"Special arrangements": a limited panacea

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

Aboriginal Medical Services Alliance Northern Territory

“Special arrangements”: a limited panacea

1.0 Introduction

1.1 Aboriginal Medical Services Northern Territory [AMSANT] represents the Aboriginal community-controlled health sector in the Northern Territory. Our emphasis is on the delivery of Comprehensive Primary Health Care to Aboriginal Territorians[1].

1.2 AMSANT is a member of the Northern Territory Aboriginal Health Forum [NTAHF], a tripartite body also made up of the Northern Territory and Commonwealth governments. As such, we are a major provider of policy advice on health issues to both governments.

1.3 At the heart of our work is the development of a practice—both clinical and social—that displays our strong and central commitment to Comprehensive Primary Health Care.

1.4 This model was codified at an international level at Alma Ata in 1978, and subsequently endorsed by the World Health Organisation (WHO) and the United Nations:

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

1.5 Comprehensive Primary Health Care is socially and culturally appropriate, universally accessible, scientifically sound, first level care.

1.6 It is provided by health services and systems with a suitably trained workforce comprised of multidisciplinary teams supported by integrated referral systems in a way that:

- gives priority to those most in need and addresses health inequalities;
- maximises community and individual self-reliance, participation and control, and;
- involves collaboration and partnership with other sectors to promote public health.

1.7 Comprehensive Primary Health Care includes health promotion, illness prevention, treatment and care of the sick, community development, advocacy and rehabilitation services.

1.8 Comprehensive Primary Health Care prioritises dealing with health as a holistic process, which includes a strong emphasis on working with families and the communities we live in.

1.9 AMSANT has a strong commitment to an evidence-based approach to policy development. This includes matters subject of the current Senate Inquiry into “the effectiveness of special arrangements for the supply of Pharmaceutical

[1] For further information on AMSANT and its Members, see www.amsant.org.au and links.

Benefits Scheme (PBS) medicines to remote area Aboriginal Health Services".

1.10 AMSANT has contributed submissions on these "special arrangements"—in shorthand known as "S. 100"—on a number of occasions previously, including reviews in 2003 and 2010. While some of those submissions were successful in part, there are still some fundamental problems in the way these "special arrangements" fall short in terms of effectiveness and equity. We welcome the interest of the Australian Senate in this current Inquiry.

1.11 For the purposes of this Submission, AMSANT will take it as read that the Senate Community Affairs Committee is well aware of the disproportionate burden of disease experienced by Aboriginal people compared to their fellow Australians, and the concomitant additional resources required to "close the gap" in health outcomes. We will therefore only make passing references to this burden where relevant.

1.12 With respect to an evidence-based approach to the questions posed by the current Inquiry we will, however, make reference to the growing jurisdictional, national and international data as to the efficacy of community control in improving Aboriginal health outcomes, and how that might assist the Committee in designing its recommendations.

2.0 S 100 (and related measures): a study of growth in complexity

.2.1 Those familiar with policy development over time, and the legislative and regulational amendments enacted over time to amend, enhance or modify government policies or programs, will be aware that there is an innate tendency towards growth in complexity.

2.2 Some changes and amendments may well be for the beneficial purpose of improving initiatives, or excluding unintended consequences of those policy initiatives. In other situations, the growth in complexity is not necessarily matched by efficacy:

One notable and undesirable outcome of … reforms and … changes has been the exponential growth in complexity of the … system … The boundaries between … systems are uncertain and each appears to pursue slightly different objectives and be based on different policy principles. Not surprisingly, compliance and administrative costs are far out of line …

The result has been a process of ceaseless tinkering and piecemeal responses to lacunae and overlaps resulting from half measures cobbled together as substitutes for the more comprehensive reforms originally proposed and to the inclusion of generous concessions in the new systems.

2.3 It is only with a certain amount of tongue in cheek that the quotation cited above relates not to health, but to our notoriously complex taxation system[2], but the lesson is apposite. There should be no complacency, or expectation, that the health sector is somehow immune from this growth towards complexity, and away from efficacy. Confusion and counter productivity abounds:

[2] Evans, C and Krever R, "Tax Reviews in Australia: A Short Primer", University of New South Wales, Faculty of Law Research Series 2009, Paper 24.

There is a bewildering array of funding programs, each with its own eligibility criteria, accountability requirements, timelines and access barriers. Even experienced managers and clinicians find it hard to be sure their services are getting the funding they're eligible for. Duplication and gaps are the norm. Funding complexity spawns regulatory and reporting complexity – witness the complicated requirements for GPs, and the overhead costs of administering 'vertical' population health programs.[3]

2.4 Unsurprisingly, the Aboriginal health funding is infected by complexity, undermining efforts of the Aboriginal Community Controlled Health sector, and indeed those in government charged with administering contractual arrangements with the sector:

Our review of the funding and regulatory practices of Australian governments confirms the complexity and fragmentation of funding arrangements, and the perceived heavy burden of acquiring, managing, reporting and acquitting funding contracts for both sides of the funding relationship.[4]

2.5 In the context of Aboriginal health inequity is compounded as complexity in systems and service delivery, let alone funding mechanisms, can reduce rather than increase efficacy of programs—especially over time.

2.6 As a parliamentary Inquiry pointed out in 2006, change in health service delivery and finance systems are inevitable, noting:

The complexity of the health delivery and financing systems, the rate of development of new health technologies, the ever changing evidence base about best practice and rising community expectations mean that ongoing reform is needed.[5]

2.7 However, it is for this reason, that while AMSANT supports enhancement and change to the current S. 100 arrangements, it recommends that in doing so there should be a reduction in complexity in designing a new approach to delivering Pharmaceutical Benefits Scheme (PBS) medicines to Aboriginal Health Services. In other words, keep it simple: let efficacy augment equity.

2.8 Fundamental to such a reform is for current programs such as S 100, QUMAX and CTG to be integrated in a single program, substantially reduced in complexity, and made available to all Aboriginal people in the Northern Territory no matter who the provider might be. The role of these programs, and that of pharmacists and pharmacy software is discussed further in this Submission.

3.0 Current usage of and access to PBS in the Northern Territory

3.1 It is generally accepted that relative access to and usage of the Medicare Benefits Schedule [MBS] and Pharmaceutical Benefits Scheme [PBS] are strong proxies for determining relative levels of benefit from "universally accessible health care" in Australia.

3.2 On that basis, the Northern Territory does very poorly. Studies over a 15 year period have showed that the Northern Territory has consistently poor access to and usage of MBS and PBS benefits; and that this is not due to the lower

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3 Dwyer J and Eagar K "A paper commissioned by the National Health and Hospitals Reform Commission", Canberra August 2008.

4 Dwyer, J., O'Donnell, K., Lavoie, J., Marlina, U. & Sullivan, P. 2009, *The Overburden Report: Contracting for Indigenous Health Services*, P 28, Cooperative Research Centre for Aboriginal Health, Darwin.

5 *The Blame Game: Report on the inquiry into health funding*, House of Representatives, Parliamentary paper: 424/2006, Canberra 2006.

age structure of our population.

3.3 If anything, the gap between the Territory and national figures has been widening despite extra incentives being introduced, and new programs being introduced: the new incentives and programs have been taken up at a higher rate in jurisdictions other than the Northern Territory. This also does not take into account the higher levels of Aboriginal versus non-Aboriginal morbidity, and the extra costs of remote area service delivery.

3.4 Malyon et al point out that "the NT's share of total MBS and PBS benefits – 0.5 per cent and 0.3 per cent, respectively – was much less than its share of the Australian population (1.0 per cent)". They go further:

> A key constraint to increasing the NT's share of MBS and PBS funding is the availability of general practitioners (GPs). The NT has about half the number of fulltime workload equivalent GPs per 100,000 people as nationally despite having a rate of disease and injury that is 1.7 times the national average.[6]

3.5 This shortage of access to GPs—and thus PBS—has devastating consequences, as might be imagined. Recent studies by Baker IDI in central Australia suggest that only 20 per cent of Aboriginal diabetes sufferers access a GP in a given year.

3.6 In other words, so-called "universal health care" is accessed at less than universal levels in the Northern Territory compared to other jurisdictions. Quoting again from the report from Malyon et al:

> *In 2005, a report by the Health Gains Planning branch of the Northern Territory (NT) Department of Health and Families showed that the NT's share of the pool of MBS and PBS benefits was substantially less than its population share. More specifically, NT residents accounted for about one per cent of the Australian population, but over the period 1993-94 to 2003-04 they received only 0.5 per cent of MBS benefits and 0.3 per cent of PBS benefits.*

3.7 Despite the obvious benefits of S. 100, the gap between utilisation of PBS in the Northern Territory and other jurisdictions persists. Despite new programs—and increased complexity—we have seen little change over that 15 years:

> *Even when additional streams of Australian Government funding on medical services and PBS Section 100 funding were taken into account, there was still a substantial gap between actual benefits and what would have been expected had NT residents received the average benefit for their age group.*
>
> *The shortfall was in stark contrast to the need for health services. Indigenous people comprise 30 per cent of the NT population and their poor health outcomes are well documented. The relative size of this population and their level of ill-health should have meant that MBS, PBS and other primary care funding was higher than average. Moreover, for the gap in life expectancy between Indigenous Territorians and non-Indigenous Territorians to close, it is likely that an even larger investment would be needed.*
>
> *Since the previous Health Gains Planning publication, there have been a number of Australian Government initiatives to expand access to, and improve the affordability of, MBS and PBS services. These initiatives include chronic disease management items; health assessments; new items and reforms to the PBS; and the Strengthening Medicare initiative, which began in 2004. Primary care services for Indigenous people have continued to be enhanced under the Primary Health Care Access Program (PHCAP) program, Healthy for Life, the Indigenous Chronic Disease Package and other Australian Government programs.*

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[6] Malyon R, Zhao Y, Guthridge S. M*edicare Benefits Schedule and Pharmaceutical Benefits Scheme utilisation in the Northern Territory 1993-94 to 2008-09*. Department of Health and Families, Darwin, 2010

3.8 Financial implications for Aboriginal health—and indeed the Northern Territory Health budget, are considerable. For PBS alone, Malyon et al calculate an age-standardised shortfall of $38.7 million in 2008-2009, and that this gap was greater than in previous years. “Payments from other Australian Government program reduce the gap … (but) there is still a shortfall … of $16.2 million for pharmaceutical services”.

3.9 This gap persists despite the Northern Territory Emergency Response and its associated programs:

For the NT specifically, there have been child health checks and referrals to specialist services under the Australian Government’s NT National Emergency Response and recently, the Expanding Health Service Delivery Initiative has increased the delivery of primary care services in the NT. For these initiatives to narrow the funding gap, the NT needs to receive a greater than average share of the additional funding.

3.10 Given a crude calculation on the basis of Aboriginal health occupying 50 per cent of the health budget for the Northern Territory, a pro rata shortfall of around $8 million should be seen as a working minimum requirement for equitable Northern Territory Aboriginal pharmaceutical services delivery. Even accounting for our proposed universal extension of S.100 to the Darwin region (see below at 5.13-5.14), this would allow for nearly $0.5 million to be pooled into each Health Service Delivery Area [HSDA] in the Northern Territory.[7]

3.11 Indeed this sum must be regarded as very conservative, and is based on Northern Territory access to PBS reaching average Australian per capita usage. High levels of chronic disease, and consequent need for far greater access to acute medications and Dose Administration Aids [DAAs] suggest an even greater shortfall.

3.12 Through the Northern Territory Aboriginal Health Forum, there is to be a costing study to be carried out on a revised Core Services to Primary Health Care formula. Such a study should be able—if the PBS shortfall be made up by the Commonwealth—to contemplate a process of pooling PBS into the HSDAs based on a per capita calculation. There is a precedent for this in past pooled funding formulae for the previous Coordinated Care Trials [CCTs] and Primary Health Care Access Program [PHCAP]. The recent evaluation of the NTER Child Health Check Initiative and EHSDI would appear to support such a mechanism:

The CCTs and PHCAP provide examples of how pooled funding has been operationalised in the past. In the CCTs, funds were provided to regional health boards on the basis of the average per capita expenditure on MBS and PBS nationally. This was to be pooled with funds allocated by the NT Government. The health boards acted as purchasers of services provided to trial populations, with the ability to develop their own priorities for service provision … for the first time this provided a mechanism for managing service delivery based on regional and community perspectives. PHCAP was intended to operate under a similar model, which involved the provision of per capita funding to [the then] *21 Health Service Zones. This was to be pooled with current DHF expenditure on health and used in accordance with decisions made by local health boards. While the establishment of regionalised health services under the EHSDI has not yet progressed to the point where regional health boards could act as*

[7] Under the tripartite Northern Territory Aboriginal Health Forum policy document *Pathways to community control* [see http://www.amsant.org.au/documents/article/114/Final_Pathways%20to%20Community%20Control.pdf], administration of Comprehensive Primary Health Care under Aboriginal community control is to be divided into around 15 regional HSDAs.

funding purchasers, this could be investigated as a potential mechanism. In the medium term, we recommend that the NT AHF partner organisations engage in discussion about how to better coordinate the funding provided by different levels of government and different departments.[8]

3.12 Such pooled funds could then increase access to PBS via increased employment of GPs into Aboriginal Primary Health Care, thus helping overcome the major constraint to PBS utilisation identified by Malyon et al.

3.13 In addition, or alternately, these pools—at the direction of regional health boards—may be available to directly employ pharmacists and expand Quality Use of Medicines programs.

4.0 Medicine and cultural safety

4.1 Aboriginal people in rural areas face many issues related to accessing medical services, some of which stem from more widespread issues relating to cost or travel due to a lack of or inconvenient transport. However, the main issues identified and addressed by the ACCHO sector are concerned with poor medication compliance and problems associated with use of prescribed medications within Aboriginal communities. There are cultural issues which cannot be overlooked due to their large influence on the less than optimal use of prescribed medication.

4.2 Hamrosi, Taylor and Aslani (2006) identify through qualitative research, a cultural issue which is a limiting factor for Aboriginal people and their full utilisation of available pharmaceutical medicines. It is a western priority to immediately treat health issues with medication (p9). For many Aboriginal people, where treating health problems with Western medication is already of low importance, it becomes a much lower priority when the cost is factored in, effectively lowering accessibility (p4). Diabetes and cardiovascular diseases are the main health concerns for Aboriginal people, (Stoneman & Taylor 2007a p5) so usage, and also correct usage of medicine is necessary to ensure the health of Aboriginal people through a cost effective manner (Couzos 2005 p2).

4.3 Research into the effectiveness of medication regimes strongly suggests that people within the Aboriginal community often feel embarrassed, discomforted and even ashamed when seeking medication. This occurs when the person accessing the medicine does not fully understand how the medicine should be taken, or what its effects are and instead of asking for further clarification instead chooses to leave feeling “frightened and ashamed.” (Hamrosi et al 2006 p5).

4.4 This lack of patient understanding further leads to misuse of medicines which carries onto the Aboriginal community. Hamrosi et al (2006) identify the emergence of medicine sharing within communities as further affecting adherence to prescribed medicines. Whilst sharing means there is more exposure to medicine, the medicines may not be suitable for use by other members of the community, and due to lack of understanding of the medicine

[8] Allen and Clarke 2011, *Evaluation of the Child Health Check Initiative and the Expanding Health Service Delivery Initiative: Final report,* P 120, Department of Health and Ageing, Canberra.

(which may occur with the initial person) it is highly likely that others taking the medication also will not understand the effects.

4.5 Many Aboriginal people cease taking medications after an initial dose, feeling it is unnecessary to complete the full course of medication should they already be feeling improvements. Experiencing side-effects is also a main influence of medication non-adherence.

4.6 Patients will simple cease use of the medication instead of seeking advice, from the same reasons of embarrassment or feeling ashamed which may occur when accessing the medication. Sharing medications within the community can be seen as a contributor towards the misuse of medicines and it has the result that the person prescribed the medication has less available to take (Hamrosi et al 2006 p6).

4.7 There is opposition stemming mainly from the elder population of communities towards taking medication under the belief that it is not cultural to begin with (Hamrosi et al 2006 p6). For Aboriginal people, health is more than the physical wellbeing of a person but also entails the social, emotional and cultural wellbeing of the entire community (Stoneman & Taylor 2007b p4). Partly for these reasons, the complex Western medication regimens are difficult to understand for Aboriginal people (Hamrosi et al 2006 p6).

4.8 A clear consequence of these problems is to increase the levels of knowledge and skills within the workforce over use of medicines. Greater interaction between Aboriginal Health Workers [AHWs] and pharmacists, including the potential training of AHWs as medicine assistants, has strong potential to increase the levels of proper use of medicines by the Aboriginal population.

5.0 S. 100: a limited panacea

5.1 The S. 100 scheme has had significant successes in addressing access to required medications in remote communities, and has certainly increased access to medicines for a significant number of people[9] Yet, as has been noted in this Submission, access to PBS still falls far short of what might be expected—and certainly far short of what is required given disease burdens experienced by Aboriginal people.

5.2 Access to essential medicines makes a substantive contribution to the secondary prevention of premature death for sick people. In the case of Coronary Heart Disease (CHD) the expert reference panel to the National Primary Care Collaborative has estimated that the use of a few essential medicines will reduce subsequent mortality by 50% over two years. For people with diabetes the use of statins to ensure that total cholesterol is less than 4 will reduce mortality by nearly 50% as well (Pyorala K, et al. Diabetes Care 1997) .

5.3 Section 100 access to pharmaceuticals in remote areas has proved itself to be a cost effective way to ensure that Aboriginal people throughout Central

[9] Kelaher, M, Taylor Thomson, D, O'Donoghue, L, Dunt, D, Barnes, D, and Anderson, I. Evaluation of PBS Medicine Supply arrangements for Remote Area Aboriginal Health Services Under S. 100 of the National Health Act, P 26, Melbourne: Cooperative Research Centre for Aboriginal Health & Program Evaluation Unit, University of Melbourne, 2004.

Australia gain access to the essential medicines that they need to improve their health outcomes. This is very likely to be one of the factors that has contributed to the health gains that are now being made in the Northern Territory (Zhao et al MJA 2006; Thomas et al MJA 2006; Wilson et al ANZJPH 2007).

5.4 Apart from the benefits to bush patients in terms of better compliance and corresponding health outcomes the proposed system is likely to be less expensive to the PBS.

5.5 However, it should be noted that S 100 medication access regime is far from universal. In the Northern Territory, this specifically excludes the Northern Territory's largest concentration of Aboriginal people: the Darwin-Palmerston region. This is a cruel and discriminatory situation.

5.6 As it is outside "remote" areas S 100 access is disallowed in Darwin-Palmerston, even though the local Aboriginal population experiences the same levels of disease burden as their remote brothers and sisters. Further, access to S 100 medicines is disallowed to people visiting Darwin from remote areas.

5.7 The greater Darwin region is served by Danila Dilba Health Service[10], a founding Member of AMSANT. It currently expends some $600,000 annually paying for medicines for the people it serves, meeting the "gap" in co-payment costs of medicine. Despite a long history of submissions from it, and AMSANT, Danila Dilba has met a brick wall in trying to access S 100, which has benefited all other Aboriginal Territorians. The "gap" is met by accessing MBS income—uniquely, such income from Medicare Benefits is being cost shifted to meeting the costs of Pharmaceutical Benefits, something no private practice is obliged to do.

5.8 Danila Dilba can theoretically meet perhaps half this amount through signing up patients to Practice Incentive Payments [PIP] as part of a Closing the Gap program—an additional "complexity" in the system. However, there are major practical barriers to this. Customer Support Officers who run reception at Danila Dilba are already overstretched and stressed as it is, and they are certainly not able to reliably check people's addresses, let alone sign them up for PIP.

5.9 Danila Dilba's most disadvantaged patients tend to fall into the category of people who won't use normal pharmacy services and need point of care medications in any case. This means that Danila Dilba maintains four pharmacies across its various sites and all these medications are bought outright without any PBS subsidy albeit at wholesale prices.

5.10 As well, at least 25% of the regular Danila Dilba clientele are from remote communities and it would not be appropriate for them to sign up to Danila Dilba as their main provider with PIP, but they still need medication while they are in Darwin. Thus, without access to S 100, supply to visiting clients would have to continue even if all the Darwin based eligible clients are captured within the Close the Gap program. This can be an extremely financially onerous exercise as, for example, when clients arrive in Darwin from

[10] See http://www.daniladilba.org.au

elsewhere who are on very expensive and necessary medications (eg mycophenelate for lupus nephritis) which they normally receive through S100 where they live remotely and then they run out whilst in Darwin.

5.9 The whole idea of requiring patients and health centres to engage in the PIP based system where they sign up with one provider is problematic as it fails to acknowledge the regular mobility of many Aboriginal people which requires them to access different health providers.

5.11 In any case, complex schemes such as PIP produce variable income. There are some suggestions from OATSIH that income from PIP, in any case, should be used to pay for accreditation renewal costs. Although the budgetary implications are unclear to AMSANT at present, PIP payments have declined by $250 million since 2008, and in forward estimates are destined to fall by another 18% [Russell: 2011].

5.12 PIP payments *should not* be used as a replacement for access to S 100 PBS.

5.13 There is a further complexity—and anomaly—experienced by other services in major towns. For example the S 100 contract with Central Australian Aboriginal Congress, in Alice Springs, does not allow Aboriginal people from remote communities to have access to the same service. Even if they have a current script from their own GP they cannot go direct to the Congress pharmacy as they need to have their script repeated by a Congress GP. This means that these people have to see a GP unnecessarily before they can access their medicines from Congress.

5.14 This is an unnecessary barrier to access. Congress would therefore like to have its Section 100 contract amended so that any Aboriginal person with a current script can go directly to its pharmacy and get their medicines if that is all they need. This will make it easier for Aboriginal people from bush communities who come to town without their medicines, or who run out of medicines while visiting Alice Springs, to have easier access to further supply. Congress notes that this should also assist compliance.

5.15 There is, of course, a non-complex solution to this: S 100 should be able to be accessed by *all* Aboriginal people, whether PIP signed-up, remote identified, a client of private general practice: whatever. Anything else also falls to the fatal problem of complexity in systems and programs.

5.16 It is recommended that the current inquiry should adopt the idea of universal access to S 100.

6.0 Pharmacists as part of Comprehensive Primary Health Care

6.1 At 1.6 above, AMSANT seeks to deliver Comprehensive Primary Health Care through “a suitably trained workforce comprised of multidisciplinary teams supported by integrated referral systems”. It is our contention that pharmacists should be regarded as an integral part of these “multidisciplinary teams”.

6.2 As has been noted above, while S 100 has undoubtedly benefited many Aboriginal people in being able to access medications. However, as it provides Aboriginal health services with bulk supply of medications, the issue of appropriate dispensing to patients has not been fully addressed, and this has

become more apparent since the implementation of the S 100 program.

6.3 S 100 drugs are currently being dispensed in many—not all—situations with handwritten, and in some cases no labels. This does not meet the minimum dispensing requirements in the Northern Territory.

6.4 In many cases, dispensing is not being recorded by the dispenser other than in the patient's progress notes, making it difficult to monitor individual patient prescribing or to audit stock.

6.5 Most dispensing is carried out by staff who have inadequate training in dispensing.

6.6 This is exacerbated by high staff turnover across the entire sector. For example, at one remote clinic in Central Australia, in the 2008-09 financial year, 17 remote area nurses were recruited for the three positions in the health centre and in the 2009-10 financial year, 10 nurses were recruited for the same number of positions. This high staff turnover is typical of remote clinics in the NT.

6.7 AMSANT believes that the Section 100 allowance provided to pharmacists is not enough to effectively manage remote dispensing. Pharmacists are unable to make regular visits to remote pharmacies to carry out necessary housekeeping duties.

6.8 The logic of integrating pharmacists within the Comprehensive Primary Health Care system appears inescapable. One option for funding these positions is discussed at 3.10. An additional option is available, and that is to meet the current shortfall in "pharmacist time" available to S100 drug recipients who are currently denied $6.42 worth of pharmacist time for every prescription item they receive.

6.9 There is a fundamental equity issue here, as well. Pharmacists should be seeing patients, and working as a primary healthcare workers, with Aboriginal Australians as they do with the rest of society. The effect of PBS supply arrangements is to allow the presence of a pharmacist to add value to the dispensing function. The PBS system across Australia resources pharmacists to be present at every outlet where PBS medicines are dispensed. No such money is provided to ACCHSs. Quite simply, they should be.

6.10 In the context of the Aboriginal Community Controlled health sector, access to pharmacists as part of a multi-disciplinary team will also do much to provide ongoing support and training to other clinicians, as well as maintaining stock control.

6.11 At present, a resourced pharmacist could easily fit into the multidisciplinary model in at least six existing regional health services, with two more HSDAs closing fast as regional Aboriginal Community Controlled Health Services. Other proposed HSDAs, a number of which have a mixed balance of Government and Aboriginal community controlled health services, could have pharmacists "hubbed" into these HSDAs as they move, over time, to regional control.

7.0 Clinical Information Systems [CISs]

7.1 The uptake of electronic Clinical Information Systems in delivering Aboriginal Comprehensive Primary Health Care is arguably more advanced that in any other part of the primary health care system in Australia, and is indeed regarded as a model that might be taken up throughout the system.[11]

7.2 Within the Northern Territory, the ACCH sector primarily uses a CIS system called Communicare; with the Department of Health sector using PCIS. Communicare is also used widely in other jurisdictions in Australia by our sector. The use of electronic CISs will shortly be universal in the Northern Territory, and in any case has been well established over the past decade in many services.

7.3 As well as providing greater levels of care at the individual level, these systems have been developed to provide important health data across the whole system. These are vital at the level of individual services in Continuous Quality Improvement (CQI) programs, as well as providing data for the Northern Territory Aboriginal Health Key Performance Indicators [NTAHKPIs]. The NTAHKPIs, in turn are a critical planning and monitoring tool across the system of improving Aboriginal health.

7.4 While these systems are used for dispensing medicines, they are currently unable to be linked with pharmacy systems, including the important issue of stock control. There is an urgent need to improve the quality of dispensing and stock control methods in many Aboriginal Health Services and, ideally, pharmacy software should be integrated with the major CISs in use in the Northern Territory and beyond. While there is one system that has been developed for use in the Aboriginal Medical Service environment that records, labels and maintains an inventory control mechanism, it is not compatible with the CISs in use in the Northern Territory (and elsewhere).

7.5 In the mainstream pharmacy system, the PBS has funded the installation of computers and the necessary software at every Approved Pharmacy to allow dispensing to be done in an accurate, timely and compliant way. Clearly, resources should be made available for such infrastructure in the ACCHS sector.

7.6 A first step in this direction—whether funded through the PBS or OATSIH—should be to upgrade existing CISs so that they might incorporate an integrated pharmacy system. In the case of Communicare, this would be of immediate benefit in other Australian jurisdictions.

8.0 Conclusions

8.1 The S 100 system has undoubtedly improved access to medicines for Aboriginal people.

8.2 However, the system has become overly complex over time, and excludes a significant number of Aboriginal Territorians from accessing those benefits.

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[11] See for example, Phillips C, Pearce C, Hall S, Travaglia J , Luisignan S, Love T and Kljakovic M (2010). "Can clinical governance deliver quality improvement in Australian general practice and primary care?" *MJA*: 193 . 602-607.

8.3 Rather than introducing more complex approaches to S 100, the initiative should be radically simplified, allowing universal access to S 100.

8.4 Despite access to S 100, and other measures such as those through the Northern Territory Emergency Response, there is still a large level of inequity, with no real increase in Aboriginal access to MBS and PBS over 15 years in the Northern Territory. Conservatively, this is a shortfall of $8 million a year in access to the PBS.

8.5 Having access to pharmacists as a key element of the multi disciplinary primary health care team approach is seen as a vital addition towards improving Aboriginal health in the Northern Territory. A funding mechanism should be developed to provide at least one pharmacist for each HSDA in the Northern Territory.

8.6 Resources should be made available as a matter of urgency to develop a pharmacy software system that is compatible with the two CISs in use in the Northern Territory.