Chapter 5

Other issues

5.1 Term of Reference (j) provides for the consideration of any other related matters.

Program integration and complexity

5.2 Program and system complexity is an issue that was raised by a number of submitters, with concern being expressed about the lack of integration between relevant programs,[1] as well as narrow business rules within programs that do not allow for the best use of funding, or for innovation to occur.

5.3 While it is outside of the specific terms of reference for this inquiry, the committee has considered evidence in relation to the Closing the Gap PBS co-payment measure, which provides for the removal of the co-payment for patients of Aboriginal Community Controlled Health Services in rural or urban areas. This co-payment is not available to patients when they attend a remote area AHS or a public hospital.[2] The Centre for Remote Health states that there are now three programs providing access to PBS medicines: section 100, QUMAX (Quality Use of Medicines maximised for Aboriginal and Torres Strait Islander peoples, which is available for clients of Aboriginal Community Controlled Health services only) and the Closing the Gap co-payment measure.[3] While each may have evolved to deal with separate issues, there appears to be no overarching program governance. The Australian Medical Association (AMA) considers that a disconnection between these programs means that access to medicines may be prevented if Aboriginal and Torres Strait Islander people are using a private general practice or an AHS that is not community controlled.

5.4 On this basis the AMA recommends that the section 100 program be broadened to apply to all AHSs regardless of their location, as well as to mainstream general practices that have a demonstrable Aboriginal and Torres Strait Islander population.[4]

5.5 The South Australian Department of Health also raised a practical issue with the Closing the Gap PBS co-payment measure. While they say that removing the co-payment in remote areas through the section 100 supply program, and in urban and regional areas through this measure is welcome, there is no way for health services to identify

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1 NACCHO, *Submission 13,* p. 5

2 Society of Hospital Pharmacists, *Submission 2,* p. 12.

3 Centre for Remote Health, *Submission 10*, p. 14.

4 Australian Medical Association, *Submission 12*, p. 4.

patients who receive the Closing the Gap PBS co-payment. Consequently when patients participating in the scheme present at a public hospital, they are required to pay the patient co-payment for their discharge medicines.[5] This issue is also raised by Ngaanyatjarra Health Service which suggests that public hospital pharmacies should have access to the section 100 scheme when discharging Aboriginal patients. As they state in their submission:

> With section 100 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 it is ironic that the only place medications need to be paid for are on discharge from a public hospital.[6]

5.6 SA Health recommends that consideration be given to the development of a 'single, universal, multifaceted program' for all Aboriginal and Torres Strait Islander patients regardless of the service they are accessing and in what location so that equity of access is achieved across the continuum of care.[7] The Pharmacy Guild of Australia and the National Rural Health Alliance agree that a mechanism for ensuring the interoperability of the schemes is needed.[8]

> The increasing mobility of people living in remote areas should be recognised along with their need to travel for specialist treatment and hospitalisation. Initiatives to improve ATSI people's access to PBS benefits in urban areas (QUMAX and CTG co-payment relief) have been successful. Mechanisms are needed to allow patients to travel between remote and urban areas and between hospital and home and still have access to their PBS medicines.[9]

5.7 Another possible unintended consequence of the Closing the Gap co-payment measure is that it may be inadvertently drawing patients away from AHSs that can offer a greater level of QUM support specifically tailored to meet the needs of Aboriginal and Torres Strait Islander people.[10] NACCHO recommends that participation in this measure be made available to remote area AHSs in circumstances where patients have access to a community pharmacy in order to dispense the prescription. NACCHO says that this would reduce some of the burden of maintaining

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5 South Australian Department of Health, *Submission 17*, pp 2-3.

6 Ngaanyatjarra Health Service, *Submission 18*, p. 7.

7 South Australian Department of Health, *Submission 17*, p. 3.

8 National Rural Health Alliance, *Submission 21*, p. 4; Minister for Health, NSW, *Submission 25*, p. 3.

9 Pharmacy Guild of Australia, *Submission 19*, p. 9

10 NACCHO, *Submission 13*, p 4; Queensland Aboriginal and Islander Health Council, *Submission 11*, p. 5.

in-house stock in locations where patients had ready access to a community pharmacy as well as an AHS.[11]

5.8 The Queensland Aboriginal and Islander Health Council (QAIHC) agrees, stating that the often unconnected and unintegrated nature of these programs add to complexity for primary health care providers, requiring greater coordination within primary health care settings. Both QAIHC and NACCHO suggest that the dispensing fee gap of $3.68 could be used to fund the introduction of a scheme:

> ...to allocate QUM budgets to [Aboriginal Community Controlled Health Services] from which services can draw from, and negotiate service-specific activities with community pharmacy or academic pharmacists. The difference between the SECTION 100 program handling fee ($2.79) and the PBS dispensing fee ($6.42) per item comprises a PBS under spend that could be used to fund a range of service specific QUM initiatives within ACCHSs.[12]

5.9 While pharmacists may be able to provide extended clinical programs such as medicine use reviews, dose administration aids, disease state management for conditions like diabetes and asthma, and health promotion, it appears that funding for the exclusive provision of these services is limited to members of the Pharmacy Guild of Australia. The committee considers that where AHSs wish to, and have capacity to do so, provision should be made for these services to be provided by the AHS directly by using the funding to place a pharmacist within an AHS.[13]

5.10 A related program supporting improved adherence to medicines is the Home Medicines Review (HMR). The Society of Hospital Pharmacists says that access to this program is in practice not available to patients of AHSs by rules which require referral from a GP and for the review to be conducted via a community pharmacy. These are rules developed by the Pharmacy Guild of Australia and Medicare Australia.[14] As previously discussed, the 2008 evaluation of the HMR program found that Aboriginal and Torres Strait Islander people are amongst those least likely to receive a HMR but are amongst those in greatest need of one, and that it was rare for a HMR to have been conducted for those most in need of access to the program. 'Overall the research confirmed that those in greatest need of a HMR are the least likely to receive one...'.[15]

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11 NACCHO, *Submission 13*, p. 16.

12 Queensland Aboriginal and Islander Health Council, *Submission 11*, p. 6; NACCHO *Submission 13*, p. 5.

13 Centre for Remote Health, *Submission 10*, p. 14.

14 Campbell Research and Consulting, *Home Medicines Review Program - Qualitative Research Project, Final Report*, December 2008, p. 17.

15 Campbell Research and Consulting, *Home Medicines Review Program - Qualitative Research Project, Final Report*, December 2008, p. 5.

Recommendation 9

5.11 The committee would like to see greater integration of existing programs to provide complementary services to patients of AHSs. The evidence the committee received during the course of this inquiry supports this. Therefore the committee recommends that DOHA develop a process for integrating existing programs, and that a clear policy and program logic is published to show how these programs will work together.

Aboriginal and Torres Strait Islander patients in remote aged care facilities

5.12 Ngaanyatjarra Health Service advised the committee that there is some doubt as to whether Indigenous patients in remote aged care facilities are covered under the section 100 program. The service has been advised by DOHA that it is not possible for patients in aged care facilities to be covered by the program as it is only available through AHSs or other participating primary health services.[16]

5.13 Ngaanyatjarra Health Service owns and runs an aged care facility called Kungkarrankalpa and says that this situation means that technically a patient in an aged care facility has to be taken to the remote clinic, seen by an appropriate practitioner and be given medications from the clinic. 'It also means a remote aged care facility cannot access section 100 pharmacy support allowance funds which would allow greater pharmacist input and systems.'[17]

Recommendation 10

5.14 The committee recommends that the Commonwealth Government clarify the application of the section 100 supply program to remote aged care facilities, and advise operators of these facilities accordingly.

Royal Flying Doctor Service

5.15 The committee was also presented with evidence from the Royal Flying Doctor Service that while it could not access the section 100 supply program, nor the Closing the Gap co-payment measure, it estimated that up to 40 percent of its patients are Aboriginal and Torres Strait Islander people.[18] DOHA has advised the committee that the RFDS is unable to participate in the program because it does not meet the legislative requirements for participation. DOHA states that the RFDS received $247 million in the period 2007-08 to 2010-2011 in order to provide health care clinics, primary aero-medical evacuations, medical chests and remote consultations.[19]

16 Ngaanyatjarra Health Service, *Submission 18*, p. 6.

17 Ngaanyatjarra Health Service, *Submission 18*, p. 7.

18 Royal Flying Doctor Service, *Submission 9*, p. 3.

19 Correspondence from DOHA to the Committee, 12 September 2011.

5.16 The committee suggests that the Commonwealth Government consider whether the RFDS should be included in the RAAHS program.

Senator Rachel Siewert
Chair