made by an AHS pharmacist. The core business of pharmacists, especially in hospitals is the safe and effective use of medicines. The involvement of pharmacists with this skill set is essential to the safe and effective use of medicines in all populations but particularly important for Indigenous persons as a crucial factor in closing the gap in health outcomes between Indigenous and non-Indigenous Australians.

Pharmacists have been shown to make a difference by using health dollars cost effectively by helping to keep people out of hospital and contributing to prevention activities. Pharmacists want to use their unique knowledge of the safe and effective use of medicines and impact on disease management. They want to continue to complement other health professionals in a team approach.

In recent decades there has been a major shift of the pharmacist's role in hospitals from a mainly supply service to a contemporary model where they spend two-thirds of their time as a medicines expert working in the healthcare team on the care for individual patients. This includes activities to optimise the outcomes from using medicines and also minimising the risk of adverse medication events. Education of patients and other healthcare staff is a vital component.

As well as working one-on-one with patients, **pharmacists work in teams on system-wide approaches**. This means that pharmacists are actively involved in many healthcare teams and if available for remote Australia, typical functions could be:

- Participating in local drug and therapeutics committees to determine which medicines will be used in a healthcare facility [or Aboriginal Health Service (AHS)].
- Developing local prescribing protocols to support the safe use of medicines.
- Administering agreed protocols and 'coaching' prescribers (or Aboriginal Health Workers (AHWs) in AHS) locally, as the pharmacist can actively monitor and review the medicine orders as part of their usual role.
- Undertaking evaluations of the use of certain medicines and working with other healthcare team members (especially AHWs) to improve the use and monitoring of medicines.
- Having a strong focus on appropriate antibiotic use to support safe care and to reduce the emergence of resistant microorganisms.
- Medicines information services via a pharmacist's specialised literature review skills.
- Supporting the establishment and administration of any clinical trials involving medicines.

- Administering requirements for government information about highly specialised drugs and subsidy systems.
- Developing protocols with a focus on the safe use of medicines and avoidance of harm.
- Adverse drug reaction management and recording systems.

SHPA believes that services such as these need to be delivered to support the use of medicines in remote area Aboriginal Health Services.

Pharmacist activities can be considered in three streams:

1. providing clinical pharmacy services to individual patients (e.g. primary care, home medicines reviews)
2. the distribution and supply of medicines to patient care areas and individual patients
3. the management of services including the system-wide services listed above.

Each of these pharmacist activity streams has a specific focus and all are required concurrently to ensure the safe and effective use of medicines.

The business rules for the plethora of Commonwealth funded programs for Indigenous Australians do not encourage, and in many ways discourage, an integrated and comprehensive pharmacy service. In addition they **do not allow a tailored service suitable for individual communities nor do these programs support innovation**.

PERMANENT SALARIED PHARMACIST POSITIONS

Recommendation
2. That remote area Aboriginal Health Services should have permanent salaried pharmacist positions to ensure access to a pharmacist, designed to meet the needs of its community.

A model that should be seriously considered is where salaried clinical pharmacists are employed by, or contracted to, AHS to provide clinical and system-wide services to each community based on the clinical need of the individuals in the community.

SHPA believes that AHS pharmacists could:

- act as a community resource able to be accessed when required (primarily through face-to-face contact)
- provide clinical pharmacy services to all members of the community
- provide primary care services including the use of over the counter medicines (e.g. treatment of scabies)
- use standardised assessment tools to identify community members who have difficulties with using medicines (e.g. reading labels, opening containers, using inhalers)
- maintain and update pictorial medication lists for all community members. This list would act as a prompt for the individual, a record of current medications for health care professionals and could possibly be used as part of audit activities
- use standardised assessment tools identify community members who would benefit from a medication review
- fill / maintain appropriate records of dose administration aids
- record information given to individuals about the use of medicines (e.g. consumer medicines information, self care information) and record feedback from patients about their use of medicines, both would inform other health care professionals and assist with tailoring counselling services or medication reviews

The AHS pharmacist would also act as an additional resource for AHWs, particularly through teaching and training. AHS pharmacists would work in partnership with AHWs when undertaking counselling and HMR activities with individual patients or looking at system-wide issues that impact on the use of medicines in that community.

In addition as the AHW is part of the discussion with the patient they have a clearer understanding of the patient's use of their medicines, strategies to assist them with their medicines use, the further support they could offer that individual and identify any information that should be shared with other members of the healthcare team.

This team approach is crucial to providing timely, accessible, and cultural and gender appropriate pharmacy services.

Experience in the hospital sector with locum pharmacists in rural areas has taught us that it is easier to attract pharmacists to a team environment where they are have access to usual employment conditions and workplace support than it is to attract sole practitioners who must continually look for the 'next job' with fluctuating cash flow and no allowance for leave, attending professional development activities etc.

Being a salaried employee working as part of a team is attractive to pharmacists as they:

- are permanent employees with access to usual employment terms and conditions (e.g. annual leave, long service leave)
- work as part of a pharmacy team as well as the AHS team
- are covered during periods of leave
- would be acknowledged as working in a specialised field and
- are supported in their day-to-day work and professional development opportunities through the pharmacy department of the hospital.

SHPA believes that pharmacists should be included in the range of health professionals considered by the Aboriginal and Torres Strait Islander Health Workforce Working Group (ATSIHWWG). Pharmacists should be seen as part of the Aboriginal and Torres Strait Islander health workforce, especially for roles separate from the 'supply of medicines'. Pharmacists should be included in the national strategic framework to build a competent health workforce to address the health needs of Indigenous Australians.

The ATSIHWWG could also consider supporting the training of intern pharmacists to encourage more pharmacists to choose a career in Indigenous health.

Experience in the hospital sector has proven that pharmacy graduates are more likely to choose a career in the hospital sector if they have exposure to that sector during their intern training. Supporting intern training positions shared between 'local' hospitals and an AHS would expose pharmacy graduates to Indigenous health and over time build a pharmacist workforce with a focus on Indigenous health.

FUNDING OF PERMANENT SALARIED PHARMACIST POSITIONS

Recommendations
3. That remote Aboriginal Health Services should receive additional monies so that they can fund permanent salaried pharmacist positions.

4. That remote Aboriginal Health Services should have the option of cashing out existing subsidies to partially fund the direct employment of pharmacists.

5. That remote Aboriginal Health Services should be empowered to directly employ individual pharmacists or contract for the services of pharmacists through any existing pharmacy team or pharmacy practice setting.

6. That the Commonwealth should assist individual remote Aboriginal Health Services in identifying the services needed to support the use of medicines in their community.

A strong relationship between the pharmacist and AHS is required to maximise the benefits of the current Section 100 support program.

Where this relationship is strong pharmacists have moved to providing clinical services to individual patients and HMRs. In fact several AHSs employ pharmacists to provide clinical services outside the Section 100 support program.

The *Evaluation of Indigenous Pharmacy Programs* by Nova Public Policy and other reviews have highlighted the advantages of a direct employment model for pharmacists. In this model the pharmacist would sit within the AHS and give immediate advice about adherence issues, provide counselling and assistance before and after the patient sees the doctor, undertake home visits when appropriate and supporting AHWs looking after the supply of medicines to the community.

The *Evaluation of Indigenous Pharmacy Programs* also noted that options for improving the funding of pharmacy programs included: "To provide an option of cashing out existing subsidies to make possible direct employment of pharmacists." SHPA believes the business rules governing the Section 100 Pharmacy Support Allowance Program and HMRs should be reviewed to allow AHSs to cash out funding for pharmacist services outside the supply of medicines. This would allow AHSs to directly employ pharmacists or access a pharmacist from a pharmacy team that specialises in Aboriginal health (possibly through a local public hospital).

The variability in the extent and level of service currently available to AHSs means that many AHSs have a limited understanding of what a pharmacist can offer to members of their community. The *Evaluation of Indigenous Pharmacy Programs* notes that **there are no standards related to the types of support that is delivered by pharmacists through the program and the same package is applied to all AHSs irrespective of local conditions**. In addition the current system does not adequately manage for performance of community pharmacies providing Section 100 support program services.

SHPA believes the Commonwealth should assist individual remote AHSs in reviewing the pharmacist (and associated) services offered to support the safe and effective use of medicines in their community and identifying improvements that are required.

Independent pharmacists (i.e. not eligible to provide any services to the individual AHS) could provide advice about the community's requirements and ways to improve the services already provided by pharmacists to that community. This process should sit outside the Community Pharmacy Agreement (CPA) arrangements.

The following information would need to be quantified to undertake such an assessment:

- the level of chronic disease burden (e.g. the number of individuals with chronic disease plans)
- the level of health and English literacy in the community
- the number of transient members of the community and how these individuals could access services
- how many people meet HMR criteria and would receive HMR services if they lived in urban Australia?
- how many people require or should have Dose Administration Aids?
- how many people require or should have medication lists provided to support their use of medicines?
- how many people require medicines outside the PBS or Section 100 supply arrangements?
- are there issues relating to the timeliness and cost of medicines supply?
- what are the cultural and social issues that are impacting on the use of medicines in their community?

In addition AHSs need to undertake a census of the AHWs skills, training, qualifications and their current role. How these workers can support the safe and effective use of medicines in their community can then be articulated and gaps in service delivery identified.

Together these allow the AHS to identify what is required from pharmacists and AHWs to support the health needs of their community. It also provides the AHS with the information required to inform decisions about the quality of current services, managing current services and contracts, if there is a case for cashing out existing subsidies or how to directly employ pharmacists to provide these services.

A new approach is needed to attract and retain pharmacists to this sector**.** What is needed is a group of pharmacists who want to work in the bush full time. SHPA believes that teams of clinical pharmacists employed directly by AHSs or through a contract arrangement with another employer (e.g. a hospital or community pharmacy) would encourage pharmacists to have an interest in Indigenous health. Once they have experience in the sector they should be supported to remain in the sector through workplace support and professional development activities. As noted earlier there is also a need to support the training of intern pharmacists to encourage more pharmacists to choose a career in Indigenous health.

There are a handful of salaried pharmacists already providing clinical services through AHSs and others providing services through the HMR program. Their experience suggests that given the substantial chronic disease load and the level of health literacy (both drive the number of conversations required to build trust and understanding), the number of clinics offered by AHSs, and the transient nature of many communities one full-time pharmacist could provide services to a the maximum 1,000 persons.

The number of individuals covered by one full time pharmacist would need to be adjusted if there were additional factors such as considerable distances between clinics, poor literacy and numeracy skills, degree of mental health issues in the population etc.

As 25% of Indigenous Australians (between 125,000-130,000 Australians) are thought to live in remote areas this implies that at around 125 (100-150) full time salaried pharmacists would be required to offer a comprehensive and accessible pharmacy service to these communities.

Indigenous Australians in remote areas require the same access to pharmacists as Australians living in rural and urban Australia. They need access to **100-150 pharmacists** who can provide them with the same primary care and clinical pharmacy services their rural and urban counterparts receive from community and hospital based pharmacists.

As recommended in previous reviews and evaluations, the business rules of Commonwealth funded programs (outside the supply of medicines) should allow service provision from individual pharmacists and pharmacy services, rather than be limited to section 90 community pharmacies (i.e. those covered under the Community Pharmacy Agreement).

STREAMLINING CURRENT PLETHORA OF FUNDING PROGRAMS

Recommendation
7. That the plethora of current funding programs should be streamlined to maximise health outcomes and to improve equitable access, efficiency, consistency and to be inclusive of all healthcare settings.

Indigenous Australians need an approach that focuses on needs of their community and individuals. Currently services are artificially driven by business rules that do not support policy objectives. In addition they restrict pharmacy services to the current community pharmacy service delivery model and do not support innovation.

For example the primary aim of the Close the Gap PBS copayment (CTG) is to improve health outcomes through better access to PBS listed medicines. However the program is only open to Indigenous Australians when they attend an Aboriginal Community Controlled Health Services (ACCHS) in rural or urban Australia, **not when they receive care through a remote AHS or a public hospital.** The same individual may be exempt from or have to pay a copayment based purely on where they see a doctor or pharmacist.

Similarly, in theory all Indigenous Australians have access to the Home Medicine Review (HMR) program. In practice access for individuals in remote areas is limited by:

- access to an AHW to support the pharmacist undertaking the HMR acting as a cultural and lingual translator and being a resource on bush medicines
- the high numbers of transient members of the community
- the current business rules that require referral from a GP
- access to a suitably qualified and credentialed pharmacist
- access to the patient's medical record before and after the HMR
- completeness of patient's medical records with respect to medicines prescribed and supplied

Access would be improved if AHS staff could refer individuals for HMRs, directly to an accredited pharmacist who works at the AHS. (If the AHS had a salaried pharmacist they could provide this service as part of their role removing the need to claim HMR funding on an individual patient basis.)

The Campbell Research & Consulting report noted that a redesigned model for HMRs that could be considered was linkages through the chronic disease register and pooled funding via the AHS so that Indigenous patients could access in-clinic or regular visits by a pharmacist.

The current CPA programs have been developed with little, if any, consultation with pharmacists and pharmacy organisations outside the Pharmacy Guild of Australia through consecutive CPAs. In practice the business rules of most programs effectively restrict the choice of pharmacy providers to Section 90 community pharmacies or pharmacists employed in / through these pharmacies. They actively exclude the provision of services by individual pharmacists or from a pharmacy team that specialises in Aboriginal health.

All of the current pharmacy programs are funded on an input rather than an output or outcome basis. No programs are based on the needs (perceived or actual) of individuals or the community as a whole.

There is a need to move towards an integrated quality use of medicines (QUM) approach (which means: selecting management options wisely; choosing suitable medicines if a medicine is considered necessary; and using medicines safely and effectively). Evidence suggests that the focus of current programs remains on improving the distribution and supply of medicines or stock control (only one of the barriers listed) rather than the other structural, cultural and individual patient barriers.

The *Evaluation of Indigenous Pharmacy Programs* by Nova Public Policy highlighted that under the section 100 Support Program the following services are being provided:

- audit processes
- getting drug rooms functional
- improving security
- checking of stock levels and currency
- examination of storage and handling facilities
- support of appropriate supply practices including checking and labelling of products

All of these relate to the **supply** of medicines.

The report also noted that the following activities were offered to a much lesser extent:

- advice on individual patient medication regimens
- checking of medication charts
- case conferences
- home medicines reviews

All of these support integrated QUM.

AHSs want pharmacists to deliver more HMRs (or services like HMRs), visit their communities more often and provide more education to both their staff and community members. In the *Evaluation of Indigenous Pharmacy Programs* it was also discussed how AHSs are accessing clinical pharmacist and system-wide service through recurrent funding, accessing mainstream HMR services and contracting the local public hospital to provide additional pharmacist support.

There is considerable evidence that although there has been improvement in the supply of medicines to Indigenous Australians in remote areas over past decade the current programs and business rules do not achieve desired outcomes.

SHPA believes that the use of medicines and health outcomes for Indigenous Australians could be improved by the better use of, and improved access to, the plethora of pharmacy and aboriginal health programs already available.

Access to medicines through the Special Section 100 supply arrangements for AHSs in remote areas need to continue. However there is room for considerable improvement in the services that support the safe and effective use of medicines, delivered in a culturally appropriate manner and setting, for Indigenous Australians.

As recommended in previous reviews and evaluations, **the business rules of Commonwealth funded programs (outside the supply of medicines) should allow service provision from individual pharmacists and pharmacy services outside section 90 community pharmacies**. This includes the following programs:

- Section 100 support program – AHSs should be able to directly employ pharmacists or contract with individual pharmacists or pharmacy teams to provide the clinical and system-wide QUM services covered in this program
- Home Medication Reviews (HMRs) – AHSs should be able to refer patients for HMRs and contract with individual pharmacists or pharmacy teams to provide HMRs

- Dose Administration Aid Program – AHSs should be able to access monies to provide DAA services where appropriate
- Aboriginal and Torres Strait Islander Pharmacy Scholarship Scheme (ATSIPSS) - should be expanded to include hospital based intern positions
- Aboriginal and Torres Strait Islander Pharmacy Apprenticeship Scheme (ATISPATS) – the competencies and qualifications required should be reviewed and access should be expanded to include hospital based training opportunities

The *Guidelines and Standards for pharmacists for the provision of pharmacy services to Aboriginal and Islander health services* is a key document describing the range and extent of pharmacist activities that should be provided through AHSs. This document requires some updating: specifically minimum service requirements should be detailed.

The sample pharmaceutical services contract is unclear about the extent of clinical and system-wide pharmacist activities that will be delivered and does not clearly define how the AHS or pharmacist will decide which services will be offered to individuals or how individuals that require particular services will be identified. There is a lack of accountability. Reasonable or poor service delivery cannot be defined on the basis of this sample contract.

The *Business Rules for Section 100 Pharmacy Support Allowance Program* is far from definitive and allows community pharmacies to claim monies for services that may or may not be delivered. In addition under the *Business Rules for Section 100 Pharmacy Support Allowance Program* the AHS does not have the ability to withhold monies for lack of service delivery or poor service delivery.

Restrictions of payment to Section 90 community pharmacies in these business rules should be removed. In addition, the business rules should state that to be eligible for full funding the contracted pharmacist / pharmacy must deliver all contracted services, language such as ‘could provide’ or ‘where possible’ should be removed where full funding is sought.

The Outreach Pharmacists for Remote AHSs program (OPRAH) should reflect the *Guidelines and Standards for pharmacists for the provision of pharmacy services to Aboriginal and Islander health services*

SHPA RESPONSE TO TERMS OF REFERENCE

In addition to our general submission SHPA offers the following specific comments on the special arrangements established in 1999 under Section 100 of the National Health Act 1953.

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

(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.

In practice the current arrangements do not adequately addresses the barriers experienced by Indigenous Australians living in remote areas of Australia in accessing essential medicines through the PBS.

The physical supply of medicines has been improved by the special arrangements established in 1999 under Section 100 of the National Health Act. However the level of service provision relating to:

- the physical supply process
- the presentation of medicines
- devices that assist with the better use of medicines and
- the counselling about the use of each medicine

are not comparable with services available to (and expected by) non-Indigenous Australians or Australians living in rural and urban Australia.

Contact with a pharmacist in a culturally appropriate setting remains problematic in many urban, rural and remote locations. Indigenous Australians in remote locations have limited access to pharmacist counselling and medication review services. This is impacting on the quality use of medicines for Indigenous Australians especially patient understanding of and adherence to prescribed treatment.

(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.

SHPA is unaware of any data that suggests an improvement in patients' understanding of medicines or adherence to medicines prescribed as a result of improved access to PBS medicines.

Access to medicines is crucial to allow adherence to prescribed treatment but availability of the physical product does not ensure adherence. Many issues and barriers must be specifically addressed to improve medication adherence. This requires an **ongoing dialogue** between individuals and a healthcare professional, ideally a pharmacist, about:

- the individual's belief system
- the individual's understanding of their condition and health literacy
- the use of Western style health care
- the use of medicines in general

- using medicines to prevent disease
- using medicines in acute diseases
- using medicines to manage chronic diseases
- ways to support the individual to improve each individual's medication adherence

Indigenous Australians in remote locations do not enjoy the benefits of contemporary pharmacy practice. They have extremely limited access to pharmacist counselling and medication review services and other activities pharmacists perform to optimise the outcomes from using medicines and minimising the risk of adverse medication events.

Few Indigenous Australians in remote areas have access to advice from a pharmacist or services such as HMRs. This is impacting on the quality use of medicines for Indigenous Australians especially patient understanding of and adherence to prescribed treatment.

(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.

The evidence suggests that the focus of current pharmacy programs remains on improving the distribution and supply of medicines or stock control rather than improving the use of medicines for individuals.

The *Evaluation of Indigenous Pharmacy Programs* by Nova Public Policy highlighted that under the section 100 Support Program the following services are being provided:

- audit processes
- getting drug rooms functional
- improving security
- checking of stock levels and currency
- examination of storage and handling facilities
- support of appropriate supply practices including checking and labelling of products

All of these relate to the supply of medicines.

The report also noted that the following activities were offered to a lesser extent

- advice on individual patient medication regimens
- checking of medication charts
- case conferences
- home medicines reviews

All of these support the quality use of medicine (QUM).

There is a need to move towards an integrated QUM approach - that is pharmacist services that support: selecting management options wisely; choosing suitable medicines if a medicine is considered necessary; and using medicines safely and effectively.

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

The level of service provision relating to:

- the physical supply process
- the labelling and presentation of medicines
- devices that assist with the better use of medicines
- the counselling about the use of each medicine and

- record keeping

are not comparable with services available to non-Indigenous Australians or Australians living in rural and urban Australia.

Pharmacists are required to dispense medicines in accordance with Guidelines published by the Pharmacy Board of Australia (available at http://www.pharmacyboard.gov.au/Codes-and-Guidelines.aspx). SHPA understands that the majority of medicines supplied through Aboriginal Health Services are not provided to this standard / level of care.

(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.

SHPA notes that the mandatory linking of funding for clinical pharmacist services and system-wide services with the supply of medicines through current programs has not supported an integrated QUM approach, appropriate record keeping or the appropriate delivery services within Aboriginal Health Services.

There is a disconnect between the payment of a dispensing fee and the actual provision of a medicine with advice and counselling to the patients. Dispensing fees are not paid if a medicine is dispensed through an Aboriginal Health Service which limits the Service's ability to provide medicines presented and labelled to the same standard expected / delivered in the general community. A dispensing fee is paid when the prescription is supplied through a community pharmacy but as the pharmacist is not located within the patient's community there is no communication between the patient and the pharmacist.

This is why SHPA has recommended that Indigenous Australians should be able to have direct access to a pharmacist under separate arrangements and/or in addition to the supply of their medicines.

(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 (AHW) perform medicine distribution activities for their community. Few have the literacy and numeracy skills, qualifications or training equivalent to pharmacy support staff in community pharmacies or hospitals.

The *Evaluation of Indigenous Pharmacy Programs* by Nova Public Policy notes that a dedicated and suitably trained and qualified AHW is critical to the safe distribution and supply of medicines. A lack of suitably trained and qualified staff is thought to be a major impediment to safe and effective use of medicines for Indigenous Australians living in rural and remote areas.

SHPA understands that at this time the skills, capabilities and qualifications of AHW in remote areas lag behind those of AHWs in rural and urban AHSs. This is limiting the impact of AHW in supporting their communities.

There is an urgent need to improve the literacy and skills of AHW in remote areas, particularly in their role of manage the ordering, distribution and supply of medicines (through the contracted community / hospital pharmacy) for their community.

SHPA has provided suggestions and advice about the current and future role of Aboriginal Health Workers and the training and support required to realise the potential of this

workforce to support the better use of medicines in their community based on our experience with hospital pharmacy technicians. These are detailed in Appendix B.

(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 remains room for considerable improvement in the services that support the safe and effective use of medicines delivered in a culturally appropriate manner and setting for Indigenous Australians.

All of the issues raised in this submission have been highlighted in numerous reviews, evaluations and published literature yet the business rules driving services have not been altered to allow all pharmacists to offer services to AHSs nor allow AHSs to adequately identify and manage the pharmacist services required by their community. Changes have been minor and have continued the focus on the supply of medicines rather than the use of medicines.

(h) Access to PBS generally in remote communities.

The issues identified in previous reviews and evaluations remain. The appropriate use of PBS listed medicines is limited by:

- culture and belief systems
- health literacy
- access to primary healthcare professionals including pharmacists
- the timeliness of supply
- the safe supply of the medicines and
- the individual's ability to afford copayments (this has been addressed through current supply arrangements)

Current programs focus on the supply of medicines and in essence ignore the other factors that impact on the use of medicines.

(i) Any other related matters.

Indigenous Australians need an approach that focuses on needs of their community and individuals. Currently services are artificially driven by business rules that do not support policy objectives. In addition they restrict pharmacy services to the current community pharmacy service delivery model and do not support innovation.

The plethora of current funding programs should be streamlined to maximise health outcomes and to improve equitable access, efficiency, consistency and to be inclusive of all healthcare settings.

APPENDIX A: SHPA'S UNDERSTANDING OF CURRENT SERVICES AND PROGRAMS

About SHPA

The Society of Hospital Pharmacists of Australia (SHPA) is the national professional organisation for 3,000 pharmacists, pharmacists in training, pharmacy technicians and associates working across Australia's health system. SHPA is the only professional pharmacy organisation with a core base of members practising in public and private hospitals and other health service facilities. These pharmacists work within healthcare teams with a focus on supporting the safe and effective use of medicines as their core business.

The use of medicines by Indigenous Australians

SHPA acknowledges the National Aboriginal Community Controlled Health Organisation (NAHHCO) definition of Aboriginal health, that health is not just the physical well-being of an individual but the social, emotional and cultural well-being of a whole community in which each individual is able to achieve their full potential as a human being.

The majority of Aboriginal deaths occur in middle age. In all the major diseases causing premature death among Indigenous people, pharmacological treatment is advised. *"Circulatory and respiratory diseases, diabetes, musculoskeletal conditions, kidney disease and mental and behavioural disorders are conditions that account for most consultations with GPs for Indigenous people. The prevalence of diabetes in the Indigenous population if four times that of the non-Indigenous population. These are all conditions that, more often than not, require continuous pharmacological therapy, along with constant lifestyle advice."*

Access to health services and therefore the health of Indigenous communities, is influenced by many factors including:

- Indigenous Australians living in remote areas have a chronic disease load five times greater than non-Indigenous Australians.
- Literacy and numeracy skills are generally poor and health literacy is influenced by belief systems.
- Approximately 25% of Indigenous Australians living in remote areas would be considered transient members of the community.
- By definition there is considerable distance to 'usual' primary care services such as community pharmacies.

In addition, identified barriers to adherence and the effective use of medicines by Indigenous Australians include:

- health literacy
- the concurrent use of and the replacement of traditional healing remedies (bush medicines)
- cultural issues around the concept of taking medicines in the absence of any symptom, considerable problem given the wide use of medicines in chronic disease to prevent or reduce harm
- 'shame' involved in accessing medicines in a culturally alienating setting
- issues associated with extended families and multiple carers
- English literacy and the ability to understand instructions

- safety net scheme attached to the PBS is impractical
- communication, cultural and behavioural elements and lack of shared knowledge and understanding that impact the success of consultations with mainstream health providers
- what constitutes a reasonable service for the provision of and management of medicines outside mainstream pharmacy services is poorly defined
- lack of appropriate stock control and stock housekeeping systems for medicines
- accessibility of health professionals
- high turnover rates of health professionals

All of these issues and barriers must be specifically addressed if medicines are to be used effectively by individuals. This requires an ongoing dialogue between individuals and a healthcare professional, ideally a pharmacist, about:

- the individual's belief system
- the individual's understanding of their condition and health literacy
- the use of Western style health care
- the use of medicines in general
- using medicines to prevent disease
- using medicines in acute diseases
- using medicines to manage chronic diseases
- ways to support the individual to improve their medication adherence

Aboriginal Health Services

SHPA understands and supports the need for two essential complementary strategies to improve the use of medicines (and therefore health outcomes) for Indigenous Australians:

1. to increase the capacity of AHSs and
2. to enhance the accessibility of mainstream services

SHPA notes that not all AHSs are ACCHS and that there are differences between services required in remote, rural and metropolitan areas. However the same principles should apply and the same range of pharmacist services should be available irrespective of the ownership or the management structure of an individual AHS or the pharmacy service.

As this Senate enquiry seeks submissions on services to remote area AHSs this submission focuses on the use of medicines for the 25% or so of Indigenous Australians who live in remote Australia (estimated 125,000-130,000 Australians). SHPA believes that the principles discussed in this submission are equally applicable to Indigenous and non-Indigenous Australians; irrespective of where the live.

Special S100 supply program

This program details special supply arrangements for PBS medicines to approved remote area AHSs. The arrangements seek to address identified barriers to access of essential medicines. The program provides monies for the supply of PBS medicines to Indigenous Australians accessing services through AHSs in remote areas. Medicines may be dispensed directly to patients through the community pharmacy (or in some cases through a Section 94 hospital pharmacy) or supplied in bulk to the AHS which is then responsible for the supply of these medicines to individual patients.

Access to medicines through the Special Section 100 supply arrangements for Aboriginal Health Services in remote areas needs to continue. However there is a disconnect between the payment of a dispensing fee and the actual provision of a medicine with advice and counselling to the patients under the current arrangements.

Dispensing fees are not paid if a medicine is dispensed through an AHS which limits the Service's ability to provide medicines presented and labelled to the same standard expected / delivered in the general community. A dispensing fee is paid when the prescription is supplied through a community pharmacy but, as the pharmacist is not located within the patient's community, there is no communication between the patient and the pharmacist.

S100 Support program

This program provides payment of an allowance to a Section 90 community pharmacy for a pharmacist to deliver support services to remote area AHSs. The objective of the program is to improve the quality use of medicines in these communities which means: selecting management options wisely; choosing suitable medicines if a medicine is considered necessary; and using medicines safely and effectively.

Services funded through this program should seek to address the structural and individual barriers to adherence and the effective use of medicines by Indigenous Australians listed earlier. However the evidence suggests that many services funded through the program are minimal at best and focus on the supply of medicines rather than the use of these medicines.

The S100 support program has limited to impact upon barriers to adherence and the effective use of medicines as access to pharmacist is limited to occasional visits to the AHS. There is no scope for an ongoing dialogue between individuals and pharmacists to support the effective use of medicines for that individual.

In addition, there is a disconnection between funding and accountability; community pharmacies can receive payment on signing an agreement with the AHS, this is not linked to actual service provision or the quality of the services provided.

Home medicines review (HMRs)

As noted in the Campbell Research & Consulting report into Home Medicines Review (HMRs): *"The extremely high incidence of medication misadventure, non-adherence and resulting hospitalisation among Indigenous consumers as well as the flow-on effects such as organ damage and amputations were matters of grave concern to those respondents who work with Indigenous consumers. The co-morbidities because of the lack of adherence to medications were considered to be as high as three to four times that of non-Indigenous consumers."*

The report also noted: *"The key request was for recognition of the importance of time to build rapport as part of an effective HMR and that multiple HMRs would enable gradual education and follow-up over time."*

In theory all Indigenous Australians have access to the HMR program. In practice access for Indigenous Australians in remote areas is limited by:

- access to a AHW to support the pharmacist undertaking the HMR acting as a cultural and lingual translator and being a resource on bush medicines
- the high numbers of transient members of the community
- the current business rules that require referral from a GP

- access to a suitably qualified and credentialed pharmacist
- access to the patient's medical record before and after the HMR
- completeness of patient's medical records with respect to medicines prescribed and supplied

Under the 4th CPA the HMR program was reviewed and a sub-committee established in May 2009 to develop recommendations on how to address issues of targeting, effectiveness and timeliness of HMRs. There was a focus on 'at risk' groups e.g. those discharged from hospitals and Aboriginal and Torres Strait Islanders, as well as including an option for GPs to directly refer to a pharmacist of their choice, with consumer consent etc.

SHPA understands that changes to the HMR program are scheduled for 'sometime' during the 5th CPA. SHPA believes these changes should be immediately actioned to improve access to HMRs for Indigenous Australians living in remote areas.

Access to HMRs would be improved if AHS staff could refer individuals for HMR directly to an accredited pharmacist who works at the AHS. (If the AHS had a salaried pharmacist they could provide this service as part of their role removing the need to claim HMR funding on an individual patient basis.)

Close the Gap (CTG)

The primary aim of the CTG program is to improve the health outcomes of Indigenous Australians attending ACCHSs in rural and urban areas. By definition it is not open to Indigenous Australians accessing services in remote Australia. SHPA notes that there are in effect two different systems for Indigenous Australians. Those living in remote areas are covered through the Special S100 supply program (and therefore do not have access to CTG or the DAA program) and those living in rural and urban areas who do have access to CTG and the DAA program.

Indigenous Australian can access the CTG program if they visit a GP registered as a Practice Incentive Program – Indigenous Health Incentive (PIP-IHI) GP and there is anecdotal evidence to suggest that this is the preferred method of accessing PBS medicines rather than through the Special S100 supply program for some consumers / AHS.

Individual consumers often have to deal with both systems depending on where they are living at any given time.

In addition, having parallel systems has resulted in two groups of pharmacists providing services with differing support structures and programs.

Dose Administration Aid Program (DAA Program)

This program aims to support eligible patients to live effectively and confidently in their homes through better medication management. However funds are only available to Section 90 community pharmacies and not other providers of primary health care. This means that AHSs (with or without a pharmacist) that offer DAA services do not receive any monies to provide these services.

Aboriginal and Torres Strait Islander Pharmacy Scholarship Scheme (ATSIPSS)

This scheme aims to encourage Aboriginal and/or Torres Strait Islander people to undertake studies in pharmacy at university. The scheme is limited to supporting students while they undertake their under-graduate studies, it does not support students during their intern year or in sitting their final exams required to gain registration as a pharmacist.

Aboriginal and Torres Strait Islander Pharmacy Apprenticeship Scheme (ATSIPATS)
This scheme aims to improve access to community pharmacy services by Indigenous Australians through supporting the pharmacy workforce by encouraging Aboriginal and/or Torres Strait Islander people to enter pharmacy assistant / technician roles.

SHPA believes the current scheme has limited applicability / effectiveness in remote area as:

- the objective of the scheme is to increase the number of Aboriginal and/or Torres Strait Islander pharmacy assistants in community pharmacies; not to increase the number of Aboriginal and/or Torres Strait Islander people working as medicines support Aboriginal Health Workers (AHWs). The training supported focuses on services offered in a community pharmacy, not an AHS setting. They undertake training in a community pharmacy business then must adapt what they have learnt to the AHS setting. Monies are not available if the AHW trains within an AHS under the supervision of a pharmacist providing service to that AHS
- there is a pressing need to improve the literacy and numeracy of AHWs working with medicines
- a variety of training programs are available but none fully meet the competencies expected of AHWs working independently with medicines
- the AHWs are not supported in their work setting once their training is complete as they train in a community pharmacy setting but work within AHSs
- there is no dedicated resource to raise community awareness of this role or promote entry to the scheme to young Aboriginal and/or Torres Strait Islander people.

In addition to information provided by the SHPA membership and pharmacists working in Aboriginal health in remote Australia SHPA has considered information from the following reports, documents and published papers:

- *The Evaluation of Indigenous Pharmacy Programs, Final Report June 2010* produced by Nova Public Policy Pty Ltd
- *Home Medicines Review Program Qualitative Research Project*, *Final Report December 2008* produced by Campbell Research and Consulting
- *Assessing the Training needs of Aboriginal and Torres Strait Islander Pharmacy Assistants working in Aboriginal Health Services in the Northern Territory, October 2009* produced by Lindy Swain and Rollo Manning
- *An Evaluation of the Home Medicines Review (HMR) process at the Pika Wiya Aboriginal Health Service (PWHS), September 2009* produced by Amanda Sanburg, RGH Pharmacy Consulting Services
- *Aboriginal Peoples making the Health System Equitable* produced by National Aboriginal Community Controlled Health Organisation
- *Business Rules Section 100 Pharmacy Support Allowance Program, November 2008* produced by Australian Government Department of Health and Ageing and The Pharmacy Guild of Australia
- *Guidelines and Standards for Pharmacists. The Provision of Pharmacy Services to Aboriginal and Islander Health Services, October 2005* produced by the Pharmaceutical Society of Australia
- *Improving access to medicines in urban, regional and rural Aboriginal communities – is expansion of Section 100 the answer? June 2007* by J Stoneman and SJ Taylor published in Rural and Remote Health

APPENDIX B: THE ROLE OF ABORIGINAL HEALTH WORKERS

Ideally Indigenous Australians would have access to a full range of pharmacy services available to Australians in urban and rural areas. SHPA acknowledges that in the absence of this level of service there is a need for AHWs to act as a substitute to support the distribution of medicines through AHSs.

The *Evaluation of Indigenous Pharmacy Programs* by Nova Public Policy notes that a dedicated and suitably trained and qualified AHW is critical to the safe distribution and supply of medicines. A lack of suitably trained and qualified staff is thought to be a major impediment to safe and effective use of medicines for Indigenous Australians living in rural and remote areas.

SHPA understands that at this time the skills, capabilities and qualifications of AHW in remote areas lag behind those of AHWs in rural and urban AHSs. This is limiting the impact of AHW in supporting their communities.

There is an urgent need to improve the literacy, numeracy and general skills of AHW in remote areas, particularly in their role of manage the ordering, distribution and supply of medicines (through the contracted community / hospital pharmacy) for their community. AHWs need to be supported by their employer and any pharmacist involved in providing services to that AHS.

Aspirational goals

In the medium to long term it is hoped that AHW could have more particular / better identified role to better manage the distribution and use of medicines in AHSs. SHPA uses the term 'medicines support AHW' to identify AHWs with this specialised training and role. The education and training these workers would require is additional to the core AHW competencies and qualifications.

For nearly a decade SHPA has supported the need for national competency standards for workers involved in handling medicines. In a position statement made in 2003 SHPA stated that: "only individuals who have achieved or are undertaking Certificate III or IV in Health Service Assistance with appropriate work based experience, should be classified and employed as hospital pharmacy technicians".

The competencies and qualifications for hospital pharmacy technicians have been reviewed twice since that statement was released and the role of hospital pharmacy technicians continues to evolve. Experience in the hospital sector illustrates that appropriately trained and qualified support staff can 'free up' the time of pharmacists, considerably enhance the work of pharmacists and independently provide technical services under the supervision of a pharmacist.

SHPA believes that supported by a pharmacist, appropriately trained and qualified medicines support AHWs could:

- manage the ordering, distribution and supply of medicines (through the contracted community / hospital pharmacy) for their community
- use standardised assessment tools identify community members that would benefit from a medication review
- use standardised assessment tools to identify community members that have difficulties with using medicines (e.g. reading labels, opening containers, using inhalers)

- maintain and update pictorial medication lists for all community members. This list would act as a prompt for the individual, a record of current medications for health care professionals and could possibly be used as part of audit activities
- fill and maintain appropriate records of dose administration aids
- assist community members with the use of over the counter medicines
- record information given to individuals about the use of medicines (e.g. consumer medicines information, self care information) and record feedback from patients about their use of medicines, both would inform healthcare professionals and assist with tailoring counselling services or medication reviews
- facilitate consent for pharmacist services and organise HMR appointments with individual community members
- act as a cultural and lingual translator for pharmacists providing counselling services or medication reviews and act as a resource on bush medicines

Medicines support AHWs would work in partnership with AHS pharmacists when they undertake counselling and HMR activities with individual patients or look at system-wide issues that impact on the use of medicines in that community. The medicines support AHW could provide the pharmacist with the patient's current medication list, use of DAAs, information already provided, use of bush medicines etc which would streamline the HMR process.

In addition as the medicines support AHW is part of the discussion with the patient they have a clearer understanding of the patient's use of their medicines, strategies to assist them with their medicines use and further support they could offer that individual. Medicines support AHWs would also assist with answering non-medical questions raised at these consultations e.g. Centrelink rules, housing issues.

SHPA notes that the community and hospital based qualifications for pharmacy assistants and technicians are under review, both due for completion in 2011. This provides an ideal opportunity to identify the competencies required for medicines support AHWs to undertake the role described above and identify an appropriate qualification (existing or to be identified) for these workers.

SHPA understands that the community pharmacy assistant qualifications have been / will be changed considerably. Units that were previously offered as part of the Certificate III have been moved to Certificate IV qualifications. The new Certificate III qualification will focus on 'front of shop' activities which may have limited applicability to AHWs working with medicines. The new Certificate IV qualification will include the ordering, distribution and supply of medicines

SHPA believes that the considerable changes to the community pharmacy assistant qualifications due to come into effect in 2011 requires a review of the ATISPATS. **The new qualifications may have limited applicability to workers in AHSs and it may be appropriate that a different or new qualification be covered by the scheme.**

The Hospital / Health Services Pharmacy Support competency development project being undertaken by the Community Services and Health Industry Skills Council (CSHISC) originally sought to investigate the needs of Aboriginal and Torres Strait Islander pharmacy support workers but it was decided that the work was outside of the scope of the project.

However it was noted that many of the competencies and study units for hospital pharmacy technicians were equally applicable to this group. For example:

BSBMED301B	Interpret and apply medical terminology appropriately
HLTAP301B	Recognise healthy body systems in a health care context
HLTPH304C	Maintain pharmaceutical ward or imprest stock
HLTPH306C	Package pharmaceutical products
HLTPH312B	Procure, store and maintain pharmaceutical products
HLTPH313B	Distribute pharmaceutical products in a health setting
HLTPH416B	Support pharmacists by collecting and providing specific information to / for clients
HLTPH417B	Support pharmacists by collecting and presenting workplace data and information

SHPA strongly recommends that the Aboriginal and Torres Strait Islander Health Workforce Working Group (ATSIHWWG) identifies the competencies and training required for AHW to specialise in the safe handling of medicines and the management of medicines for AHSs. This would allow the identification of job descriptions and dedicated positions for medicines support AHWs. SHPA offers its support and expertise to support such a project.

Similar to the review of competencies and qualifications for hospital pharmacy technicians in progress the following process should be undertaken:

1. Identify the scope of the current role of medicines support AHWs across AHSs.
2. Identify the scope of the potential role of medicines support AHWs across AHSs.
3. Undertake review of current competencies and qualifications for medicines support AHWs.
4. Identify any suitable current qualification or if appropriate identify sector specific competencies and qualifications for medicines support AHWs.
5. Endorsement of qualification.
6. Uptake of qualifications by registered training organisations (RTOs).
7. Awards and EBAs recognise attainment of qualification and provide appropriate remuneration.

AHWs will require access to appropriate support and training to undertake and complete these qualifications which should be available through a revised ATSIPATS.