The Senate

Community Affairs References Committee

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

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Secretariat

Dr Ian Holland (Committee Secretary)
Ms Toni Matulick (Committee Secretary)
Ms Jo-Anne Holmes (Administrative Officer)
Mr Tim Hillman (Administrative Officer)

PO Box 6100
Parliament House
Canberra ACT 2600
Ph: 02 6277 3515
Fax: 02 6277 5829
E-mail: community.affairs.sen@aph.gov.au
Internet: http://www.aph.gov.au/Senate/committee/clac_ctte/index.htm

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43rd Parliament

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ACRONYMS AND ABBREVIATIONS

ACCHs	Aboriginal Community Controlled Health Services
AHS	Aboriginal Health Service
AHWs	Aboriginal Health Workers
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMSANT	Aboriginal Medical Services Association of the Northern Territory
APHRA	Australian Health Practitioner Registration Board
DAAs	Dose Administration Aids
DOHA	Commonwealth Department of Health and Ageing
EAP	Expert Advisory Panel on Aboriginal and Torres Strait Islander Medicines
GPs	General practitioners
HMR	Home Medicines Review
KAMSC	Kimberley Aboriginal Medical Services Council
MBS	Medicare Benefits Schedule
MOUs	Memoranda of Understanding
NACCHO	National Aboriginal Community Controlled Health Organisation
NPS	National Prescribing Service
OPRAH	Outreach Pharmacists for Remote Aboriginal and Torres Strait Islander Health Services
PBS	Pharmaceutical Benefits Scheme
PIP	Practice Incentive Program
QAIHC	Queensland Aboriginal and Islander Health Council
QUM	Quality Use of Medicines
QUMAX	Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People
RAAHS	Remote Area Aboriginal Health Services
RRMA	Rural, Remote and Metropolitan Areas Classification
WA	Western Australia

RECOMMENDATIONS

Recommendation 1

2.19 The committee considers that to the extent that compliance with privacy laws and obligations can be maintained, Medicare Australia and DOHA should facilitate the release of information to parties requesting it to ensure that opportunities to understand the impact of the program are not wasted.

Recommendation 2

2.28 The committee recommends that the Commonwealth Government undertake an evaluation to ascertain whether the increased supply of PBS medicines provided by the program is having a clinical impact on the health of Aboriginal and Torres Strait Islander people in remote communities.

Recommendation 3

2.46 The committee recommends that the Commonwealth Government provide specific funding for remote area AHSs to be able to provide dose administration aids (DAAs) to their patients.

Recommendation 4

2.70 The committee agrees with submitters and recommends that program flexibility be implemented to give remote area AHSs increased and direct access to the services of a pharmacist. This could be done by AHSs engaging a pharmacist directly or in collaboration with other stakeholders or service providers. Options for funding and operating these services could include cashing-out existing program funding, access to alternative funding measures, expansion of the Practice Nurse Incentive Program to include pharmacists, remunerating remote pharmacists for services though the Medicare Benefits Schedule, and removal of legislative barriers that prevent the operation of pharmacy businesses in remote areas.

Recommendation 5

2.71 The committee recommends that the Commonwealth Government establish a consultative body of relevant stakeholders to develop proposals and options to increase direct access to pharmacists for remote area AHSs, consult program participants and others, and provide support to AHSs to allow them to make informed choices about options.

Recommendation 6

3.8 The committee is surprised to note that there is no universal system in place to provide for accurate and legible labelling and recording of medicines. The committee therefore recommends that the Commonwealth Government urgently support the development and introduction of efficient standardised systems for accurate labelling of medicines in remote area AHSs, and that these systems are developed to ensure accurate collection of medicine data and use.

Recommendation 7

4.31 The committee recommends that the Commonwealth Government publish information on the status of recommendations from previous reports, making it clear which recommendations will be implemented, timeframes and responsibility for implementation.

Recommendation 8

4.32 The committee recommends that the Commonwealth Government ensure that participants in the section 100 program have sufficient opportunities to participate in the implementation process.

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.

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.

Chapter 1

Introduction

Terms of Reference

1.1 On 24 March 2011 the Senate referred the following matter to the Senate Community Affairs References Committee for inquiry and report:

> 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 (AHSs), with particular reference to:
>
> (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;
>
> (h) access to PBS generally in remote communities; and
>
> (i) any other related matters.

1.2 The initial reporting date was 18 August 2011 however on 29 June 2011, the Senate granted an extension of time for reporting until 11 October 2011.

1.3 The committee received 29 submissions. Due to the comprehensive nature of submissions received by the committee, no public hearings were held.

1.4 The committee is grateful to submitters for assisting them in the course of the inquiry, and to the Commonwealth Department of Health and Ageing (DOHA) and the Queensland Government for responding to questions on notice.

Framework for the supply of PBS medicines in Australia

1.5 The Commonwealth government subsidises a wide range of prescription drugs under the Pharmaceutical Benefits Scheme (PBS). Items included in the PBS are subsidised to make them accessible and affordable. Each time a prescription is filled, the patient pays an amount that is often much less than the actual cost of the drugs. In 2011, the general patient contribution is $34.20 and the concessional patient contribution is $5.60.[1]

1.6 PBS medicines are dispensed through a network of approximately 5000 community pharmacies. These privately owned and operated pharmacies are represented by the Pharmacy Guild of Australia.

1.7 Five year Pharmacy Agreements between the Commonwealth and the Pharmacy Guild of Australia govern arrangements for community pharmacies to be remunerated for dispensing PBS medicines and to provide pharmacy programs and services. The current Pharmacy Agreement sets out rules for the operation of Community Services Obligation arrangements which provide financial support to pharmaceutical wholesalers to supply the full range of PBS medicines via community pharmacies, usually within 24 hours of ordering, and regardless of where these pharmacies are located.

1.8 While the arrangements for the provision of PBS medicines through community pharmacies described above may provide good access for most Australians, people who do not live in areas where community pharmacies are located will find accessibility and affordability much more difficult.

Special arrangements for the supply of PBS medicines to AHSs

1.9 Special arrangements for the supply of PBS medicines to Aboriginal and Torres Strait Islander people in remote communities are in place in order to improve access and use of PBS medicines. The two main programs are:

(a) The section 100 supply program, which provides payments to community pharmacies for dispensing PBS medicines in bulk to remote area Aboriginal Health Services (AHSs).

1 DOHA, *New PBS Safety Net Thresholds*, http://www.health.gov.au/internet/main/publishing.nsf/Content/pbs-safetynet-changes (accessed 26 September 2011).

(b) The section 100 pharmacy support allowance, which provides payments to community pharmacists to help AHSs improve the way that their patients use PBS medicines.

1.10 Collectively these two programs are known as the Remote Area Aboriginal Health Services (RAAHS) program. A number of other programs have direct and indirect impact on the operation of the RAAHS program and will be referred to in the course of this report.

1.11 Section 100 of the *National Health Act 1953* (National Health Act) provides for special arrangements to be made to ensure that an adequate supply of pharmaceutical benefits will be available to people living in isolated areas. The RAAHS program operates under this provision and provides for PBS medicines to be dispensed in bulk through community pharmacies and hospital authorities to Aboriginal Health Services. These medicines are supplied, at no cost to patients, by doctors, nurses or Aboriginal Health Workers (AHWs). In this sense PBS medicines provided under this program are 'free' to patients.

1.12 The section 100 supply program commenced in 1999. Participation in the scheme is, with a few exceptions, limited to AHSs operating in remote areas.

1.13 In order to be able to participate in the program, the community pharmacy or hospital authority, as well as the remote area AHS, must be approved by DOHA in order to carry out relevant functions. The PBS items must be dispensed directly by a pharmacist or hospital authority to the remote area AHS. PBS medicines are then supplied to patients of the AHS by a qualified and approved health professional in accordance with relevant state and territory law.[2]

1.14 Medicare Australia reimburses the supplying community pharmacist or hospital authority.[3]

1.15 The *National Health (Remote Aboriginal Health Services Programs) Special Arrangements Instrument 2010* sets up the eligibility criteria for the assessment and approval of AHSs.

1.16 Health services must meet eligibility criteria set out below:[4]

(a) The health service must have a primary function of meeting the health care needs of Aboriginal and Torres Strait Islander peoples.

(b) The clinic, or other health care facility, operated by the AHS from which pharmaceuticals are supplied to patients must be in a remote zone as

2 DOHA, S*ubmission 24*, p. 5.

3 DOHA, *Submission 24*, p. 5.

4 DOHA, *Alternative Arrangements for Medicines*, http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-indigenous-eligibility (accessed 12 July 2011).

defined in the Rural, Remote and Metropolitan Areas (RRMA)[5] Classification 1991 Census Edition.

(c) The AHS must not be a party to an arrangement, such as a coordinated care trial, for which funds from the Pharmaceutical Benefits Scheme have already been provided.

(d) The AHS must employ or be in a contractual relationship with health professionals who are suitably qualified under relevant state/territory legislation to supply all medications covered by the section 100 arrangements and undertake that all supply of benefit items will be under the direction of such qualified persons.

(e) The clinic or other health care facility operated by the AHS from which pharmaceuticals are supplied must have storage facilities that will:

(i) prevent access by unauthorised persons;

(ii) maintain the quality (eg chemical and biological stability and sterility) of the pharmaceutical; and

(iii) comply with any special conditions specified by the manufacturer of the pharmaceutical.

1.17 Information on the DOHA website indicates that the remuneration and claims system for pharmacists and hospital authorities participating in the program operates in the following way:

> The Australian Government reimburses pharmacies and hospital authorities under the section 100 Remote Program for pharmaceutical benefits supplied by approved health services.
>
> The remuneration is the sum of the approved price to pharmacists, mark-ups, as appropriate for the cost of the item and a handling fee.
>
> The approved price and mark-up are defined under section 98B(3) and 98B(1)(a) of the Act respectively. Current mark-up amounts are detailed by Medicare Australia...
>
> The handling fee historically was $1.14 and temporarily increased by $1.55 to $2.69 per Pharmaceutical Benefit Schedule (PBS) item supplied. This was the result of discussions between the Australian Government, the Pharmacy Guild of Australia, and a number of individual pharmacists. This increase was included as a measure in the 2009-10 Federal Budget and was effective from 1 January 2009 to 30 June 2010 at a cost of $3.1 million.

5 Australian Bureau of Statistics, *8689.0 - Private Medical Practitioners, Australia, 2002*, http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/8689.0Explanatory%20Notes12002 (accessed 30 August 2011). The RRMA Classification has been used to classify the geographical location of medical practitioners according to their main private practice address. The RRMA classification was originally developed in 1994 by the former departments of Primary Industry and Energy, and Human Services and Health. The original RRMA classification assigned locations to seven categories according to geographic boundaries based on the 1991 population census.

> [An] Ongoing increase to the section 100 handling fee was announced in the 2010/2011 Budget. The fee was increased to $2.74 on 1 July 2010, and will be indexed annually.[6]

Purpose of the program

1.18 The section 100 supply program commenced in 1999 in response to the low use of PBS medicines by Aboriginal and Torres Strait Islander people in remote areas relative to other Australians. The program was introduced after a review[7] of PBS expenditure showed that Aboriginal and Torres Strait Islander people in both urban and remote areas had reduced access to PBS medicines compared with non-Indigenous people. The Centre for Remote Health notes that this review found that that there was only 33c spent on the PBS for Aboriginal and Torres Strait Islander people compared with $1 for non-Indigenous people, with this comparison subsequently being used as a measure of access to the PBS.[8]

1.19 Research by the Australian Institute of Health and Welfare (AIHW) shows that current Medicare expenditure is much lower for Aboriginal and Torres Strait Islander people than that for non-Indigenous Australians, with 57 cents per dollar being spent on Aboriginal and Torres Strait Islander people. In relation to the use of the PBS, the Indigenous to non-Indigenous expenditure per person ratio is 0.74. The only PBS service type with a high expenditure ratio occurs under RAAHS program.[9]

1.20 The Centre for Remote Health puts it in another way:

> The AIHW last year estimated that [per person expenditure] had risen to 60c per dollar. However, the same report found that in Remote/very remote areas, Indigenous Australians received PBS expenditure of $23 more per person than non-Indigenous Australians (a ratio of 1.12). It attributes this to the fact that Section 100 arrangements allow patients attending an approved remote area Aboriginal and Torres Strait Islander health service to receive PBS medicines without the need for a prescription form and at no charge.[10]

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6 DOHA website, http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-indigenous-remuneration (accessed 12 July 2011).

7 Keys-Young, *Aboriginal and Torres Strait Islander access to Medicare and the Pharmaceutical Benefits Scheme*, 1996, Health Insurance Commission, Canberra.

8 Centre for Remote Health, *Submission 10*, p. 4.

9 AIHW, *Expenditure on health for Aboriginal and Torres Strait Islander people 2008-09*, Health and welfare expenditure series no. 44. Cat. no. HWE 53, p. 18, http://www.aihw.gov.au/publication-detail/?id=10737419257&tab=2 (accessed 18 July 2011).

10 Centre for Remote Health, *Submission 10*, p. 4.

1.21 It is well known that the prevalence of chronic disease in remote Aboriginal and Torres Strait Islander communities is much higher than in the general Australian population, with many factors contributing to this situation. Barriers to the use of medicines to treat chronic disease include levels of English and health literacy, the ability to understand instructions for use of medicines, cultural issues around taking medicines and accessing services, concurrent use of bush or traditional medicines, issues related to continuity of care and forming relationships with health practitioners, as well as geographical isolation and physical access to health services.[11]

1.22 DOHA's submission to the inquiry states that geographical, cultural and financial issues impact on access to PBS medicines by Aboriginal and Torres Strait Islander people in remote areas.[12] Aboriginal and Torres Strait Islander people living in remote communities can experience delays in obtaining medicines through standard prescription-based supply arrangements due to the shortage of both prescribers and pharmacists with established services in these remote areas. They may face difficulty in demonstrating their eligibility for PBS concessional benefits, and they may also have difficulty in affording medicines. The RAAHS program tries to overcome these barriers.

1.23 DOHA has provided the committee with the following information:

> From its inception in 1999, the RAAHS Program has grown from servicing 35 remote Aboriginal Health Services to 173 in 2011.
>
> The supply of PBS items has increased from around 250,000 in 1999-2000 to more than 1.4 million in 2010-11.
>
> In 2010-11, expenditure under the RAAHS Program had grown to $43 million from $3.9 million when it commenced in 1999.
>
> Around 170,000 Aboriginal and Torres Strait Islander people are estimated to benefit from the increased access to PBS medicines and better quality use of medicines activities.[13]

1.24 Program expenditure and participation is shown in the tables below.

Fin year	2006-07	2007-08	2008-09	2009-10	2010-11
Total exp	26.8	32.9	34.1	37.3	43.0

Table 1: RAAHS Program PBS expenditure 2006-07 to 2010-11 ($ million)[14]

11 Society of Hospital Pharmacists, *Submission 3,* p. 3.

12 DOHA, *Submission 24,* p. 5.

13 DOHA, *Submission 24,* p. 4.

14 Chart kindly supplied by DOHA.

	Community operated	State/Territory operated	Total
NSW	5	-	5
NT	25	54	79
Qld	5	39	44
SA	5	2	7
Tas	2	-	2
WA	17	19	36
Total	**59**	**114**	**173**

Table 2: Number of AHSs by State and Territory approved to participate in the RAAHS Program[15]

1.25 Participating AHSs are either community-controlled services, or are operated by state or territory governments in Western Australia, South Australia, Queensland or the Northern Territory. Of the 173 AHSs currently participating in the program, the majority of these are state/territory government-run AHSs. Only one third of participating services are Aboriginal Community Controlled Health Services (ACCHSs).

1.26 The National Aboriginal Community Controlled Health Organisation (NACCHO) has advised the committee that ACCHSs are distinct from state and territory government-run services and private general practices on the basis that they are governed by an Aboriginal body elected by the local Aboriginal community and are not for profit services.[16]

1.27 DOHA advised the committee that Memoranda of Understanding (MOUs) were agreed between DOHA and the governments of the Northern Territory, Queensland, South Australia and Western Australia to facilitate their participation in the program.[17] Queensland Health has advised the committee that the MOU between the state of Queensland and DOHA expired on 31 December 2009.[18] The committee understands that this is true for all jurisdictions, and there are no current MOUs. While there are no MOU in place, services under the RAAHS program are continuing to be provided, with a framework for their operation set out in the National Health (Remote Aboriginal Health Services Program) Special Arrangements Instrument 2010. The instrument covers some of the areas that were contained in the MOUs, such as eligibility criteria for participation in the scheme, aspects of the protocols for participation, such as how stock is to be obtained and dispensed, and how remuneration for items is to be determined. Other aspects of the MOUs are absent

15 Chart kindly supplied by DOHA.

16 NACCHO, *Submission. 13,* p. 8.

17 DOHA, *Submission 24,* p. 6.

18 Correspondence to Committee from Queensland Health, 12 September 2011.

from the regulation, in particular how savings achieved through the program are to be assessed and used.[19]

> Exploring options for new MOUs with state/territory governments to strengthen reporting requirements and to ensure ongoing consistency of the MOUs with the program's objective of meeting the health care needs of Aboriginal and Torres Strait Islander people.[20]

1.28 In Queensland, the Northern Territory and Western Australia where these governments manage remote AHSs, a tender process for the supply of pharmacy services under the section 100 program is used.[21] This tender process has evolved to include state or territory-specific conditions and means that the supply model can differ significantly between the states and the Northern Territory. [22]

1.29 The committee notes that non-Indigenous people may be recipients of PBS medicines under the program as the section 100 supply arrangements apply to all clients of remote AHSs. As Ngaanyatjarra Health Service points out, it 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.[23]

1.30 The committee is interested to note that the number of participating health services in New South Wales and South Australia is relatively low considering the population of Aboriginal and Torres Strait Islander people living in remote areas in these states.

Section 100 Pharmacy Support Allowance

1.31 The section 100 pharmacy support allowance complements the section 100 supply program. It commenced in 2001 and funds the provision of services from a pharmacy to AHSs in order to improve the way in which patients use the medicines that are supplied under the program.

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19 See for example, Memorandum of Understanding between the Commonwealth of Australia through the Department of Health and Aged Care and the State of Queensland through the Department of Health, *Supply of PBS medicines to Queensland Health operated and/or funded remote area Aboriginal health services under the provisions of section 100 of the* National Health Act 1953 (Cwlth), available at http://www.health.qld.gov.au/atsihealth/documents/16911.pdf

20 DOHA, *Submission 24*, p. 6.

21 Detailed information about section 100 arrangements in Queensland government operated clinics is provided in correspondence to the committee from Queensland Health, 12 September 2011, available at http://aph.gov.au/Senate/committee/clac_ctte/pbs_medicines/submissions.htm

22 Pharmacy Guild of Australia, *Submission 19*, p. 11.

23 Ngaanyatjarra Health Service, *Submission 18*, pp 3; 5.

1.32 The allowance is an amount of between $6000 and $10 500 per annum per AHS. The program also provides for a flat rate of $6000 to be paid in relation to outstations attached to AHSs. For the purposes of the program, these outstations must be a:

> ...remote permanent health service, staffed by at least one permanent healthcare worker, where prescription only ('Schedule Four') medicines are stored in compliance with an approval issued by the relevant State/Territory health authority.[24]

1.33 Payment of the allowance is based on the amount of PBS items supplied each year and travel loadings are calculated on distance from the supplying pharmacy to the AHS. In addition, another loading is payable if the AHS is on an island or if aircraft or boat transport is required to attend the AHS.

1.34 The Community Pharmacy Kit, developed by the Pharmacy Guild of Australia and DOHA to support participants in the program, states that services under the section 100 pharmacy support allowance should include:

- Developing and implementing a work plan for supply arrangements within the AHS;
- Providing assistance to implement appropriate procedures and protocols for managing supply arrangements, including establishment of a medicine store;
- Developing a range of other measures to enhance the quality use of medicines (which may include assistance with dose administration aids, participation in regular meetings with health staff, and review of patient medication);
- Implementing agreed measures which aim to enhance quality use of medicines; and
- Providing a range of education services to AHS clinical and support staff relating to medicines and their management.[25]

1.35 Like the section 100 supply program, applications are assessed by DOHA and payments made by Medicare Australia.

Quality Use of Medicines

1.36 Quality Use of Medicines (QUM) is the name of a policy described by DOHA as 'one of the central objectives of Australia's National Medicines Policy'.[26] QUM

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24 *Pharmacy Information Kit –Section 100 Pharmacy Support Allowance Program*, DOHA and Pharmacy Guild of Australia, 2008, pp 1-5, http://www.ruralpharmacy.com.au/LinkClick.aspx?fileticket=LKurJbHcR8U%3D&tabid=655&language=en-AU (accessed 18 July 2011).

25 Pharmacy Information Kit –Section 100 Pharmacy Support Allowance Program, Department of Health and Ageing and Pharmacy Guild of Australia, 2008, pp 1-6, http://www.ruralpharmacy.com.au/LinkClick.aspx?fileticket=LKurJbHcR8U%3D&tabid=655&language=en-AU (accessed 18 July 2011).

means managing medicine treatment options wisely, choosing suitable medicines if a medicine is considered necessary, and using medicines safely and effectively.[27] The Centre for Remote Health describes QUM as:

> ...ensuring patients know how to take [their medicine], why they should take it, what alternatives there are to taking medicines, what will happen if they don't take it, possible side effects they should look out for and how will they know if it is helping them?[28]

1.37 The section 100 pharmacy support allowance is designed to provide specific services to AHSs that lead to improved use of medicines by their patients.

Other support programs

1.38 Workforce programs designed to attract more workers into pharmacy in rural areas are in operation, such as the Aboriginal and Torres Strait Islander Scholarship Program for pharmacy studies and the Rural Pharmacy Workforce Program's Scholarship for people from rural areas.

1.39 DOHA says that these programs:

> ...increase the likelihood of a larger rural pharmacy workforce, and potentially lead to more pharmacists being available to provide QUM support visits to remote AHSs. In addition, there is the Aboriginal and Torres Strait Islander Pharmacy Assistant Traineeship Program. This Program aims to increase the number of Indigenous health workers employed as pharmacy assistants. Such people could be well placed to work directly for remote AHSs and to support QUM activities.[29]

QUMAX and PBS Co-payment Relief Measure

1.40 Two other PBS co-payment schemes operate to improve access to PBS medicines for Aboriginal and Torres Strait Islander peoples, but these do not apply to patients of remote area AHSs. QUMAX, or Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People, commenced in 2008 and is jointly administered by NACCHO and the Pharmacy Guild of Australia.

1.41 NACCHO explains the program's application and impact in the following way:

> QUMAX was developed jointly by the Pharmacy Guild of Australia and the National Aboriginal Community Controlled Health Organisation under the

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26 Website http://www.health.gov.au/internet/main/Publishing.nsf/Content/nmp-quality.htm (accessed 18 July 2011).

27 Website http://www.health.gov.au/internet/main/Publishing.nsf/Content/nmp-quality.htm (accessed 18 July 2011).

28 Centre for Remote Health, *Submission 10,* p. 5.

29 DOHA, *Submission 24,* p. 6.

> 4th Community Pharmacy Agreement in 2006-07. It commenced a program of intensive QUM support, provision of dose-administration aids (DAA's), transport support and co-payment relief in 2008 until 30 June 2010, in non-remote ACCHSs. Thereafter, the co-payment relief function was transferred to the PBS co-payment relief measure (CTG scripts). QUMAX continues to provide DAA's and substantial QUM support to 2015 under the 5th Community Pharmacy Agreement.
>
> QUMAX has been highly successful at increasing medicines access for 'needy' and disadvantaged Aboriginal peoples by eliminating co-payment across 70 ACCHSs in nonremote locations.
>
> Between November 2009 and April 2010, the proportionate increase in the number of PBS medicines dispensed to patients of non-remote ACCHSs was nearly five times greater than the increase in medicines dispensed to all Australians, and exceeded the increase seen in remote areas (SECTION 100) by a factor of seven.[30]

1.42 The PBS co-payment relief measure under the Indigenous Chronic Disease Program is based on a person self-identifying as an Aboriginal or Torres Strait Islander person and then being eligible for registration with Medicare Australia to participate in the program:

> ...through either a private general practice registered with the Indigenous Practice Incentive Program (PIP) and living anywhere in Australia; or an 'Indigenous Health Service', if the service is in a nonremote area. Once PIP registered, the general practice receives an incentive payment from Medicare Australia, and if the patient is deemed eligible they can have their PBS scripts annotated 'CTG' (Close the Gap), to receive either free medicines or significantly reduced co-payments for medicines.[31]

1.43 There are no QUM activities linked with the CTG co-payment measure.

1.44 While these programs do not apply to patients of remote AHSs the committee has considered it important to refer to the programs for three reasons: firstly they provide examples of other schemes in operation; secondly because the QUMAX scheme specifically includes funding for dose administration aids (DAAs) which are compartmentalised boxes or blister packs designed to provide a specific dose of medication, raised as an issue by a number of submitters during the course of this inquiry and thirdly because there seems to be a high level of frustration that each of the programs do not integrate with each other when they are specifically designed to target a highly mobile population.

30 NACCHO, *Submission 13*, pp 12-13.

31 NACCHO, *Submission 13*, pp 13-14.

Outreach Pharmacists for Remote Aboriginal and Torres Strait Islander Health Services

1.45 The Outreach Pharmacists for Remote Aboriginal and Torres Strait Islander Health Services (OPRAH) program is run by the National Prescribing Service (NPS)[32] and provides training to pharmacists to develop the skills required to work directly with AHSs. The OPRAH program operates on a very small budget, estimated at $60 000 for the 2010-11 year and a budget yet to be approved for the 2011-13 years but anticipated to be $140 000.[33] This program aims to train 45 participants a year[34] who participate in structured training and attend workshops designed to improve their ability to support quality use of medicines in AHSs.

Good Medicines Better Health

1.46 The Good Medicines Better Health program is also funded by the NPS to train Aboriginal Health Workers to support their colleagues in the quality use of medicines. It is based on the 'train the trainer' model, with approximately 60 AHWs expected to complete training as trainers over the three year program which ends in 2014.[35]

32 The National Prescribing Service is a not for profit organisation established in 1998 to provide information to individuals and health professionals to allow them to make better decisions about medicines and medical tests, leading to better health and economic outcomes, NPS website, http://www.nps.org.au/about_us (accessed 4 October 2011).

33 National Prescribing Service, *Submission 8,* p. 3.

34 National Prescribing Service, *Submission 8,* p. 3.

35 NACCHO, *Submission 13,* p. 25.

Chapter 2

Impact of the program

Does the program address barriers to access of PBS medicines?

2.1 Term of Reference (a) considers whether the RAAHS program arrangements adequately address barriers experienced by Aboriginal and Torres Strait Islander people living in remote areas of Australia to access essential medicines through the PBS, and Term of Reference (h) considers access to PBS generally in remote communities

2.2 Submitters agree that the section 100 supply program has been very successful in providing an increased amount of PBS medicines to patients of AHSs. To the extent that the program is a supply arrangement, it has certainly met its objectives.[1] As the Pharmacy Guild of Australia states:

> The [section 100 Remote Aboriginal Health Services Program] provides a solid base for ensuring access to medicines, and should be allowed to evolve to offer more Quality Use of Medicines…to patients of remote AHS's.[2]

2.3 Chart 1 below shows the number of PBS items supplied through participating AHSs as well as expenditure on the program.

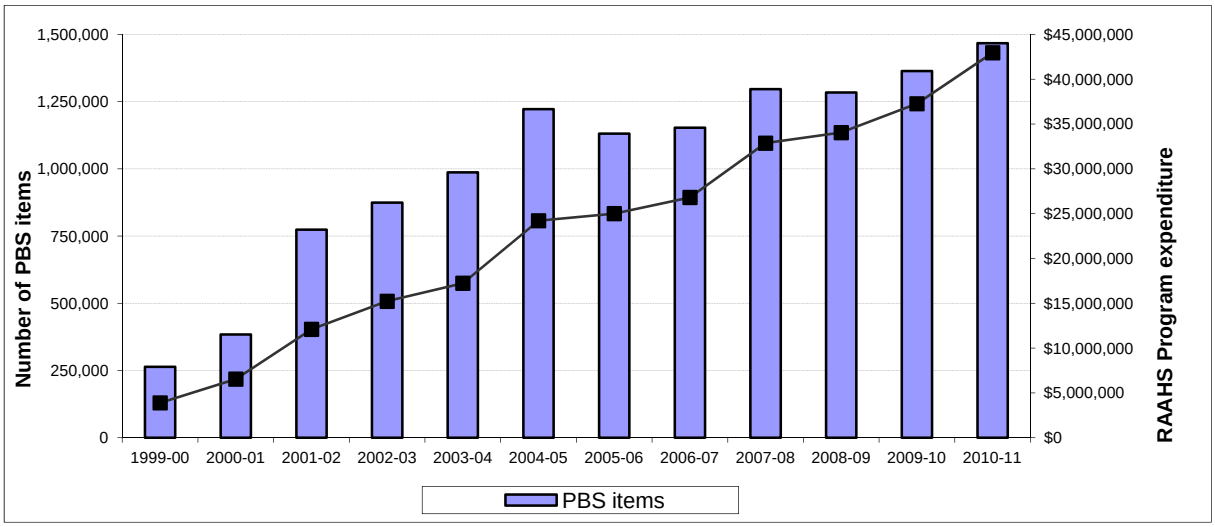

Chart 1: Number of PBS items supplied to participating AHSs and RAAHS Program expenditure[3]

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1 Kimberley Pharmacy Services, *Submission 6, p. 2;* Centre for Remote Health, *Submission 10,* p. 4; Australian Medical Association, *Submission 12,* p. 1; Mr Rollo Manning, *Submission 26,* p. 8; Name withheld, *Submission 15,* p. 1; Pharmacy Guild of Australia, *Submission 19,* p. 7.

2 Pharmacy Guild of Australia, *Submission 19,* p. 7.

3 Chart kindly supplied by DOHA.

2.4 Chart 1 above shows that since the program's commencement there has been steady growth in the number of PBS items supplied to participating remote area AHSs. Studies completed by the AIHW, discussed previously in Chapter 1, confirm that the supply program has had an impact on the amount of PBS items being supplied to remote AHSs.

2.5 The DOHA submission states that a major review of the section 100 supply program published in 2004 concluded that the program had improved access to PBS medicines.[4] In addition:

> The…Program has grown over the last 13 years. It now provides access to around 1.4 million PBS items per year at no cost to patients, reaching many isolated communities where Aboriginal and Torres Strait Islander peoples would otherwise experience difficulty in accessing medicines.
>
> In recent years, the number of PBS items supplied to participating AHSs has been relatively steady, at around 1.3 million items annually. The …Program is meeting a need for essential medicines in remote Aboriginal and Torres Strait Islander communities.
>
> Improvements have been made in many areas, as outlined in this submission. These improvements ensure that the…Program continues to meet the need for affordable access to the PBS for Aboriginal and Torres Strait Islander peoples living in remote communities.[5]

2.6 While there is general agreement that an increased supply of PBS medicines is being provided through participating AHSs, concern has been expressed about the level of access to PBS medicines for some Aboriginal and Torres Strait Islander people living in towns that do not have an AHS approved to supply PBS medicines under the program.

> Access to the PBS is variable, most remote communities are reasonably well served by the current arrangements insofar as supply goes, however for [Aboriginal and Torres Strait Islander] residents in Kimberley towns, access can be limited. [6]

2.7 The Northern Territory Government also has concerns about possible inconsistencies in the program, stating that some urban AHSs are able to access the program while some remote AHSs cannot. They recommend a review of the current selection criteria.[7]

2.8 The Aboriginal Medical Services Association of the Northern Territory (AMSANT) has identified a lack of access to general practitioners (GPs) in the Northern Territory as a factor that reduces the impact of the supply program.

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4 DOHA, *Submission 24*, p. 9.

5 DOHA, *Submission 24*, p. 18.

6 Mr Roy Finnigan, *Submission 3*, p. 2.

7 Department of Health, Northern Territory, *Submission 20*, p. 1.

AMSANT has advised the committee that a shortage of GPs in remote AHSs means that patients have a reduced opportunity to see a doctor and therefore a reduced opportunity to access PBS medicines.[8] Access to health professionals in rural and remote areas is a significant issue that is beyond the scope of this inquiry; however the committee notes that a lack of access to doctors in remote communities is likely to have an impact on access to PBS medicines.

2.9 In summary, the committee has formed the view that the program has been successful in increasing access to PBS medicines through participating AHSs. However, concerns about inconsistent levels of access should be addressed. Issues related to quality use of PBS medicines are explored below.

Clinical outcomes of the program, patient understanding and adherence to treatment

2.10 Term of reference (b) seeks to understand the clinical outcomes that have been achieved under the program and whether an increase in supply has led to a corresponding increase in patient understanding and adherence to treatment.

Data collection and analysis

2.11 While the committee acknowledges that the program was initially designed to address a problem of supply, evidence presented during the inquiry indicates that the absence of comprehensive data collection and studies to assess the program's clinical outcomes is a missed opportunity. The committee is concerned that there appears to be little or no accurate recording of what PBS medicines patients receive under the program and that if available, this information is certainly not readily available, nor is it being analysed for the long-term clinical impact it may be having.[9]

2.12 In response to this term of reference, DOHA has advised the committee that this research is outside of the scope of the program:

> Program data provides information on the number of PBS medicines supplied to participating AHSs, but does not include clinical data. Any study of clinical outcomes and adherence to prescribed treatment would require access to and linking of personal level medicine usage and clinical data in accordance with privacy laws. Such a study would require careful design within the constraints of the data and the need to maintain individuals' consent and privacy. Such research is outside the scope and resourcing of the RAAHS Program.[10]

8 AMSANT, *Submission 29,* p. 7.

9 Pharmaceutical Society of Australia, *Submission 7,* p. 2; Centre for Remote Health, *Submission 10,* p. 5; Charles Sturt University, *Submission 27,* p. 3.

10 DOHA, *Submission 24,* p. 9.

Linking adherence to medicines with improved health outcomes

2.13 While the Centre for Remote Health acknowledges that whether the section 100 supply program is associated with improved clinical outcomes would be a complex question in any setting, comparable studies have shown that adherence can be improved by some relatively simple interventions such as improved instructions for patients, counselling about the disease, simplifying dosage regimens, reminders, involving patients in their care and 'augmented pharmacy services'.[11]

2.14 An Australian study has shown that the cost of medicines is only a secondary determinant of whether people choose to take their medicines, with a North American evaluation of a similar program showing that reducing cost while improving access to medicines had no increased health outcomes.[12] The Centre for Remote Health therefore concludes that it is difficult to claim that the section 100 supply program has any impact on clinical outcomes but rather can be seen as providing financial benefits to AHSs, noting that AHSs in the Northern Territory provided medicines free of charge to their clients even before the introduction of the program.[13]

2.15 Wurli-Wurlinjang Health Service, a remote area AHS, has advised the committee that it is currently attempting to source medicine utilisation data related to its service but cannot obtain it in a manageable format.[14] The Centre for Chronic Disease at the University of Queensland's School of Medicine has also been seeking data from Medicare Australia arising from the supply of PBS medicines under the program. The Centre has advised the committee that '[t]his effort has been unsuccessful to date, for reasons which vary according to the agency we are petitioning and within agencies over time.'[15]

2.16 DOHA advises that in relation to the Centre for Chronic Disease's request, data was not provided because it was not releasable under the National Health Act, it could potentially identify personal information (the income streams of pharmacies), and because the Expert Panel on Aboriginal and Torres Strait Islander Health found that the project would not necessarily answer the questions raised.[16]

2.17 The Centre for Chronic Disease has advised the committee of an example of where analysing the impact of supply would be of great use in future practice.

> 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

11 Centre for Remote Health, *Submission 10,* p. 5.

12 Centre for Remote Health, *Submission 10,* p. 5.

13 Centre for Remote Health, *Submission 10,* p. 5.

14 Wurli-Wurlinjang Health Service, *Submission 14,* p. 5.

15 Centre for Chronic Disease, *Submission 28,* p. 2.

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

> 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 [Central Australian Rural Practitioners Association] 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 SECTION 100 data.[17]

2.18 DOHA has advised the committee that it is the responsibility of AHSs to record the PBS items supplied to patients, and that it does not hold data about particular medicines provided to their patients. However it may, on request, provide individual AHSs with the number of each PBS item supplied to them. DOHA has also advised that it has no current plans to link the supply of PBS medicines with clinical outcomes. [18]

Recommendation 1

2.19 The committee considers that to the extent that compliance with privacy laws and obligations can be maintained, Medicare Australia and DOHA should facilitate the release of information to parties requesting it to ensure that opportunities to understand the impact of the program are not wasted.

Adherence to prescriptions

2.20 The committee received considerable evidence to indicate that adherence to medicines is a major issue affecting chronic disease in remote Aboriginal and Torres Strait Islander communities. Indeed some submitters argue that it is *the* issue in chronic disease control in Aboriginal and Torres Strait Islander populations.[19]

> Remote community aboriginal patients are a very different group of people from suburban [even suburban aboriginal] patients. In general…the level of health literacy is very poor, understanding of the concept of preventive care is non-existent, the motivation to use ongoing medication is low and the concept of regular dosing is a mystery of no personal relevance.
>
> The result is that compliance/adherence is a big issue, I daresay the MAJOR issue, in the control of our rampant chronic disease. It requires huge effort from the health providers, requires constant follow-up and re-

17 Centre for Chronic Disease, *Submission 28,* p. 3.

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

19 Drs Peter and Jan Bowman, *Submission 1,* p. 2.

> education for success, and is inevitably not very successful in remote communities.[20]

2.21 The Pharmaceutical Society of Australia refers to a recent AIHW publication that reported that 80% of the life expectancy gap between Indigenous and non-Indigenous Australians could be attributed to chronic disease.[21] Combined with lifestyle factors, long-term medicine treatment is usually needed to reduce disease progression.

2.22 The committee received evidence that a lack of understanding of the effect and utility of medicines on the part of patients, as well as the lack of integration of advice on medicine use has the potential to put Aboriginal and Torres Strait Islander people at risk of harm. The committee was presented with an example of an infant being administered a double dose of antibiotics, leading to serious consequences, as well as prescription drugs being shared and inappropriately used. [22]

2.23 While there is a wide level of agreement that the program has certainly increased supply, the Society of Hospital Pharmacists argues that there needs to be a more complete response to addressing barriers affecting the use of PBS medicines:

> All of the issues and barriers must be specifically addressed if medicines are to be used effectively by individuals. This requires an ongoing dialogue between individuals and a health care professional, ideally a pharmacist, about:
>
> - the individual's belief system
> - the individual's understanding of their condition and health literacy
> - the use of Western style health care
> - the use of medicines in general
> - using medicines to prevent disease
> - using medicines in acute diseases
> - using medicines to manage chronic diseases
> - ways to support the individual to improve their medication adherence.[23]

2.24 The Centre for Remote Health agrees:

> ...the section 100 program has improved access to PBS medications in remote Aboriginal health services...while access to support for quality use

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20 Drs Peter and Jan Bowman, *Submission 1,* p. 2.

21 Pharmaceutical Society of Australia, *Submission 7,* p. 3. See also AIHW report *The health and welfare of Aboriginal and Torres Strait Islander people: an overview 2011.*

22 Ms Heidi Williams, *Submission 5,* p. 1.

23 Society of Hospital Pharmacists, *Submission 2,* p. 4.

> of medicines...in the remote Indigenous population remain desperately under-resourced. Supply alone does not ensure quality use of medicines.[24]

2.25 Professor Patrick Ball, the Foundation Professor of Rural Pharmacy at Charles Sturt University has advised the committee that for people living in a remote community with a chronic disease, medication assumes a disproportionate importance when compared with those living in urban areas where there may be a range of other therapeutic interventions available. Professor Ball says that to be effective, medication to address chronic disease requires four steps:

1. The patient is seen by a doctor or other appropriate health professional and a diagnosis established
2. Medication is prescribed and supplied
3. The medication is taken regularly, every day as directed
4. Any adverse effects of the medication are followed up on.[25]

2.26 It is Professor Ball's view that steps one and two above are being addressed but that steps three and four require more attention.

> When metropolitan Australians receive their medication they are entitled to advice from a pharmacist at the time of supply, but remote living Aboriginals receiving supplies under the present arrangements not only have time to forget what the doctor, nurse or Aboriginal health worker told them, they are handed a package with no explanation and little opportunity for follow up on any difficulties they have in understanding what to do with their medications or if their medication causes adverse effects.[26]

2.27 While the section 100 supply program has clearly been successful in creating opportunities for access to PBS medicines, the low adherence rates, as well as the absence of clear evaluation of the clinical impact of the program is of great concern to the committee. As a number of submitters point out, even though there is evidence that the section 100 supply program is delivering an increased amount of medicines to patients of AHSs, there is an absence of evidence to show whether or not this has any impact on improved health outcomes. The committee considers that the Commonwealth Government should develop a clear plan to test the assumption that more medicines equals better health outcomes for patients of remote area AHSs.

Recommendation 2

2.28 The committee recommends that the Commonwealth Government undertake an evaluation to ascertain whether the increased supply of PBS medicines provided by the program is having a clinical impact on the health of Aboriginal and Torres Strait Islander people in remote communities.

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24 Centre for Remote Health, *Submission 10,* p. 1.

25 Charles Sturt University, *Submission 27,* p. 2.

26 Charles Sturt University, *Submission 27,* p. 2.

The degree to which QUM has been achieved by the program

2.29 Term of Reference (c) seeks to ascertain the degree to which quality use of medicines, or QUM, has been achieved, including the amount of contact with a pharmacist available to these patients compared to urban Australians.

2.30 While the committee acknowledges that there are several programs in place that are designed to support appropriate use of medicines, it has received significant evidence to show that more effort needs to be applied to deliver quality use of medicines.

2.31 DOHA's submission states that QUM is supported primarily through the section 100 pharmacy support allowance previously discussed. Changes to the program now mean that support can be delivered by a pharmacist outside of the section 100 supply arrangements, and in remote areas where community pharmacies are unable to provide support services this can be provided by a hospital authority. DOHA advises that at present there are 172 remote area AHSs approved to participate in the program with 123 receiving support from 23 pharmacists. [27]

2.32 Expenditure across the program is illustrated in the tables below. Table 3 shows funding for program under the Fourth Community Pharmacy Agreement 2005-2010. Table 4 shows funding available under the Fifth Community Pharmacy Agreement (2010-2015).

($ million GST Exclusive)						Total $ million
Funding	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-10**	
Actual	0.37	0.45	1.34	2.39	1.79	**6.33**

Table 3: SECTION 100 Support Allowance funding under 4CPA (2005 – 2010) [28]

($ million GST Exclusive)						Total $ million
Funding	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**	
Allocation	2.5	2.7	2.8	3.0	3.4	**14.4**

Table 4: SECTION 100 Support Allowance funding under 5CPA (2010 – 2015) [29]

2.33 DOHA advises the committee that activities under the support allowance are focused on:

27 DOHA, *Submission 24*, p. 10.

28 Table kindly supplied by DOHA.

29 Table kindly supplied by DOHA.

- providing advice and support on pharmacy services relating to QUM management, and staff training;
- providing improved access to the services and expertise that pharmacists can provide through increasing the awareness and understanding of medicines;
- addressing cultural and other issues that may affect the effectiveness and acceptability of pharmacy services; and
- developing cooperative arrangements with Indigenous communities that pharmacists service.[30]

2.34 The ability for remote area AHSs to negotiate a work plan with the pharmacy providing the support is seen by DOHA as flexible enough for the AHS to tailor services to their needs. For example, activities could include assisting with procedures and protocols for managing section 100 supply arrangements, establishing and maintaining a medicine store, providing assistance with DAAs, participation in regular meetings with health staff, review of patient medications, and education services to clinical and support staff on medicines and their management.[31]

2.35 DOHA has advised the committee that payments to section 100 pharmacy support providers range from $8000 to $337 000 per provider, based upon 2009 figures, and are dependent on how many clinics or outstations the remote area AHS services.[32]

2.36 In its evidence to the committee, DOHA has not directly addressed the issue of the amount of time with a pharmacist available to patients of remote area AHSs when compared with urban Australians. However other evidence presented to the committee has led us to conclude that access is far less than that provided to urban Australians, and in many instances non-existent.

2.37 While the committee considers that there is certainly a need for AHSs to be supported by pharmacists to do important work such as help devise and maintain appropriate stock management control systems and medicine stores, train staff in the use of medicines, and attend meetings with staff, the committee is very concerned that this program is not providing patients with increased and direct access to a pharmacist. It is also concerned to note that while the program funds pharmacists to assist AHSs, the corresponding resourcing required of the AHSs is not funded:

> From the point of view of the Aboriginal Health Service, the Section 100 program covers the cost of the medicine for their clients and provides a reliable channel for the supply of medications. It does not cover the costs to the Aboriginal Health Service for the time of the front line workers, including nurses and Aboriginal Health Workers, in helping people to

30 DOHA, *Submission 24*, p. 10.

31 DOHA, *Submission 24*, p. 10.

32 DOHA, *Submission 24*, p. 13.

> understand about their medicines and the importance of following the dosing instructions.
>
> Further, the Section 100 Scheme does not cover the costs of equipment for standard computer generated dispensing labels with relevant instructions and warnings, or the cost of dose administration aids to help people with chronic conditions and multiple medications to take their medicines as prescribed. Any additional support or equipment the Aboriginal Health Service provides must come from core funding.[33]

2.38 The committee has formed the view that significant work has been done to establish relevant guidelines and tools to assist pharmacists in the provision of services funded under the section 100 pharmacy support allowance and that other supporting initiatives such as OPRAH and Good Medicines Better Health programs (discussed earlier) provided by the NPS are offering opportunities for up-skilling pharmacists to work with staff of AHSs. However, it appears that there are few examples of pharmacists being able to provide direct support and continuing advice to patients when it is required.

2.39 Overwhelmingly the evidence presented to the committee indicates that more direct access to a pharmacist is required by both AHSs and their patients in order to support better use of PBS medicines. Kimberley Pharmacy Services suggest that a first step to achieving this is to increase the frequency of visits that pharmacists make to AHSs under the section 100 pharmacy support allowance. They also suggest that funding should be based on a needs model, arguing that clinics with a high number of complex chronic disease clients should be able to access greater funding than those with less complex clients.[34] The Pharmaceutical Society of Australia and the Pharmacy Guild of Australia agree that the current situation where current program funding covers one or two pharmacist visits per year is inadequate.

> One to two annual pharmacist visits are usually insufficient to provide effective QUM services to the AHSs and their outstations. The majority of these visits relate to establishing ordering, dispensing and stock management systems, rather than QUM initiatives or staff education.[35]

2.40 The Pharmacy Guild of Australia suggests that a review of the section 100 pharmacy support allowance program be conducted in order to ascertain the optimum number of visits to that would support and deliver QUM.[36]

2.41 High transport costs associated with visiting remote area AHSs is a recurring theme throughout submissions, with some submitters suggesting that pharmacists

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33 National Rural Health Alliance, *Submission 21,* p. 4.

34 Kimberley Pharmacy Services, *Submission 6,* p. 2.

35 Pharmaceutical Society of Australia, *Submission 7,* p. 4. See also Pharmacy Guild of Australia, *Submission 19,* p. 21.

36 Pharmacy Guild of Australia, *Submission 19,* p. 21.

providing support under section 100 pharmacy support allowance program should be able to claim the actual cost of travel and accommodation, rather than receive a predetermined sum.[37] The Pharmacy Guild of Australia collated responses from pharmacists providing services under this program and provided an example of the complexity and distance involved in providing a face-to-face QUM service. A pharmacist at the Thursday Island Pharmacy states:

> …the current funding is not adequate to allow me to visit my 20 AHS's more than one day per year. If you study a map of the AHS's I visit, review the current schedule of flights and the cost of those flights available in my area, combine this with a study of which communities have accommodation and food...you will realise why I had to purchase a ship to allow me to service my AHS properly.[38]

2.42 Rollo Manning explains the role that building good relationships with communities can play in improving use of medicines.

> It takes time to get to know a community, be accepted by the Aboriginal workers at the health centre and as a pharmacist be accepted as a part of the primary health care workforce. This requires positive contributions that can only be developed over time. A two day visit every six months is by no means enough and yet this is what the section 100 'Support Allowance' provides for the supplying pharmacy.[39]

2.43 Another issue associated with the current funding model raised during the inquiry is the cost of dose administration aids or DAAs. DAAs such as 'blisterpacks' or 'Websterpacks' are seen as a useful tool in managing patient dosage however the committee understands that pharmacies are not funded specifically to dispense PBS medicines to AHSs in this way. Instead, they can use part of the section 100 pharmacy support allowance, or DAAs requested by remote area AHSs can paid for using other AHS funding sources. Several submitters argue that DAAs should be specifically funded from current program arrangements, or as an additional arrangement to assist with medicine adherence and QUM.[40]

2.44 As Ngaanyatjarra Health Service points out, DAAs as a standalone measure do not increase health literacy or a patients' understanding of their medication but they can free up staff time and encourage patients to take the correct dose. They present data from the Tiwi Islands Pharmacy project, which supplied DAAs to patients. The supply of DAAs resulted in an increase in the pickup rates of medicines from the Tiwi Health Service Pharmacy. Of a possible 160-180 patients, regular

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37 Kimberley Pharmacy Services, *Submission 6*, p. 3; Queensland Aboriginal and Islander Health Council, *Submission 11*, p. 6.

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

39 Mr Rollo Manning, *Submission 26*, p. 6.

40 Pharmaceutical Society of Australia, *Submission 7*, p. 5; NACCHO, *Submission 13*, p. 6.

collection increased from 18 to 105 patients over a 21 month period.[41] In this service, DAAs had been prepared for patients to collect, waiting time was minimised for the patient and staff were on hand to discuss the patient's medication, providing an opportunity for improved understanding of the medication and its purpose.

2.45 Although DOHA has advised the committee that there are no plans to provide specific funding for DAAs,[42] the committee considers that adequate funding for DAAs and appropriate QUM activities to accompany use of DAAs should be specifically provided through the section 100 program.

Recommendation 3

2.46 The committee recommends that the Commonwealth Government provide specific funding for remote area AHSs to be able to provide dose administration aids (DAAs) to their patients.

Increasing access to pharmacists

2.47 Many submitters present compelling arguments for locating pharmacists within remote AHSs, with several existing models showing that it can work well. DOHA acknowledges that in terms of achieving quality use of medicines, the location of pharmacists within AHSs is desirable. However it is the Department's view that this cannot be achieved due to workforce shortages:

> Whilst the Australian Government acknowledges that from a QUM perspective it may be desirable to have a pharmacist employed at all AHSs, given current rural workforce levels across all areas of the health workforce, it is not practical to expect that this would occur at all participating AHSs and their outstations/outreach clinics. It is difficult to attract and retain pharmacists and general practitioners to many remote areas.[43]

2.48 It is clear to the committee that there is a high degree of frustration amongst submitters about the lack of direct access to a pharmacist that is available for remote AHS patients. Given the volume of medicines being prescribed through the program, submitters question why money can't be invested to increase the efficacy of the medicines prescribed. Dr Peter and Dr Jan Bowman put it this way:

> The rate of chronic disease in aboriginal communities is several times that of a typical white Australian community, and the total volume of medicines prescribed is commensurately higher.
>
> ...
>
> As doctors, we cannot help speculating that there must be enough money associated with this huge volume of medicine to provide funding for

41 Ngaanyatjarra Health Service, *Submission 18,* p. 8.

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

43 DOHA, *Submission 24,* p. 9.

> front-line pharmacist service. A town of 1800 people elsewhere in Australia can support a full-time private pharmacist. How is it that this volume of medicine cannot support even a part time pharmacist in remote communities?[44]

2.49 Many submitters suggest that there is no substitute for the type of advice and assistance that a pharmacist can provide,[45] with some suggesting that Indigenous and non-Indigenous Australians should have equal access to a pharmacist irrespective of where they live.[46] Many submitters also suggest that high rates of non-adherence are caused by the lack of connection between pharmacist and patient.

2.50 The possible grave consequences of non-adherence to prescriptions was described in a 2008 Report on the Home Medicines Review Program commissioned by DOHA, and cited in the submission of the Society of Hospital Pharmacists.[47]

> The extremely high incidence of medication misadventure, non-adherence and resulting hospitalisation among Indigenous consumers as well as the flow-on effects such as organ damage and amputations were matters of grave concern to those respondents who work with Indigenous consumers. The co-morbidities because of the lack of adherence to medications were considered to be as high as three to four times that of non-Indigenous consumers.[48]

Maintaining a standard drug list

2.51 Ngaanyatjarra Health Service advised the committee that one of the most important public health programs provided by a health service is the 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.'[49] While this activity is possible under the section 100 pharmacy support allowance program, Ngaanyatjarra Health Service raises concerns about the ability of participating pharmacists to actually supply and maintain stock control appropriately according to the list because of the distance from the health service.[50] The service is concerned about the waste of medications that is occurring under the system which they say is due to poor stock

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44 Drs Peter and Jan Bowman, *Submission 1,* pp 2-3.

45 Drs Peter and Jan Bowman, *Submission 1,* p. 4; Society of Hospital Pharmacists, *Submission 2,* p. 4.

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

47 Society of Hospital Pharmacists, *Submission 2,* p. 3.

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

49 Ngaanyatjarra Health Service, *Submission 18,* p. 5.

50 Ngaanyatjarra Health Service, *Submission 18,* p. 5.

control,[51] as well as the inability for individual services to access their own supply data. Ngaanyatjarra Health Service states that '...[d]ue to a paper based claim system and the cost of the medications known only to pharmacies and Medicare, health services have no indication of the cost of medications supplied under the program.[52]

2.52 Ngaanyatjarra Health Service says that having a pharmacist located at their health service results in cost saving to the Commonwealth as it provides more appropriate and more reflexive stock control. An evaluation of the in-house pharmacy service at Ngaanyatjarra Health Service showed that with an imprest list in place the amount of PBS medicines supplied was reduced, resulting in a cost saving of 14% in the first year. There was also a reduction in expenditure on non-PBS medicines, paid for by the health service. These rates were a reduction of 7% in the first year and 40% in the second year. Ngaanyatjarra Health Service says that these savings can be used to directly fund increased patient care.[53]

2.53 The service points out the flow on effect of operating a more efficient stock control system. Transport and freight costs for moving expired drugs out of the clinic are reduced, the amount of stock on the imprest shelves is reduced therefore lowering the risk of inadvertently supplying the wrong drug or drugs that have expired.[54]

Models for providing direct access to pharmacists

2.54 The Pharmaceutical Society of Australia proposes a model whereby a pharmacist would be located in an AHS, but with PBS medicines still dispensed from the community pharmacy. In this model the pharmacist would focus on supervising the ordering of medicines, labelling and recording, as well as give advice, patient education and medication review. The cost of this model could be offset by the savings provided by adherence, reduced wastage of medicines and reduced hospital costs associated with poor control of chronic disease.[55]

2.55 The Centre for Remote Health describes the example used by Central Australian Aboriginal Congress to provide 1.5 pharmacists and two full time pharmacy technicians in this AHS. The pharmacists and pharmacy technicians are employed by a community pharmacy but the AHS has contributed significant funds to the operation of the pharmacy service, not relying on section 100 funds.[56]

2.56 Another current working model of a pharmacist located in a remote area AHS operates in the Kimberley region of Western Australia, where the section 100

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51 Also discussed by Drs Peter and Jan Bowman, *Submission 1,* pp 2-3.

52 Ngaanyatjarra Health Service, *Submission 18,* p. 5.

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

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

55 Pharmaceutical Society of Australia, *Submission 7,* pp. 7-8.

56 Centre for Remote Health, *Submission 10,* p. 7.

pharmacy support allowance is redirected by contract with the approved pharmacist to the Kimberley Aboriginal Medical Services Council (KAMSC), which then employs its own pharmacist to deliver QUM services according to the business rules of the allowance.[57] KAMSC advises the committee that their single pharmacist provides a variety of direct services to support QUM of across 14 clinics and 440 000 square kilometres. These are services such as audit and quality improvement activities, training of clinic staff including, training for Medication Assistants and a major contribution to the development and review of the Kimberley Standard Drug List.[58]

2.57 The Queensland Department of Health has advised the committee that the Cairns and Hinterland Health Service District funds one full-time pharmacist and one pharmaceutical assistant to provide supply and outreach services to 12 000 Aboriginal and Torres Strait Islander people in the ten primary health care services operated by the Cape York Health Services Division. This enables the outreach pharmacist to be available by phone, and visit each clinic for a few hours two to three times per year. Queensland Health states that the purpose of the visit is primarily to provide QUM education and training for clinic staff but does not allow for contact between clients and the pharmacist.[59]

2.58 Another example of a pharmacy business operating successfully in a remote Aboriginal and Torres Strait Islander community was provided by Mr Rollo Manning. This involved the establishment of a pharmacy on Bathurst Island in the Northern Territory that met the legal requirements for approved pharmacies. Mr Manning provided the committee with analysis of remote communities with a population of 1000 or more in the Northern Territory which, based on his analysis, would be able to sustain a full time pharmacist.

> The PBS item volume would be likely to be in the order of 20,000 a year which in itself would generate an income of $70.000 a year. By the time additional fees for items such as Home Medication Reviews are added in this could well mean [an] income in excess of $100,000 to meet the cost of a pharmacist.[60]

2.59 AMSANT offers another suggestion for locating pharmacists within AHSs in the Northern Territory.

> At present, a resourced pharmacist could easily fit into the multidisciplinary model in at least six existing regional health services, with two more [Health Service Delivery Areas] closing fast as regional Aboriginal Community Controlled Health Services. Other proposed [Health Service Delivery Areas], a number of which have a mixed balance of Government and Aboriginal community controlled health services, could have

57 NACCHO, *Submission 13,* p. 24.

58 Kimberley Aboriginal Medical Services Council, *Submission 22,* pp 5-6

59 Correspondence to Committee from Queensland Health, 12 September 2011.

60 Mr Rollo Manning, *Submission 26,* p. 6.

> pharmacists "hubbed" into these...as they move, over time, to regional control.[61]

2.60 The committee is satisfied that there are a number of AHSs that wish to and have the capacity to host or employ a pharmacist as part of the primary health care team; for example the Wurli-Wurlinjang Health Service in the Northern Territory has developed a substantial project proposal to fund a full time pharmacist within their service.[62]

2.61 The committee considers that services able to employ their own pharmacist should be supported to do so. With the existence of functioning and successful models available, the committee considers that more support should be offered to remote area AHSs to develop their own models for the location of pharmacists within services, and that DOHA and other relevant stakeholders should provide guidance for AHSs on options for the establishment of in-house pharmacy services.[63]

2.62 NACCHO proposes a system whereby responsibility for the payment of QUM related pharmacist services is transferred to remote area AHSs. Pharmacists would then be added as additional allied health professionals under the Practice Nurse Incentive Program. This program was announced in May 2010 and will contribute $390.3 million to general practices and ACCHSs to employ practice nurses and/or Aboriginal Health Workers. Funding will allow ACCHSs to employ a part-time allied health professional, such as a physiotherapist, dietician and occupational therapist, instead of, or in addition to, a practice nurse and/or Aboriginal Health Worker. DOHA has listed the types of allied health professional eligible under this measure; however, NACCHO noted that 'pharmacists' and 'dentists/assistants' were not listed, and has recommended that the program be amended to include pharmacists.[64]

2.63 In addition, NACCHO proposes that a more systematic and coordinated approach to existing QUM budgets could be used to leverage greater benefit within the system. For example, QUM budgets could be used to subsidise the purchase of labelling equipment or provide QUM training for staff, or employ sessional pharmacists. Regional or state and territory 'QUM Pharmacists' could be employed within services (as is currently provided under the QUMAX program) to provide local support.[65]

2.64 The Northern Territory government agrees that QUM services should be transferred to AHSs:

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61 AMSANT, *Submission 29,* p. 11.

62 Wurli-Wurlinjang Health Service, *Submission 14.*

63 Mr Rollo Manning, *Submission 26*, p. 3.

64 NACCHO, *Submission 13,* p. 27.

65 NACCHO, *Submission 13,* p. 6

> Such QUM initiatives have been trialled and established in health services in regional and remote settings, where a pharmacist is directly employed to work with health centre staff to:
>
> - provide onsite clinical review
> - assist in meeting legislative requirements,
> - and undertake continuous quality improvement activities.
>
> Directly funding the health service to provide this service could also incorporate the use of interpreters and community liaison officers to support pharmacist services, either on site or during visits. This would promote cultural safety and greatly improve the delivery of QUM to clients.[66]

2.65 Several submitters offer solutions to issues of workforce supply. The Society of Hospital Pharmacists contends that it is easier to attract pharmacists to a team environment, which could easily be provided by AHSs.

> Experience in the hospital sector with locum pharmacists in rural areas has taught us that it is easier to attract pharmacists to a team environment where they have access to usual employment conditions and workplace support than it is to attract sole practitioners who must continually look for the 'next job' with fluctuating cash flow and no allowance for leave, attending professional development activities etc.[67]

2.66 While the committee notes the comments of DOHA, as well as the finding of the *Evaluation of Indigenous Pharmacy Programs*, completed for DOHA by Nova Public Policy in 2010 (Nova Review) that direct employment of pharmacists within AHSs is not possible within current workforce levels,[68] the committee considers that more can be done to support direct employment of pharmacists, or provide vastly increased time for pharmacists to spend with AHWs and other health professionals in AHSs, as well as the time that patients can spend with pharmacists.

2.67 The Society of Hospital Pharmacists supports the recommendation from the Nova Review that AHSs be permitted to cash-out existing subsidies in order to fund greater access to, or direct employment of pharmacists.[69] The Society estimates that 125 full time pharmacists are needed to provide adequate services to remote communities through AHSs, and suggests that a combination of strategies outside of the current sole reliance on the community pharmacy model would go some way to providing this.[70]

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66 Northern Territory Department of Health, *Submission 20*, p. 4.

67 Society of Hospital Pharmacists, *Submission 2*, p. 7.

68 Nova Public Policy, *Evaluation of Indigenous Pharmacy Programs*, p. 2.

69 Society of Hospital Pharmacists, *Submission 2*, p. 9.

70 Society of Hospital Pharmacists, *Submission 2*, p. 11.

2.68 The Pharmaceutical Society of Australia says that pharmacy schools have recently doubled their intake of pharmacy students, which will lead to a much greater supply of trained pharmacists.[71] Given the evidence provided to the committee of alternative models as a way of making rural and remote pharmacy practice a more attractive career option for graduates, the committee is keen for the Commonwealth to put more effort into supporting a range of options for the employment of pharmacists in remote area AHSs.

2.69 The committee has noted that there may be legal barriers to the immediate and direct employment of pharmacists by AHS. As NACCHO states:

> Legislation inhibits pharmacists in most States from dispensing outside a registered pharmacy. Thus, career/academic pharmacists employed by the RAAHS, who do not want to own a pharmacy, are legally unable to label/dispense medicines or pack a DAA, or receive remuneration for this service through regular channels. An exception to this exists in the NT.[72]

Recommendation 4

2.70 The committee agrees with submitters and recommends that program flexibility be implemented to give remote area AHSs increased and direct access to the services of a pharmacist. This could be done by AHSs engaging a pharmacist directly or in collaboration with other stakeholders or service providers. Options for funding and operating these services could include cashing-out existing program funding, access to alternative funding measures, expansion of the Practice Nurse Incentive Program to include pharmacists, remunerating remote pharmacists for services though the Medicare Benefits Schedule, and removal of legislative barriers that prevent the operation of pharmacy businesses in remote areas.

Recommendation 5

2.71 The committee recommends that the Commonwealth Government establish a consultative body of relevant stakeholders to develop proposals and options to increase direct access to pharmacists for remote area AHSs, consult program participants and others, and provide support to AHSs to allow them to make informed choices about options.

71 Pharmaceutical Society of Australia, *Submission 7*, p. 6.

72 NACCHO, *Submission 13*, p. 22.

Chapter 3

Compliance and Funding Distribution Issues

Legislative compliance for recording, labelling and monitoring of PBS medicines

3.1 Term of Reference (d) seeks to determine the degree to which state and territory legislation has been complied with in respect to recording, labelling and monitoring of PBS medicines.

3.2 One submitter describes the standards of practice in relation to the labelling and recording of medicines as 'appalling'.[1] Evidence presented during the course of the inquiry indicates that there is a desperate need for computer systems and standardised technology to be available to all remote area AHSs so that accurate and legible labelling and recording can be completed, and that computer record systems allow for data collection that can be provided and used by both the Commonwealth as well as the individual AHSs.[2]

3.3 Ngaanyatjarra Health Service recommends that software providers of electronic patient management systems should urgently incorporate dispensing modules into their systems so that improved labelling to meet the minimum standards can occur.[3] These systems could be used to complete electronic ordering of medicines, reducing some of the red tape and the frustration currently being experienced by participating AHSs and community pharmacies.

3.4 KAMSC provided the committee with an example of an electronic system that is working well.

> All the KAMSC and KAMSC affiliated clinics in the Kimberley have been using an internet based electronic health information system called MMEx for recording, labeling, stock management and monitoring of medications. MMEx is a comprehensive electronic system which maintains a record of all current, dispensed, archived medications, Websterpaks and their supply to patients. Adhesive medication labels which comply with WA Poisons Regulations are generated using MMEx.[4]

3.5 The Pharmacy Guild of Australia has advised the committee that many pharmacists responding to their survey advise that if recommendations from previous program evaluations were implemented, problems with legislative compliance could

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1 Centre for Remote Health, *Submission 10,* p. 7.

2 Australian Medical Association, *Submission 12*, p. 2.

3 Ngaanyatjarra Health Service, *Submission 18,* p. 12.

4 Kimberley Aboriginal Medical Services Council, *Submission 22*, p. 10.

be addressed. Out of five relevant recommendations from the Kelaher Review of 2004, the Pharmacy Guild of Australia says that few have been addressed since the report was released in 2004.[5]

3.6 These recommendations are detailed below:

- DOHA to examine mechanisms for providing more extensive support to ensure that [the program] is implemented in a way that is compliant with state and territory legislation and regulations.
- A self assessment tool addressing legislative compliance issues should be made available to AHSs to complete with their supporting pharmacists.
- DOHA to develop a central resource for program participants to enable sharing of information and lessons.
- DOHA in conjunction with state and territory governments, the Pharmacy Guild of Australia and NACCHO, should develop a resource that clearly states how laws and regulations should be applied to remote AHSs.
- DOHA to work with state and territory governments, Pharmacy Guild of Australia and NACCHO to identify ways of facilitating the operation of approved AHSs in jurisdictions where there are legal and regulatory barriers to program implementation.[6]

3.7 It is the view of the Pharmacy Guild of Australia that if participating pharmacists were able to visit AHSs more often, they would be able to provide more support to increase legislative compliance. On this basis the Pharmacy Guild of Australia recommends that transport costs for community pharmacies servicing remote area AHSs should be separately funded based on a model which reflects actual costs.[7]

Recommendation 6

3.8 The committee is surprised to note that there is no universal system in place to provide for accurate and legible labelling and recording of medicines. The committee therefore recommends that the Commonwealth Government urgently support the development and introduction of efficient standardised systems for accurate labelling of medicines in remote area AHSs, and that these systems are developed to ensure accurate collection of medicine data and use.

5 Pharmacy Guild of Australia, *Submission 19*, p. 22.

6 Pharmacy Guild of Australia, *Submission 19*, p. 22.

7 Pharmacy Guild of Australia, *Submission 19*, p. 23.

Distribution of funding

3.9 Term of Reference (e) deals with 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.

3.10 The Commonwealth does not fund remote area AHSs to supply PBS medicines and dispense them to their patients. The current system involves a reimbursement to the community pharmacy or hospital authority for each PBS item supplied to an AHS approved to participate in the program. It is done on the basis of an approved price to pharmacists, plus a mark-up (the level of mark-up that is applied to the medicine is determined by the cost of the medicine), plus a handling fee which is indexed annually (from 1 July 2011 the handling fee is $2.79).[8]

3.11 This level of funding is less than the $6.42 dispensing fee that a community pharmacist dispensing in the general community is reimbursed. DOHA explains this reduced dispensing fee in the following way:

> The RAAHS Program handling fee of $2.79 is lower than the dispensing fee paid to community pharmacists recognising that under the RAAHS Program, the activity required to facilitate supply is not equivalent to, and not as intensive as, dispensing to an individual in a community pharmacy context.[9]

3.12 The current distribution model is criticised by some submitters as being too inflexible to provide the best outcome for patients of AHSs, with current business rules for participation in the program restricted to community pharmacies. The Society of Hospital Pharmacists advocate creating greater flexibility within existing programs so that broader participation can be allowed.[10]

3.13 The Centre for Remote Health agrees that more access to pharmacists should be given to AHSs but cautions against a move that would simply transfer funding from community pharmacies to health services, suggesting rather that a system of collaboration and flexibility should be encouraged.[11]

3.14 The Pharmacy Guild of Australia has advised that the system of community pharmacies already in existence is regarded by pharmacists as the best way of providing direct services to AHSs.[12] One pharmacist participating in the scheme

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8 DOHA, *Submission 24*, p. 11.

9 DOHA, *Submission 24*, p. 11.

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

11 Centre for Remote Health, *Submission 10*, p. 1.

12 See also Western Australian Branch of the Pharmacy Guild of Australia's submission, appendix to Pharmacy Guild of Australia, *Submission 19*, p. 52.

cautions against comparing the section 100 supply program with the wholesale model of supplying medicines:

> You have to be careful not to compare the section 100 [program] to the wholesale model. This model implies merely sending medicines to AHS's without any professional involvement whatsoever. A storeman in a warehouse can send medicines to an AHS whereas a pharmacy sending medicines to an AHS will be overseen by a pharmacist who will pick up anomalies such as "Do they need this quantity?", "Do they have this many patients who qualify for this medicine under PBS conditions", "Are these medicines likely to be used or will they just go out of date". The section 100 [program] as it exists encourages remote pharmacies to exist, and in turn creates employment, develops training opportunities for pharmacy students, pharmacy assistants and creates employment opportunities for indigenous Australians...[13]

3.15 The Pharmaceutical Society of Australia makes the point that as a $2.74 handling fee per dispensed item is paid in relation to PBS medicines supplied under the program, there is a saving of $3.68 from the normal dispensing fee of $6.42 per item that would ordinarily be paid if the item were provided to an individual through a community pharmacy. 'The Government therefore saves $3.68 per item dispensed to remote Aboriginal Australians'. This is referred to as the 'dispensing fee gap'.[14]

3.16 Mr Rollo Manning has suggested that it is possible that an approved pharmacy supplying a high volume of PBS medicines to a single AHS under the section 100 supply program could make a gross profit of $450 000 per year.[15]

3.17 KAMSC states that revisiting the current funding models under the program would be welcome, especially the development of models that recognise the contribution that AHSs make in medication handling, and envisage changes that could vastly improve the amount of time pharmacist could spend supporting QUM.

> For example, should remote AHSs receive adequate remuneration from Medicare in the form of a dispensing fee for each PBS item, section 100 Support payments together with pharmacy incentive payment for clinical services, services would be well-placed...to enable employment of a pharmacist, whether on a full time basis, part-time basis, or under a shared arrangement across a number of contributing services.
>
> Unfortunately current pharmacy ownership laws in WA preclude remote AHSs from being registered for the purpose of dispensing medicines. Similarly dispensing by pharmacist in unregistered premises i.e. remote clinics is prohibited in WA. It is a curious situation that enables...GPs to dispense but pharmacists who are specialised in this role are prohibited.

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13 Pharmacy Guild of Australia, *Submission 19*, p. 24.

14 Pharmaceutical Society of Australia, *Submission 7,* p. 2.

15 Mr Rollo Manning, *Submission 26*, p. 8.

> Options are for a change to the regulations (section 94 Health Act) or for an exemption to be applied for ACCHS and remote AHSs to enable pharmacist to be permitted to dispense from remote clinics and outstations, as is the case in the Northern Territory.[16]

3.18 The Centre for Remote Health also raised the issue of tying the provision of the section 100 pharmacy support allowance to a supplying pharmacy unless that pharmacy declares it is unable or unwilling to provide the service. The committee has considered evidence to indicate that the level of service provided to participating AHS under the section 100 pharmacy support allowance provides varying degrees of assistance to improve QUM.[17]

3.19 One measure that could raise the standards of service or the amount of time that pharmacists can spend in AHSs would be to untie the funding of this program. The Centre for Remote Health advocates flexibility so that AHSs could choose to contract with their preferred provider if they wish to do so.[18] The Centre says that recent amendments to the method of payments to support pharmacists providing services to residential aged care facilities provides a precedent for a system that separates supply and QUM services.[19]

3.20 The committee agrees with the Centre for Remote Health that a flexible funding system should be adopted, with improved accountability and transparency of what the money is being spent on. As the Centre says:

> Any system that channels funding to any of pharmacies, AHS, state/territory governments or individual pharmacists is likely to meet the needs of some but not all AHS. Providing adequate safeguards against misdirection of funds are in place, funding should not be limited to any one group.[20]

3.21 The committee considers that flexibility in the system should be created so that AHSs, pharmacists and other stakeholders can design and tailor services to suit their client base, and which promotes innovation and collaboration. The committee also notes that there will be many AHSs that have no desire to run a pharmacy.

3.22 The committee also acknowledges that there is a wide level of agreement that the section 100 supply program utilising the existing network of community pharmacies is operating well, but that much more effort needs to be put into improving the use of medicines. The committee has found that it is not that pharmacists are unwilling or even unable in some circumstances to provide the

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16 Kimberley Aboriginal Medical Services Council, *Submission 22*, p. 11.

17 Centre for Remote Health, *Submission 10*, p. 8.

18 Centre for Remote Health, *Submission 10*, p. 9.

19 Centre for Remote Health, *Submission 10*, p. 9.

20 Centre for Remote Health, *Submission 10*, p. 10.

support, but that the system as it currently operates does not provide sufficient direct contact between pharmacists and AHSs and their patients.

Support for Aboriginal Health Workers

3.23 Term of Reference (f) seeks to discover 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.

3.24 The committee would like to clarify that AHWs do not prescribe or dispense medicines to patients. Under Northern Territory and Queensland legislation AHWs are able to supply some medications.[21]

3.25 The committee notes that the section 100 supply and support programs do not confer any specific training responsibilities on participating AHSs or pharmacies. However the committee acknowledges the important role that AHWs play in the supply of PBS medicines to clients of AHSs and discusses evidence related to this term of reference below.

3.26 The Centre for Remote Health provided the committee with detailed information about training required to comply with Northern Territory legislation.[22] While it appears that considerable work is being done in the Northern Territory to support AHWs in their work, it is clear to the committee that more support in other jurisdictions is required.

3.27 The committee was pleased to be provided with information about the Good Medicines Better Health program being implemented nationally in collaboration with the National Prescribing Service and NACCHO, referred to earlier, which aims to increase the capacity of AHWs to provide training in QUM to their colleagues.

3.28 The committee understands that the Commonwealth funds two schemes designed to improve the relevant workforce pool, the Aboriginal and Torres Strait Islander Pharmacy Assistant Traineeship Scheme, with sixteen places per year, and the Aboriginal and Torres Strait Islander Pharmacy Scholarship Scheme which offers three places per year.

3.29 The committee sought further information on the operation and uptake of these schemes. DOHA advised that the pharmacy assistant traineeship scheme funds 16 traineeships per year and provides $10 000 a year to the pharmacy owner to employ the trainee. Since the program began in 2008, 83 placements have been

21 *Poisons and Dangerous Drugs Act (NT) 2011; Health (Drugs and & Poisons) Regulation 1996 (Qld).*

22 Centre for Remote Health, *Submission 10*, pp 11-12.

funded. Twenty six are currently active with 35 completed and 23 who withdrew part way through the traineeship.[23]

3.30 The scholarship scheme provides $15 000 per year for up to four years for Aboriginal and Torres Strait Islander students to undertake pharmacy studies. Twenty three scholarships have been awarded since the program began, with 13 graduates commencing work as pharmacists. There are currently 10 scholarships in place. Both programs are administered by the Pharmacy Guild of Australia, which does not track participants in the program.[24]

3.31 While the committee is pleased that there are opportunities for improved participation of Aboriginal and Torres Strait Islander people in the pharmacy workforce, they have received considerable evidence to indicate that AHWs are not sufficiently supported in their current roles related to providing PBS medicines. One measure to improve support would be to provide greater direct access to a pharmacist. Many submitters agree that face-to-face support from a pharmacist located within, or who visits the service often, offers the best option for improved support to AHWs.[25]

3.32 The Pharmacy Guild of Australia notes that in 2012 the Australian Health Practitioner Registration Board (APHRA) will assume responsibility for the registration of AHWs. They suggest that this is an opportunity for nationally consistent standards to be set for the registration and continuing education of AHWs.[26]

3.33 The Northern Territory government considers that visiting pharmacists provide very little support to AHWs and that dedicated resources should be allocated to increase AHWs training in relation to QUM.[27]

3.34 Given the importance of the work being done by AHWs in remote AHSs, the committee considers that much greater effort should be put into training and support for AHWs, and agrees with the Pharmacy Guild of Australia that the commencement of APHRA offers an opportunity for a national training framework for AHWs to be implemented. The committee is very concerned that any new or increased requirements would have to be adequately supported and funded.

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

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

25 Society of Hospital Pharmacists, *Submission 2,* p. 7.

26 Pharmacy Guild of Australia, *Submission 19,* p. 26.

27 Northern Territory Department of Health, *Submission 20,* p. 6.

Chapter 4

Previous Reviews

Implementation of recommendations from previous reviews

4.1 Term of Reference (g) seeks to understand the degree to which recommendations from previous reviews have been implemented and the consultation that has occurred with the community controlled Aboriginal health sector about changes to the program.

4.2 The committee has had regard to a number of reviews and evaluations relevant to the section 100 program. Although it has not received detailed evidence in relation to all of the inquiries mentioned below, the committee considers it important to note a number of reviews completed since the program commenced in 1999.

- *Aboriginal and Torres Strait Islander Peoples' Access to Medicare and the PBS across Australia*, Keys Young, November 1997 (Keys Young Review) – commissioned by the former Health Insurance Commission (now Medicare Australia) to document Indigenous peoples' attitudes and experiences in relation to Medicare and the PBS and identify ways in which service delivery and program information could be improved.[1]
- *A Summary of the prescribing and dispensing issues and needs in the remote health clinics of the Northern Territory*, General Practice Divisions Northern Territory and National Prescribing Service, August 2001 – review to expand the understanding of prescribing practices in remote communities in the Northern Territory and identify issues and needs to make recommendations for changes.[2]
- *Report from surveys conducted in Commonwealth funded Aboriginal Health Services and pharmacies supplying services under SECTION 100 pharmacy allowance*, Loller, May 2003 – described the outcomes of a project commissioned by the Pharmacy Guild of Australia and NACCHO to visit pharmacies and AHSs operating under the section 100 program in order to gain increased knowledge of the program's operation, provide support to participants and report on survey findings.[3]
- *Evaluation of PBS Medicine Supply Arrangements for Remote Area Aboriginal Health Services Under SECTION 100 of the National Health Act*, Cooperative Research Centre for Aboriginal and Tropical Health, Menzies School of Health Research and the Program Evaluation Unit, University of

1 Pharmacy Guild of Australia, *Submission 19*, p. 12.

2 Pharmacy Guild of Australia, *Submission 19*, p. 12.

3 Pharmacy Guild of Australia, *Submission 19*, p. 12.

Melbourne, Kelaher et al., July 2004 (Kelaher Review) – DOHA funded review examined the program's performance and evaluated the impact of the program on pharmacists, AHS staff and AHS clients.[4]

- *Aboriginal and Torres Strait Islander Access to Major Health Programs*, Urbis Keys Young, July 2006 – study conducted for DOHA and Medicare Australia to provide information about access to current programs by Aboriginal and Torres Strait Islander people.[5]
- *Review of the Existing Supply and Remuneration Arrangements for Drugs Listed under Section 100 of the National* Health Act 1953, Australian Healthcare Associates, February 2010 (Healthcare Associates Review) – funded by DOHA to assess the effectiveness and efficiency of program arrangements, identify the impact of the supply and remuneration arrangements on community pharmacy and develop options to address any identified problems.[6]
- *Evaluation of Indigenous Pharmacy Programs*, NOVA Public Policy, June 2010 (Nova Review) evaluation of three Indigenous pharmacy programs to determine the level of need for programs, assess the extent to which the current programs met the needs of Indigenous pharmacy services and assess the efficiency of the administration and delivery of the programs.[7]

Kelaher Review

4.3 In 2004 the Kelaher Review made almost 60 recommendations. In summary, it found that the program had made significant inroads in providing access to PBS medicines but that more needed to be done in relation to QUM activities.

4.4 DOHA states that it has implemented a number of the recommendations from this review which include: [8]

- The introduction of the Expert Advisory Panel on Aboriginal and Torres Strait Islander Medicines (EAP) in 2005 to provide expert advice.
- An increase to the handling fee paid to pharmacies for each PBS item supplied to AHSs to address increases in costs for participating pharmacies. The handling fee is now indexed annually on 1 July.
- A three-fold increase in funding of the section 100 support allowance. This increase was agreed to improve accountability and transparency, and has been extended under the Fifth Community Pharmacy Agreement.

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4 Pharmacy Guild of Australia, *Submission 19,* p. 13.

5 Pharmacy Guild of Australia, *Submission 19,* p. 13.

6 Pharmacy Guild of Australia, *Submission 19,* p. 13.

7 Pharmacy Guild of Australia, *Submission 19,* p. 13

8 DOHA, *Submission 24,* pp 14-15.

- Establishment by the NPS of the Good Medicines Better Health Program to develop, deliver and evaluate a QUM train-the trainer course for AHWs.
- Establishment by the NPS of the OPRAH Program to provide pharmacists with training, support and resources to promote the safe and wise use of medicines in AHSs.
- Implementing Closing the Gap PBS Co-payment measure from 1 July 2010 to apply in non-remote areas, to reduce the cost of PBS medicines for eligible Aboriginal and Torres Strait Islander people living with, or at risk of, chronic disease.

4.5 NACCHO has advised the committee that the Kelaher Review also found that funding should be provided for DAAs under the section 100 program.[9] This is yet to be implemented, however specific funding under the QUMAX program in non-remote AHSs is provided for the use of DAAs. NACCHO and others argue that section 100 funding should explicitly provide for DAAs.

4.6 Mr Rollo Manning says that recommendations from the Kelaher Review that relate to improved information collection have yet to be implemented. He says this requires immediate attention. Relevant recommendations include that the Health Insurance Commission (now Medicare Australia) provide medicine utilisation data to AHSs to enable them to keep track of their own performance, and that a system to assess the quantum of medicines that expires in AHSs be considered to enable further evaluations. This would help AHSs judge the effectiveness of their inventory management. 'If such data could be collected in a consistent way it would also assist further evaluation by making it possible to show that increases in medicine utilisation were not due to waste.' [10]

Healthcare Associates Review

4.7 The Healthcare Associates Review was released in 2010. As a result of this review the handling fee paid to pharmacists was increased from $1.14 in 2008-09 to $2.79 from 1 July 2011, and will now be indexed annually.[11]

4.8 The Healthcare Associates Review also recommended that a streamlined electronic payment system should be implemented to reimburse pharmacists by Medicare Australia. The committee has been advised that to date this is yet to be implemented.[12]

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9 NACCHO, *Submission 13,* p.17.

10 Mr Rollo Manning, *Submission 26*, p. 9.

11 DOHA, *Submission 24*, p. 17.

12 Pharmaceutical Society of Australia, *Submission 7*, p. 5.

4.9 This review confirmed that DAAs should be funded under the program, and that AHSs should be able to employ pharmacists with possible reimbursement through Medicare Australia.[13]

Australian Pharmacy Council Review

4.10 In 2009 The Australian Pharmacy Council Review examined legislative and remuneration barriers which prevented a full range of pharmacist services in rural and remote regions, and also the section 100 supply program.[14] NACCHO says that this review recommended the following:

- Registering remote health clinics as 'pharmacy outstations' so that pharmacists may dispense in these locations. (Including also the labelling, packing of DAAs, provision of medication counseling and other pharmacy services). This would require [legislative] amendments, and there is a precedent in the NT.
- Remunerating remote pharmacists for services though the Medicare Benefits Schedule (MBS). Services to be considered include: medication counselling, patient case conferences with Medical Practitioners, (face to face or by phone), Home Medicines Review (already existing), Nurse and Aboriginal Health Worker medication education.
- Exempting RAAHSs from pharmacy ownership laws if a pharmacist is employed full time to oversee and establish QUM observance.
- For the Federal Government to employ and suitably remunerate a pharmacist for each [RA]AHS.
- Aligning, simplifying and revising State Health Poisons Acts and Pharmacy Practice Acts legislation.[15]

4.11 Ngaanyatjarra Health Service has advised the committee that they understand this review is currently being considered by the Pharmaceutical Society of Australia and advocates for recommendations from this review, including the removal of any legal impediments to the direct employment of pharmacist, to be implemented.[16]

Nova Review of support programs

4.12 The most recent review of the section 100 pharmacy support program, *Evaluation of Indigenous Pharmacy Programs Final Report 28 June 2010* by Nova Public policy found that:

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13 NACCHO, *Submission 13,* pp 21, 22.

14 Swain L., *Remote Rural Pharmacists Project,* Australian Pharmacy Council, June 2009.

15 NACCHO, *Submission 13,* p. 24.

16 Ngaanyatjarra Health Service, *Submission 18,* p. 12.

> The section 100 support program provides an important level of professional support to AHS in the management of section 100 Supply. This is a level of support which is largely valued by the AHS to which it is provided. The program has addressed some significant QUM issues, particularly with regard to the safe storage, handling and dispensing of medicines.[17]

4.13 However this review also found that while the level of improvement in QUM should not be undervalued, the majority of respondents consulted considered that little impact had been made in engaging pharmacists in the primary care activities of AHS. The review found that where pharmacists have been directly employed in the AHS, there was a high level of satisfaction reported. The review also found that the direct employment of pharmacists within AHS is not feasible based on current workforce levels.[18]

4.14 The majority of pharmacists consulted indicated that the program enabled the provision of an important level of support without which there would be serious safety and quality issues in the provision of medications. 'Pharmacists identified that the critical QUM issues addressed by the program related to labelling, records maintenance and the packing of Dose Administration Aids in clinics.'[19]

4.15 The review made a number of recommendations which were divided into 'best practice', 'accountability and reporting', 'funding', and 'improvement of administrative arrangements'. These are detailed below.

Best practice

4.16 The review identified variability in the quality and type of support provided by pharmacists to AHSs. While this was found to be inevitable given the variety of services, development of standards were recommended to provide a benchmark against which performance may be measured.

4.17 The review also found that there is currently no mechanism for the sharing of knowledge and expertise between participants in the program and recommended a yearly conference occur for this purpose, with organisation of the conference to be shared between the Pharmacy Guild of Australia and NACCHO.

Accountability and reporting

4.18 The review recommended improving accountability of pharmacists to AHS by transferring responsibility for subsidy payments to AHS and refining program reporting.

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17 Nova Public Policy, *Evaluation of Indigenous Pharmacy Programs Report*, 2010, p. 2.

18 Nova Public Policy, *Evaluation of Indigenous Pharmacy Programs Report*, 2010, p. 2.

19 Nova Public Policy, *Evaluation of Indigenous Pharmacy Programs Report*, 2010, p. 3.

Funding

4.19 A consistent QUM issue identified through the review was the lack of labelling equipment in AHS. It found that significant improvement in safety and quality could be achieved if all services had such equipment available to them.

4.20 The highest priority identified by participants in the review was for staff training. If additional funds were available to the program it would be appropriate that these be quarantined for training purposes.

4.21 Suggested improvements included providing an option of cashing out existing subsidies to make possible direct employment of pharmacists, providing a subsidy or grant for the purchase by AHS of labelling equipment and establishing a dedicated funding pool specifically for AHS staff training purposes.

Improvement of administrative arrangements

4.22 The review found that governance and responsibility arrangements between various stakeholders, including DOHA, the Pharmacy Guild of Australia and NACCHO are unclear and should be made explicit and communicated to all participants. Added to this, information sharing and coordination between DOHA, the Pharmacy Guild of Australia and NACCHO should be increased to ensure ongoing improvements of the program. The review recommended establishment of a coordinating body.

Status of recommendations

4.23 DOHA has advised the committee that the Community Pharmacy Agreement Consultative Committee, which oversees the operation of the Fifth Community Pharmacy Agreement, has had 'relevant' recommendations referred to it for implementation. [20]

4.24 The recommendation of the Nova Review that accountability of pharmacists be improved is supported through the evidence received by the committee. The Society of Hospital Pharmacists suggests that the business rules for the program allow for services not provided to be claimed for, and that there is no option to withhold money for services not provided.[21] The committee is keen for these business rules to be reviewed and amended if required to ensure that maximum efficiency is being obtained from the program.

4.25 Kimberley Pharmacy Services suggests that the development of minimum service standards for the section 100 pharmacy support allowance is essential and that

20 DOHA, *Submission 24,* p. 17.

21 Society of Hospital Pharmacists, *Submission 2,* p. 13.

outcomes from each visit should be reported to improve accountability and the level of service provided by pharmacists.[22]

4.26 The committee is concerned to note that even though this review, as well as the previous Healthcare Associates review, found that training by pharmacists for AHS staff was very highly regarded, funding to provide an increase in this type of service has not been specifically provided.[23]

4.27 It is the view of many submitters, including Ngaanyatjarra Health Service, [24] that very few of the recommendations from previous reviews have been implemented. They point out that there appears to be poor communication between stakeholders and program funders and providers. The committee is concerned that after several reviews of the section 100 supply and support programs, similar recommendations are being made in consecutive reviews but are not being acted upon.

4.28 This is confirmed by the Pharmacy Guild of Australia who states that the program is unable to realise its full potential for positive impact due to lack of funding and the fact that many of the review recommendations have not been progressed.

4.29 The committee agrees with the Pharmacy Guild of Australia that the Healthcare Associates' recommendation of 2010 that relates to improving program oversight and integration should be acted upon. This could be done in the form of an intergovernmental and stakeholder committee to oversight program operation. The committee also notes that further recommendations on this issue were made by the Nova Review in 2010. This review recommended a coordinating mechanism for agencies and stakeholders.

4.30 The committee is concerned that after so many reviews and repeated recommendations, program participants are not experiencing continued enhancements to the program. The committee considers that the Commonwealth Government should commit to a schedule of implementation for recommendations, and advise all stakeholders of the process that will be undertaken to implement the recommendations, including the opportunities they will have to participate in the process.

Recommendation 7

4.31 The committee recommends that the Commonwealth Government publish information on the status of recommendations from previous reports, making it clear which recommendations will be implemented, timeframes and responsibility for implementation.

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22 Kimberley Pharmacy Services, *Submission 6,* p. 4.

23 Pharmaceutical Society of Australia, *Submission 7,* p. 7.

24 Ngaanyatjarra Health Service, *Submission 18,* p. 14.

Recommendation 8

4.32 The committee recommends that the Commonwealth Government ensure that participants in the section 100 program have sufficient opportunities to participate in the implementation process.

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

APPENDIX 1

Submissions and additional information received by the Committee

Submissions received

1 Drs Peter and Jan Bowman
2 The Society of Hospital Pharmacists of Australia
3 Mr Roy Finnigan
4 Confidential
5 Mrs Heidi Williams
6 Kimberley Pharmacy Services
7 Pharmaceutical Society of Australia
8 NPS
9 Royal Flying Doctor Service
10 Centre for Remote Health
11 Queensland Aboriginal and Islander Health Council
12 Australian Medical Association
13 National Aboriginal Community Controlled Health Organisation
14 Wurli-Wurlinjang Health Service
15 Name Withheld
16 Name Withheld
17 SA Health
18 Ngaanyatjarra Health Service (Aboriginal Corporation)
19 The Pharmacy Guild of Australia
20 Department of Health Northern Territory
21 National Rural Health Alliance
22 Kimberley Aboriginal Medical Services Council
23 National Pharmaceutical Services Association
24 Department of Health and Ageing
25 Office of the Minister for Health NSW Government
26 Mr Rollo Manning
27 Charles Sturt University
28 Centre for Chronic Disease
29 Aboriginal Medical Services Alliance Northern Territory

Answers to Questions on Notice

1 Answers to Questions on Notice from Department of Health and Ageing, 12 September 2011.
2 Answers to Questions on Notice from Queensland Department of Health, 12 September 2011.