THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

School of Medicine
Centre for Chronic Disease

Senator Rachel Siewert - Chair
Senate Standing Committee on Community Affairs References
Parliament House
Canberra ACT 2600

18th July 2011

Dear Senator Siewert

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

I wish to lodge the attached submission relating to the above Term of Reference.

The Centre for Chronic Disease was established at the University of Queensland in Brisbane, Australia in 2002 with myself as its founding director. Its mission is to better understand the causes and mechanisms of non-communicable chronic disease and apply this knowledge to systems of prevention, early detection and better treatment. The target conditions include obesity, high blood pressure, kidney disease, type 2 diabetes and cardiovascular disease.

The main target groups are those experiencing rapid change in lifestyle and environmental conditions. This includes most populations of developing countries and minority and Indigenous groups in the western world, including in Australia.

We have 14 core staff members, five of whom work in remote settings. We have many international collaborators. These include New Caledonia, Micronesia, Senegal, South Africa and Ibadan in Nigeria, Jackson Mississippi, British Columbia, Sri Lanka and Japan. Our work is funded by research grants, including the prestigious NHMRC Australia Fellowship, the Colonial Foundation of Australia and industry, especially Amgen and Servier, Australia, and has always been strongly supported by Kidney Health Australia.

Our work has had a major impact on Indigenous primary care in Australia, and is widely respected and modelled internationally. Major contributions have included advocacy for systematic screening and treatment of chronic disease, and demonstration of the great benefit of treatment in reducing blood pressures, kidney disease progression, premature death and kidney failure. There has been widespread uptake of these practices, strongly assisted by the farsighted introduction of Medicare reimbursements for service items and the S100 mechanism for medicine supply. Recent reductions in death rates and apparent stabilisation of renal failure rates suggest that the tide might be turning. What a pity we are unable to assess these, as well as trends in community profiles, and hospitalisation rates, against medicine supply! Try as we may, we have not been able to access the S100 data

I am happy to support this submission if you decide to hold a Public Hearing in Brisbane.

Yours sincerely

WENDY HOY AO
Director, Centre for Chronic Disease
Professor of Medicine, NHMRC Australia Fellow

Submission to Senate Inquiry into:
The effectiveness of the special arrangements established in 1999 under section 100 of the National Health Act 1953, for the supply of Pharmaceutical Benefits Scheme (PBS) medicines to remote area Aboriginal Health Services

This submission

The Terms of Reference this submission will address will be the following:

(a) whether these arrangements adequately address barriers experienced by Aboriginal and Torres Strait Islander people living in remote areas of Australia in accessing essential medicines through the PBS;

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

(c) the degree to which the 'quality use of medicines' has been achieved including the amount of contact with a pharmacist available to these patients compared to urban Australians;

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

(e) the distribution of funding made available to the program across the Approved Pharmacy network compared to the Aboriginal Health Services obtaining the PBS medicines and dispensing them on to its patients;

(f) the extent to which Aboriginal Health Workers in remote communities have sufficient educational opportunities to take on the prescribing and dispensing responsibilities given to them by the PBS bulk supply arrangements;

(g) the degree to which recommendations from previous reviews have been implemented and any consultation which has occurred with the community controlled Aboriginal health sector about any changes to the program;

This submission will centre on the need to analyse data arising from drug utilisation statistics in order to properly evaluate the effectiveness of a clinical program involving pharmaceutical interventions.

The Centre for Chronic Disease at the School of Medicine, University of Queensland, has, for the past two years been endeavouring to obtain from Medicare Australia statistics arising from the supply of PBS medicines to the 170 Aboriginal Health Services Australia wide in the s100 supply program.

This effort has been unsuccessful to date, for reasons which vary according to the agency we are petitioning and within agencies over time.

In response to the Terms of Reference we make the following comments:

(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;
There is no doubt the physical barriers to accessing medicines have been overcome through the s100 arrangements. This has been a wonderful development, and has contributed to the groundswell of improved clinical practice in chronic disease care in Indigenous communities nationwide. However, no agency has evaluated whether improvements in clinical outcomes have followed. The data being sought by the Centre for Chronic Disease is to fill this information gap. It is an important piece of the story, and will surely be a good news story for health care providers and for governments.

(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;
We understand there are many elements in the chain between medicine supply, utilisation and outcomes. Documenting medicine supply is a first step. We are not aware of any data on the outcomes specified above, except for our own assessment during the Tiwi Kidney treatment program in the late 1990s. There was great benefit in that setting, in lowering of blood pressure, slowing of kidney disease progression, and reductions of all-cause natural deaths and in kidney failure. Two thirds of treated people took their medicine most of the time. There were major savings in costs of dialysis avoided. All this is in the peer reviewed scientific literature. Most recommendations have been incorporated into the CARPA treatment manual, the bible of indigenous primary health care in remote Australia. However, without any handle on medicine supply or uptake, there is no mechanism against which to assess patient adherence, impact on community health profiles, hospitalisation rates, dialysis starts, premature deaths and costs. This is what we intend to do if we have access to S100 data.

(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;

There are only a few pharmacists involved in remote Aboriginal health, and most patients have no contact with one.

(d) the degree to which state/territory legislation has been complied with in respect to the recording, labelling and monitoring of PBS medicines;
Recording of outgoing supplies of medicines is the starting point in obtaining good data with respect to patient compliance, but much of the data are of poor quality.
The requirement for scanning devices in State/Territory legislation has not been followed into the remote setting where the dispensing of medicines is a mere extension of a clinical consult. Dispensing should be recorded but this may be left until the end of the day and eventually misses out.

(**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;**
The inability of Aboriginal Health Services to employ a pharmacist has impeded delivery of good pharmaceutical care and patient education. The only real contact the Centre had in the area of pharmacy in Aboriginal health was with the Tiwi Health Board Pharmacy in 2002 when the entire operation was owned and operated by the health board itself. This gave us good insight into medicine prescription and adherence.

(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 -

No comment.

(**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;**

A key recommendation of the Kelaher Review of 2004[1] relates to the content of this submission. It stated:

> 10. **Information about the performance of S100 would be improved if the following changes were made:**
>
> 10.1 **HIC should provide medicine utilisation data to ATSIHSs to enable them to keep track of their own performance.** Originally HIC was to provide clinics with data on their medicine utilisation, but this has not occurred to date.
>
> 10.2 **A system to assess the quantum of medicines that expires in ATSIHS should be considered to enable further evaluations.**
>
> 10.3 **DoHA should update records of ATSIHS client numbers to ensure that any comparisons between centres are accurate.** In order to assess trends in medicine utilisation among different ATSIHSs the size of their client populations needs to be taken into account.

This recommendation simply re-affirmed a commitment made by officers of DoHA in 1998 when the benefits of the proposed scheme were being expounded to officers of the Territory Health Service in Darwin at a workshop held in April 1998.

A means of determining a way of documenting the amount of medicines that have to be discarded would help ATSIHSs judge the effectiveness of their inventory management, identify the extent of wastage of medicines, and potentially minimise that wastage, and allow assessment of the extent to which increased medicine supply was being effectively used.
Few of these recommendations have been realised, although we have been hearing for the past six months, that the Department is planning to make the data available on its website.

The Centre has not been solely hoping for a breakthrough with Medicare, but has also had discussions or opened correspondence with the following agencies:

a. Queensland Health - Medicines Infrastructure and Support, Medication Services Queensland
b. NT Department of Health – Remote Area Executive
c. WA Country Health
d. Wurli Wurlinjang Health Service in Katherine NT
e. Santa Teresa Health Centre - Mpwelarre Health Aboriginal Corporation

[1] Kelaher M, Taylor-Thomson D et al. Evaluation of the PBS Medicine Supply Arrangements for Remote Area Aboriginal Health Services under S100 of the National Health Act. Co-operative Research Centre for Aboriginal Health and Program Evaluation Unit, University of Melbourne

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During these discussions the following points have emerged:

1. **Medicare Australia is the most efficient agency to provide data** – the data held by Medicare is the most accurate report of the actual medicine supplied by an Approved Pharmacy to an Aboriginal Health Service. We have come to that conclusion after having examined the records of the last ten years at the Santa Teresa Health Centre with the view to being able to extract accurate data. The ordering process required of the nursing staff by the contracted pharmacy varied in its method and consistency such that records held could not be extrapolated into accurate data.
   The pharmacy which supplies Santa Teresa Health Centre (now Priceline Pharmacy in Alice Springs) quoted a cost of $1584.40 for extracting just 12 months data from the claims it had made on behalf of Santa Teresa Health Centre to Medicare.
   ATTACHMENT A.
   In another example the Northpharm Pharmacy in Darwin has been unable to provide a full 12 month of claims on behalf of Wurli Wurlinjang Health Service in Katherine following a request supported by the WWHS Board for data.

2. NT Government requirement for data from contracted pharmacy suppliers
   A clause in the contract between pharmacy suppliers and the NT Government states that the supplying pharmacy must maintain statistical information for the Ordering Officer if requested. A copy of the extract from the NT Government Tender Documentation is at **ATTACHMENT B**.
   Our experience in trying to get data from two of the five contracted pharmacies shows that the Approved Pharmacies are not geared up to provide the information likely to be sought by the Department. This emphasises the need for Medicare to meet its previous commitment to making the data available.

3. Pharmacists accepting responsibility in monitoring adherence- the task described by the Centre for Chronic Disease in this submission would have been easier if pharmacists saw their role in providing feedback to doctors and nurses on patients' compliance (adherence) as an important part of their contribution to primary health care.
   Pharmaceutical interventions are viewed by clinicians as an important aspect of chronic disease management and it would be useful for the pharmacy profession to support this with factual data regarding adherence.

WENDY HOY AO
Director

18th July 2011

ATTACHMENT A

Rollo Manning

From: s100@internode.on.net
Date: Monday 9 May 2011 3.06 pm
To: Rollo Manning rollom@iinet.net.au
Subject: Re: Medicare Claim Payment

Mr Manning,

After our phone conversation on the 9th may 2011, We would like to confirm the costing of the work involved.
The cost will be $1548.40 for 12 months Stat's for 3 days work. If extra time is required,
we will stop work & call you for approval to finish the job with a possibility of extra costs.

I hope this helps

Theresa McGreevy
S100 Manager

ATTACHMENT B

REQUEST FOR TENDER

Northern

DEPARTMENT OF
HEALTH AND FAMILIES www.nt.gov.au

NGO SUPPORT GROUP

RFT NUMBER:	D09-0125
RFT TITLE:	SELECTED REMOTE HEALTH CENTRES - PROVISION OF SECTION 100 PHARMACY SERVICES FOR A PERIOD OF 36 MONTHS

EXTRACT FROM PAGE 14

4. STATEMENT OF REQUIREMENT

4.11 DOCUMENTATION AND STATISTICS

The Contractor shall be responsible for ordering, accounting for the use of pharmaceuticals and maintenance of statistical information. The Contractor must be able to provide the following information for each RHS in an electronic format (*MS Word*, *Excel* or *Access*) to the Ordering Officer, if requested:

- Individual drug usage by month
- Highest volume drugs by volume/month
- Total drug expenditure/month
- Total cost of supply of DAA/month
- Total cost of individually dispensed medications/month
- Number of outstanding ”Request for Pharmaceutical supplies for Aboriginal Health Services” forms from each RHS

Note: These reports are not required routinely.

The Contractor shall use standard DHF documentation as required by the Ordering Officer and provide reports as requested on the Quality Use of Medicines (QUM) activities carried out at the regular visits to designated Health Centres.

The Contractor shall liaise with the Ordering Officer to conduct and participate in six-monthly performance reviews.