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Ngaanyatjarra Health Service Submission to the Community Affairs References Committee:

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.

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Submission developed by Ngaanyatjarra Lead Pharmacist Andrew “Robbo” Roberts on behalf of Ngaanyatjarra Health

Ngaanyatjarra Health Service is the only provider of health services to both indigenous and non-indigenous people in the region, which approximates an area greater to that of the state of Victoria. The closest alternative health services are in Kalgoorlie (930 kilometres to the south west) and Alice Springs (1,020 kilometres to the north east). The Ngaanyatjarra Lands remoteness classification is ASGC 5 - Very Remote.

Ngaanyatjarra Health Service provides a multidisciplinary approach to the primary healthcare model to 12 very remote communities across three local government shire areas. It is also significantly challenged by the cross border issues to the patient journey. This is not only a risk to effective patient flows but the delivery of public health programs such as environmental health that is partially funded to local government shires. For this reason, NHS has required accommodation and health facilities to be managed internally with external collaboration only possible by regionally based visiting services.

In addition to the PHC model provided in 12 the Ngaanyatjarra communities the Ngaanyatjarra Health Service manages the Wanarn aged care facility, HACC services in a variety of locations and delivers community-based programs in Chronic disease, child health, sexual health men's health, environmental health and mental health mentorship.

To achieve best practice outcomes Ngaanyatjarra Health Service collaborates with NTGP education, Goldfields Division of General Practice, MSOAP, WACHS – dental service, Renal networks in WA and NT. Support for training placements of Medical, Allied Health, Nursing, Midwifery and Aboriginal Health Worker students also comes from University- SA – Allied Health, podiatry , Curtin – Midwifery /Nursing students, Bega Garnbirringu (AMS) Aboriginal Health Worker training on the lands at the Warakurna learning Centre.

The health status of the Ngaanyatjarra people is also amongst the poorest in the nation, and the burden of disease and health care managed by NHS has increased in complexity due to the compound impacts of multiple chronic diseases and co morbidities.

Ngaanyatjarra Health Service has long seen the need for pharmacists to be part of the remote primary health care team. Ngaanyatjarra Health has employed one pharmacist since Feb 2005 (initially a one year project funded by a Rural and remote Pharmacy Workforce Developmental Program Infrastructure Grant, S100 professional support allowance and Ngaanyatjarra Health Service) and has employed a second pharmacist since May 2009 (initially with dedicated funding for the first year).

Ngaanyatjarra Health Service has employed a pharmacist living and working remote as part of the primary health care team for over six years. They have employed a second pharmacist in a Continuity of Care role since May 2009.

This submission will make comment on the Terms of Reference (ToR) highlighting how our unique pharmacist team has overcome some of the short comings and offer a response to the terms of reference.

Summary of Recommendations

- Funding for pharmacists be made available for Indigenous Health Services
- Cost of the S100 medications supplied to a remote health service to be provided to the health service
- Medicare to enable electronic claiming by supply pharmacies as a matter of urgency.
- Funding of studies to determine adherence (or at least pick up rates) of medications from remote health services and of use of medications mainly used in acute care settings in mainstream Australia to provide an accurate comparison of pharmaceutical use between remote and mainstream Australia.
- Funding to be provided to Ngaanyatjarra Health service to research adherence changes over last six years.
- Remote Aged Care Facilities to be covered by the S100 program and S100 support allowance funding
- Public Hospital Pharmacy Departments to have access to current Indigenous Programs to defray medication costs to Indigenous patients on discharge
- Funding to be provided for best practice supply of dose administration aids.
- Assistance to be provided to hospitals to provide medications suitable packaged and labelled for all patients. This may include DAAs.
- Assistance to be provided to software providers to develop dispensing and labelling modules for the electronic patient management software.
- Funding for studies to assist with developing strategies to develop adherence.
- Pharmacists to be given provider numbers to be able to claim against Medicare
- Funding for QUM activities should be funded based on need which could include parameters such as number of patients on chronic disease registers, number of mental health patients and health literacy
- Medicare rebates available for services provided by a pharmacist.
- Software providers of electronic patient management systems to urgently incorporate dispensing modules into their systems
- Funding be provided for provision of DAAs
- A review of current funding provisions for S100 supply to be undertaken
- Funding for rural academic pharmacists to be increased.
- Improved and consistent methods of communication to be put in place by DoHA to all s100 stakeholders

Ngaanyatjarra Health response to Terms of Reference

Following are our comments to the terms of reference for the inquiry of the effectiveness of the special arrangements for the supply of Pharmaceutical Benefits Scheme (PBS) medicines to remote area 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.

It is well documented that the S100 program has improved the supply of pharmaceuticals to remote area Indigenous Australians. However despite a much heavier disease burden than other Australians the pharmaceutical spend per remote Indigenous Australian is only $54.20 pa compared to a non-Indigenous Australian receiving $337.70 pa[1]. This non-Indigenous spend does not include the cost of pharmaceuticals covered in full by non-concessional card holders who pay the full amount for items up to the current co-payment level

The S100 spend for remote Indigenous Australians also includes non-Indigenous Australians. The S100 supply arrangements are for *all clients* of remote Aboriginal health services. This may include small remote townships further skewing the results.

The supply to remote health services includes large amounts of medications used to treat acute conditions than would be dispensed from a retail pharmacy. Many of these would generally be used only in a hospital situation in mainstream Australia (e.g. intravenous antibiotics and infusion fluids).

One of the biggest public health programs a health service can implement is an imprest or standard drug list so patients can be treated according to protocols and medical practitioners can prescribe with confidence knowing the range of drugs they select from are available at the clinic(s) run by the health service. However despite this activity being listed in the Pharmacy Information Kit for the S100 support program[2] it may have difficulties being implemented from a distance. A pharmacist involved in the supply of pharmaceuticals to remote health services indicated that wastage of pharmaceuticals could be 'phenomenal and could be as high as 20%'. Among the reasons given could be poor stock management processes[3].

Due to a paper based claim system and the cost of the medications known eventually only to pharmacies and Medicare, health services have no indication of the cost of medications supplied under the program. Having these costs made available would improve accountability through the supply chain.

[1] Australian Institute of Health and Welfare 2011. Expenditure on health for Aboriginal and Torres Strait Islander people, 2008–09. Cat. HWE 53 AIHW Canberra

[2] Pharmacy Information Kit: Section 100 Pharmacy Support Allowance Program. Department of health and Ageing 2008

[3] Review of the existing supply and remuneration arrangements for drugs listed under Section 100 of the National Health Act 1953. Australian Healthcare Associates. Feb 2010

This highlights that while the amount of drugs supplied to remote Aboriginal health services has increased it has not increased as much is as stated. There is still waste in the system. The amount of medication remote Australians use is still unknown.

With the employment of a pharmacist at Ngaanyatjarra Health in 2005 a standard imprest and stock control in an area covering 10% of Western Australia was implemented and fed into hospitals caring for our patients. Immediate savings were made without restricting the supply of pharmaceuticals. Our medical practitioners could prescribe with confidence knowing that a standard range of medications IS available at each of our clinics over 250000 square kilometres.

With an imprest list in place with stock levels the cost to the Commonwealth for medications was reduced by 14% in the first year[4]. There was a 7% decrease in the first year on non-PBS medications[4] and over 40% in the second year[5]. These medications are paid for by the health service and savings can be placed directly into patient care. It has also allowed with time for an increased and targeted range non-PBS pharmaceuticals such as a wide range of emergency drugs for our emergency kits.

There was a 7% decrease in the first year on non-PBS medications[4] and over 40% in the second year[5]. These medications are paid for by the health service and savings can be placed directly into patient care. It has also allowed with time for an increased and targeted range non-PBS pharmaceuticals such as a wide range of emergency drugs for our emergency kits.

This has flow on effects by reducing transport of expired drugs out of the clinics, reducing stock on imprest shelves, reducing the chance of inadvertently supplying out of date medications and with no overcrowding on shelves reducing the possibility of selection errors. Freight costs (approximately $10/kg for airfreight) are also reduced and valuable space on light aircraft is freed up.

The claim system is paper based and the cost of the medications is known eventually only to pharmacies and Medicare. Health services receive no information on savings from introducing these programs, nor of the cost of medications ordered for their clinic(s). Having these costs made available would improve accountability through the supply chain.

There is some doubt as to whether Indigenous patients in remote Aged care facilities are entitled to s100 medications. Correspondence with our Lead Pharmacist from the then Deputy Director of the Special Access Programs 2, Access and Systems Branch, Pharmaceutical Services Division on the 6th May 2009 stated:

"It is not possible to approve an Aged Care Facility to participate in the S100 Remote Program as the Program is only available to AHS or other Primary Health Services"

[4] Evaluation of a model for the provision of pharmacy services to remote Aboriginal Health services. Vaughan & Wakerman, Centre for Remote Health Alice Springs. 2007
[5] Internal Ngaanyatjarra documents

Technically this means the patient has to be taken to the clinic and be seen by a remote area nurse or medical practitioner and be given medications from the clinic. It also means a remote aged care facility cannot access S100 support allowance funds which would allow greater pharmacist input and systems.

Kungkarrangkalpa aged care facility is owned by Ngaanyatjarra Health Service.

Correspondence with the Hospital Pharmaceuticals, Access and Systems Branch, Department of Health and Ageing earlier this year indicated this issue was being looked at again. We are unaware of any outcome.

With S100 supply of pharmaceuticals to remote health services, the QUMAX program and now Closing The Gap prescriptions providing access to medications for Indigenous Australians across Australia is ironic that the only place medications need to be paid for are on discharge from a public hospital.

Many public hospitals have now utilised the PBS to supply medications to patients on discharge. Unfortunately they have no access to any of these programs to assist Indigenous Australians with medication access. While I know of no hospital refusing supply as a patient cannot pay bills are sent out into remote communities. On one occasion a bill was sent for the full cost of the multiple medications provided on discharge as a concession card number was not obtained from the patient or Centrelink while an inpatient.

Recommendations:

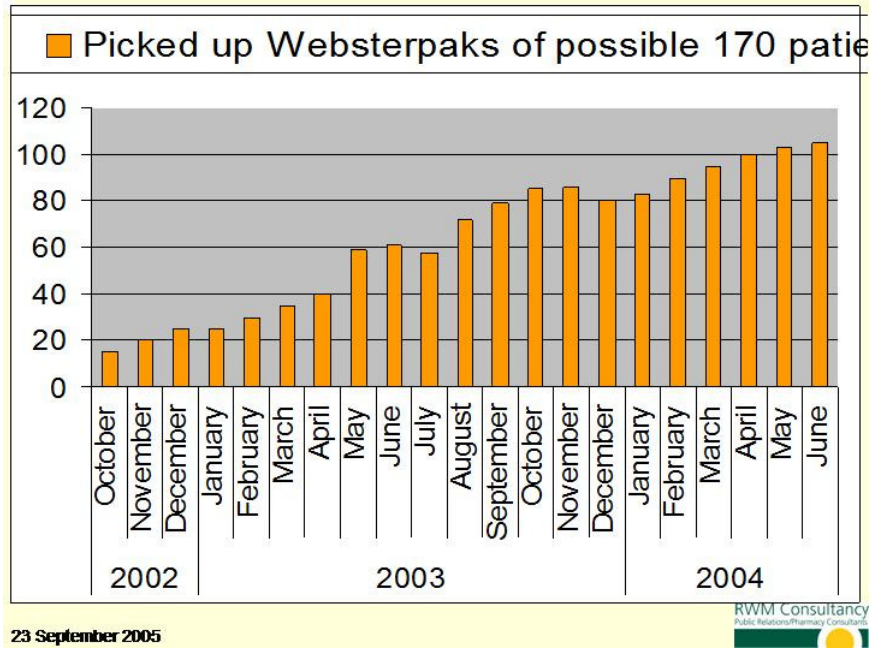
- Funding for pharmacists be made available for Indigenous Health Services
- Cost of the S100 medications supplied to a remote health service to be provided to the health service.
- Medicare to enable electronic claiming by supply pharmacies as a matter of urgency.
- Funding of studies to determine adherence (or at least pick up rates) of medications from remote health services and of use of medications mainly used in acute care settings in mainstream Australia to provide an accurate comparison of pharmaceutical use between remote and mainstream Australia.
- Remote Aged Care Facilities to be covered by the S100 program and S100 support allowance funding
- Public Hospital Pharmacy Departments to have access to current Indigenous Programs to defray medication costs to Indigenous patients on discharge

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

There are no studies Ngaanyatjarra Health is aware of that suggest an improvement in a patients knowledge of medications due to improved access to medications. There are also

no studies Ngaanyatjarra Health is aware of showing increased adherence due only to increased availability of medications.

There is some raw data available from the Tiwi Islands Pharmacy Project from Oct 2002 until June 2004[6]. This showed an increase in pick up rates of Dose Administration Aids (DAAs) from the then Tiwi Health Service pharmacy. From a possible 160-180 patients (numbers varied) regular collection of medication increased from 18 to 105 patients over 21 months



Medications in this instance had already been prepared for collection, minimising waiting times, and had a pharmacist and medication assistants on hand to provide advice specifically about medications and disease states, improving health literacy.

DAAs by themselves do not increase health literacy or understanding of their medications. Having pre-prepared DAAs sent out from supply pharmacies can currently free up nursing time for direct patient care and possibly QUM activities. However with large distances from supply pharmacies, transient patients and changes in medication regimes there is the possibility for medication errors that may go un-noticed. Error rates in DAAs of 4.3% were found in one study, with errors attributed mainly to human error, poor communication and poor systems[7]. Due to lag times in supply, large distances from supplier and lower patient health literacy it is essential best practice systems for the implementation of DAAs be used and appropriate remuneration provided for the work involved. There is no funding for the provision of DAAs for ACCHOs.

Ngaanyatjarra Pharmacists are working with Webstercare (a DAA system supplier) and Communicare (a Patient management system for ACCHOs) to enable a transfer of data from

[6] Personal communication Rollo Manning, RWM Consultancy August 2007
[7] Accuracy of packaging of dose administration aids in regional aged care facilities in the Hunter area of New South Wales. Carruthers et al. MJA 2008; 188 (5): 280-282

the patient management system to the Webster software. This will streamline the transfer of information and reduce transcription errors.

Whilst access to medications is necessary to enable adherence to a medication regimen, adherence and patient understanding or knowledge does not occur because medications are available. There are many factors that influence adherence, particularly in a patient group with different belief systems.

Ngaanyatjarra Health has a pharmacist living and working remote as part of the primary healthcare team. Other members of the team can refer patients directly to him as does the Continuity of Care pharmacist who reviews all prescriptions written by our doctors and reviews patients' adherence. He works extensively with patients where and when they feel comfortable discussing their medications. This is often in the community or at their home.

There are many patients now comfortable calling him on the telephone and we have trialled using Skype a free videophone tool to communicate with patients discharged from Perth Hospitals but not understanding their new medication regime, particularly as they are packed in similar white boxes and have no pictographs to assist those with low literacy.

Having a pharmacist, the best equipped health professional available to review and monitor adherence and to work with patients to understand their medications perform his job within a health service can financially punish the remote health service. Whilst nurses can claim for patients with care plans for adherence review and a number of other health and allied health professionals can claim for case conferencing, pharmacists cannot. It is essential that pharmacists are able to claim from Medicare directly for performing a range of services.

A couple of months before the National E-Health Transition Authority commenced developing specifications for the transfer of information in the remote setting a meeting was held in Melbourne with relevant stakeholders including the Department of Health and Ageing regarding the inability of most patient management systems used by Indigenous Health Services to produce a printed label[8].

Labels are a legal requirement to identify medications, strength, dose, patient and supplying organisation. It allows not only the patient or patient's carers, but also other health providers to identify a patient's regimen. The Ngaanyatjarra pharmacists believe it s also the first step (along with appropriate pictograms with the label) to increase health literacy and ownership of the medications.

Recommendations

- Funding to be provided for best practice supply of dose administration aids.
- Assistance to be provided to hospitals to provide medications suitable packaged and labelled for all patients. This may include DAAs.

[8] Personal communications Andrew Roberts Lead Pharmacist Ngaanyatjarra Health

- Assistance to be provided to software providers to develop dispensing and labelling modules for the electronic patient management software.
- Funding for studies to assist with developing strategies to develop adherence.
- Pharmacists to be given provider numbers to be able to claim against Medicare
- Funding to be provided to Ngaanyatjarra Health service to research adherence changes over last six years.

(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.

Quality Use of Medicines (QUM) has a different definition depending on where you are within the health system or the role you play within the Medication management cycle. At a government level it can mean policy or regulation. At a health service level it can mean for the same health professional policy for stock control and also passing on knowledge to patients to enable them to understand their medication regimen.

The National Medicines Policy defines QUM as:

- Selecting management options wisely;
- Choosing suitable medicines if a medicine is considered necessary; and
- Using medicines safely and effectively.

The definition of QUM applies equally to decisions about medicine use by individuals and decisions that affect the health of the population[9].

Ngaanyatjarra Health with two pharmacists has a strong emphasis on Quality Use of Medicines. We have achieved a great deal but can do more. Below is a brief description of some of the activities undertaken by the pharmacist team.

Stock control and the use of imprest lists have been discussed. Despite these measures there is still some waste. A best practice, secure system of transport of expired or damaged (e.g. broken cold chain) pharmaceuticals off the Ngaanyatjarra Lands for destruction has been implemented with the assistance of the Return of Medicines program. Expired medications are transported in locked containers from a central location point to a secure disposal 1400kms away in Perth. This system has worked so well it has been duplicated for the removal of sharps from the Ngaanyatjarra clinics.

Education of other health staff occurs with regular presentations at Clinical services meetings, by calling a pharmacist 24hrs a day, adhoc information supplied when working together, newsletters and other means.

[9] National Medicines Policy Quality Use of Medicines http://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-quality.htm-copy2 accessed 30/6/2011

All new prescriptions are reviewed by a pharmacist and our Continuity of Care pharmacist ensures correct medication information is sought from hospitals and other health services and is provided to the same to ensure the correct medication regimen and follow up of treatment.

Sometimes improving QUM can lead to broader systemic changes.

Darbepoetin is used in patients with end stage renal disease to stimulate red blood cell production. The original PBS requirements meant a remote patient had to visit a nephrologist in a public hospital before commencing treatment. This can mean yet another week away from home and family for a remote Australian. Discussions by the Lead Pharmacist with representatives from the PBAC over the last few years led to a relaxation in the PBS requirements:

Treatment of anaemia requiring transfusion, defined as a haemoglobin level of less than 100 g per L, where intrinsic renal disease, as assessed by a nephrologist, is the primary cause of the anaemia[10].

This has the potential to saved considerable amounts of money by reducing possible extra trips to a major regional centre.

Whilst there is a national vaccination schedule there is at times a variation between brands and strengths and even the vaccines available in each state. Ngaanyatjarra Health though in Western Australia, for logistical reasons sources many of its pharmaceuticals, including biopharmaceuticals (vaccines) from the Northern Territory.

This resulted in Ngaanyatjarra Health paying for Hepatitis B vaccine, though covered under the National immunisation schedule as the Northern Territory did not use the same strength as indicated on the Western Australian schedule. This and a few other examples led to the pharmacist initiating discussion with the Medical Coordinator, Prevention and Control Program, led to Ngaanyatjarra Health being allowed to follow the Northern Territory Immunisation schedule. This has allowed us to use the existing logistics system and reduced double transport of vaccines improving the integrity of our cold chain.

Ngaanyatjarra Health service has two pharmacists providing QUM activities to 12 communities across an area the size of Victoria. This includes direct patient contact mainly by the remote based pharmacist. However there can be considerable delays before a pharmacist is able to see a specific patient. The Ngaanyatjarra pharmacists undertake between 250 to 400 patient encounters each month involving a mix of script reviews, telephone contact and directly seeing patients.

Recommendations:

- Funding should be provided to Aboriginal Health services to employ pharmacists.

[10] Streamlined Authority listing for darbepoetin on www.pbs.gov.au accessed 30th June 2011

- Funding for QUM activities should be funded based on need which could include parameters such as number of patients on chronic disease registers, number of mental health patients and health literacy
- Medicare rebates available for services provided by a pharmacist.

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

Many of the electronic patient management systems used in remote settings do not have a dispensing function. Recording of medications can be adhoc and labelling in many cases is handwritten with pictographs. Without a dispensing module it is difficult to legally record medication dispensing, particularly in a systematic way that can be reviewed.

Ngaanyatjarra Health Service utilises such a system. Within Ngaanyatjarra health service a system has been developed to standardise the recording of all medications to improve our ability to review adherence and check if follow up or repeat treatments have been supplied. Most prescription labels are still handwritten.

We would like to make comment on other legislative matters that may hinder pharmacist employment by a remote Aboriginal health service. Ngaanyatjarra Health's Lead Pharmacist has been living and working remote as an integral part of the primary health care team for over six years. Initially there was differing and incorrect advice provided by various regulatory bodies about the limitations of what a pharmacist could do outside of a pharmacy.

Representations to the Australian Pharmacy Council (APC) led to their Remote Rural Pharmacists Project[11] which identified several legal impediments. This report is now being reviewed by the Pharmaceutical Society of Australia. We hope recommendations will be made and these will be acted upon by the various legislatures.

Within the remote setting there has been some discussion about pharmacists working outside of a bricks and mortar section 94 pharmacy when working with a remote health service. Ngaanyatjarra Health, from a pharmacy perspective, views the clinics as hospital wards with the same systems, logistics and services available in each, similar to a hospital.

In 2006 the Western Australian Poisons Regulations 10A in relation to Poisons permits for health services was amended to allow pharmacists to dispense from clinics covered under a poisons licence.

Recommendation:

- Software providers of electronic patient management systems to urgently incorporate dispensing modules into their systems

[11] Australian Pharmacy Council Remote Rural Pharmacists Project March 2009 Lindy swain

(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

We believe there is some confusion between the dispensing of medications to a patient within a pharmacy and what is basically a wholesale supply from a pharmacy to a remote health service under the section 100 arrangements. They are different supply mechanisms with different requirements. For the former a dispensing fee of $6.42 and 10% mark-up is charged for dispensing a medication to patient and providing necessary medication information. A pharmacy earns 10% mark-up plus $2.79 for every item supplied to a remote area health service. There is no obligation for items to be dispensed or advice given to patients in this supply function.

By comparison, supply from a pharmaceutical wholesaler to a pharmacy the wholesaler is allowed a 7% margin with extra funding from a Community Service Obligation funding pool to allow overnight delivery of a medication to any rural or remote pharmacy in Australia.

There is an argument that remote health services then supplying these medications to patients are entitled to full dispensing fees and mark-ups. We believe this is unworkable with smaller pack sizes than PBS quantities often supplied with both chronic medications and medications for acute conditions. Items covered by the PBS but oven used in emergency situations (e.g. normal saline 1litre) are usually not put through a dispense system and to do so would tie up a staff member for recording purposes.

Due to remoteness, inability to obtain uncommon pharmaceuticals urgently and an increase in waste pharmaceuticals that would arise if a remote Health Service operated a full pharmacy “out bush” Ngaanyatjarra Health believes the existing supply function should continue. However funding arrangements could be altered for smaller funding for wholesaler supply and increased funding should the supply pharmacy enter into a contract to label or pack medications in DAAs. This would allow pharmacists and other staff at the health service to concentrate on providing medication information and other QUM activities.

Recomendations:

- Funding be provided for provision of DAAs
- A review of current funding provisions for S100 supply to be undertaken
- Funding for QUM activities be provided

(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

Legislation exists in the Northern Territory for Aboriginal health Workers to supply some medications under Section 29 of the NT Poisons regulations for a range of conditions. This does not exist in any other state or territory.

There are currently "Medication Assistant" type training programs in the Kimberley and Central Australia. NPS also has their Good Medicines Better Health Working with Medicines program for AHWs. NPS also runs (though reducing the training) the OPRAH program allowing pharmacists who visit remote health services to provide education to staff on the latest NPS topic. There seems to be no linkages between any of these programs.

Due to varying literacy in remote areas it is essential programs are delivered to allow for this. Mentors may also be required within the health service.

Training of adherence workers, or AHWs specialising in this area would allow a lot of QUM activities to be undertaken. However programs would have to be tailored to take in belief systems (for using analogies in training), literacy and knowledge. An increase in the number of rural academic pharmacists in both rural universities and research centres and possibly at larger health remote health services would not only increase research but could develop training programs and link in available resources.

Recommendation:

- Funding for rural academic pharmacists to be increased.

(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

Our submission is based on the activities of Ngaanyatjarra pharmacists to show what can be done at other health services and to highlight some of the problems they have encountered. Ngaanyatjarra Pharmacists have seen some consultation and had direct contact due to their unique position. However it appears very few recommendations of past programs have been made, or that they have had no effect at the remote health service level.

There is also poor communication about programs, or where it has been attempted has not been carried on. There is a "living" document titled *Status Report on action in response to the Evaluation of PBS Medicine Supply Arrangements for Remote Area Aboriginal Health Services under Section 100 of the National Health Act 1953*[12] available on the department of Health and Ageing website. It has not been updated since 1997.

12 http://www.health.gov.au/internet/main/publishing.nsf/Content/2E48095A01F2543CCA256F70000A8969/$File/~3009447.pdf accessed 30th June 2011

A newsletter from DoHA titled 'PBS Remote News[13]' commenced in 2004 to *provide information for remote area Aboriginal and Torres Strait Islander Health Services participating in the special PBS supply arrangements.*

It lasted for one edition. Communication can be better.

Recommendation:

- Improved and consistent methods of communication to be put in place by DoHA to all s100 stakeholders

(h) access to PBS generally in remote communities

The supply of PBS medications to remote areas has improved. However, most remote areas use an imprest of up to several hundred items. This of course does not and cannot cover all diseases.
Ngaanyatjarra pharmacists can discuss options that may be on imprest or after discussion arrange a particular medication for a patient and review its use to ensure it is always available for that patient.

The PBS Indigenous schedule has increased the availability of necessary medications for common diseases on the PBS and we support the continued review of evidence to place other pharmaceuticals on the Indigenous schedule.

[13] http://bitethedust.com.au/bitingthedust/2008/08/28/whatever-happened-to/