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The Chair
Senate Select Committee on Regional and Remote Indigenous Communities
Parliament House
Canberra ACT 2600

30th May 2010

Dear Chair

Re: Disadvantage in remote Aboriginal communities - the supply of pharmaceutical services

"Pharmacy" - the delivery of a pharmaceutical service and pharmaceutical care to the population in remote Aboriginal communities is the subject of this submission as an example of a function that has failed to adjust itself to the needs of the population. The practice of pharmacy to this select and specific population base has been largely ignored by health planners leaving a distinct void in the planning of primary health care through the *Close the Gap* campaign.

This submission follows 14 years experience by the author in trying to establish improved delivery of pharmaceutical care to Aboriginal Australians living in remote communities across the north of Australia. The target population is estimated to be 150,000 although estimates vary according to source of data. The reason for this mediocre pharmacy service is believed to be due to:

- The target population being unaware that the manner in which they receive their "pharmacy" is below the standards applying to the rest of the Australian population
- A lack of understanding by policy makers of the needs of this population cohort
- The inability of a mainstream Government program (the Pharmaceutical Benefits Scheme) to adjust to the unique needs of the population
- An attitude that remote living aboriginal people "can wait" for improved services.

In preparing this submission the author is aware that the delivery of an efficient and culturally appropriate pharmacy service will not alone make an impact in "*Closing the Gap*". However the role that medicines play in managing the symptoms and progression of chronic diseases is well recognised with billions of dollars spent in mainstream health on this activity. To date there has been little acceptance of this function in Aboriginal health. This submission is felt to be relevant in a discussion on Indigenous disadvantage.

The example "pharmacy" provides may well be replicated in other allied health disciplines. It is here as an example of a disadvantaged and extremely "unhealthy" sector of the Australian population who deserve a system of pharmaceutical care superior to anything found elsewhere in a wealthy Nation's health program. Regrettably this is not the case, but could be given some commitment on the part of industry leaders and Government policy and program planners.

I would welcome the opportunity to speak to this submission at a Public Hearing of the Committee should that opportunity arise.

I have no conflict of interest and am not associated with any commercial firm that may benefit from the Recommendations in this submission.

Yours sincerely

ROLLO MANNING
Principal

SUBMISSION

Acronyms

ACCHOs – Aboriginal Community Controlled Health Organisations

AHS – Aboriginal Health Service – meaning includes community controlled health organisations

s100 – Section 100 arrangements in the National Health Act to supply PBS to remote AHSs

HIC – Health Insurance Commission – now Medicare Australia

SUSDP – Standards for the Uniform Scheduling of Drugs and Poisons

Introduction

Katherine Region – 1997

The author, Rollo Manning, took up a position in the Katherine Region of the Northern Territory, as "Rural Pharmacist" responsible for the medicine supplies to 23 remote Aboriginal community health centres in that region. This followed a constant nine years work in retail pharmacy including seven years as the proprietor of Manning's Pharmacy at the Karabar Shopping Centre in Queanbeyan NSW. The Katherine experience was a "culture shock" with the author completely stunned by the paucity of quality standards in the supply of medicines and the process surrounding the supply mechanism.

In retail ("community") pharmacy across Australia the attention to detail in recording, labelling, ordering and evaluating the use of medicines is beyond reproach and conducted under a close respect and adherence to the laws of the land. The ability and expectation of the pharmacist is to efficiently conduct a duty of care to consumers of pharmaceutical services and whilst this may not be carried out to the complete satisfaction of all consumers, the facility is there for it to happen. A pharmacist is present and available to advise consumers whenever a Pharmaceutical Benefit medicine is dispensed and supplied.

In the Katherine Region in 1997 there was not the slightest indication that pharmacists had ever been involved in the process of supply. Records of use were inaccurate or missing altogether; the level of understanding of what the quality use of medicine meant was a subject missing from the knowledge base of nurses and Aboriginal Health Workers involved in community health. Doctors, whilst familiar with mainstream practices, did simply not have the time to be involved in an allied health practice that should have been the responsibility of that profession – the pharmacists. While suggestions were many as to how improvement could take place and ideas from the pharmacist willingly listened to, there was not the critical mass of support within the health system for changes to be considered.

The introduction of s100

In 1998 the author was invited to return to Darwin and be involved in the policy initiative for the PBS to takeover the funding of supplies of medicines to remote communities. This move was taken up as it did present an opportunity to try and make a difference to the quality of pharmaceutical care from a higher level of management within the bureaucracy.

The Section 100 supply arrangements were implemented in April 1999 to community controlled health services and then to NT Government health clinics in May 2000 with the signing of an MoU between the Commonwealth and NT Governments.

Unfortunately the actual outcome of the arrangement was never fully understood and the Section 100 arrangements were seen by too many as the solution to all the problems associated with pharmacy services to remote Aboriginal health services. This was never the case due to the fact that the Constitutional power of the Commonwealth in health service delivery went no further than making funds available to pay for PBS medicines supplied to remote AHSs. The responsibility for the quality use of medicines including adherence to the law remained with the State/Territory. This fact was not appreciated and as a result a piece meal approach has been used to improving the quality use of medicine.

Tiwi Health Board owned pharmacy business

In November 2000 the author was approached by the (then) Tiwi Health Board seeking assistance to improve the way pharmaceutical care was being delivered to its constituency – the 2,500 people living on the Tiwi Islands. This resulted in the departure of the author from the employ of the Department of Territory Health Services and taking up a consulting role to the Tiwi Health Board.

This presented an opportunity to put in place a pharmacist orientated approach to pharmaceutical care that was in the best interests of the client base. It was a motto of the pharmacy to always ask the question "will anyone get any healthier as a result of this action" – if the answer was "no" it would be assumed the proposed action was another set of processes or procedures that pharmacists are very good at inventing to wrap a few more sheets of armour around what they are doing so nobody can "get at them". It is a protected industry with a raft of legislation that protects it from the fierce rivalry sought from other operators of supermarkets and the like. Regrettably in Aboriginal health the barriers need to be brought down and access to medicines and advice enabled to flow in the easiest possible way.

The following are seen to have been significant in the success of this project:

1. The ownership of a pharmacy business by the Tiwi Health Board – a matter not possible anywhere in Australia except in the NT.
2. The obtaining of an Approval Number for that pharmacy business to conduct its own buy in and supply on to the health service its pharmaceutical product requirements with the cost being met by the HIC.
3. The accessing of a Start Up allowance from the Health Insurance Commission to enable the establishment costs to be met external to the Tiwi Health Board's limited funds.
4. The partnering with Webstercare in the development of a software program specifically designed to meet the recording and labelling needs of a health service accessing the PBS through the s100 supply arrangements
5. The changeover from the dangerous dosette boxes to Websterpak blister packed dose administration aids.
6. The obtaining of a $250,000 grant from the Aboriginal Benefit Account to develop into a marketable product the Mirrijini Dispense System for it to be used by other health services.

The Tiwi Health Board was forced into voluntary administration in September 2003. This had nothing to do with the conduct of the pharmacy business but it did mean the pharmacy had to cease operating due to the NT Government not wishing to become involved in a pharmacy business despite the pharmacist offering to continue the operation.

Consulting to pharmacy and ACCHOs

The following years (2004 to present) have been spent encouraging Aboriginal health services to consider upgrading the way they deliver their pharmacy services. This has been across both remote and urban health services. In total some 50 AHSs have been visited across Queensland, NT and Western Australia.

This submission arises out of the conclusion that whilst there is a desperate need for upgrading the way pharmacy services are delivered to the target audience – the Aboriginal health services – those services themselves have little understanding of this need. To them the way they are supplying medicines is the only way they know and if this is acceptable to all involved they see no need to change.

The issue is that it should not be acceptable. The standards being followed are virtually non existent. The situation is not drawing the attention of pharmacy industry leaders, government policy planners or the regulatory agencies at the State/Territory level when it comes to the legal supply of medicines controlled by the Standard for the Uniform Scheduling of Drugs and Poisons (SUSDP).

Effort has been put into producing guidelines and protocols for pharmacies (retail) dealing with AHSs but not nearly enough effort has been put into an equivalent set of guidelines at the AHS pharmacy room level.
The result is nothing changes and the risks to the client base remain at unacceptable levels with only good fortune keeping medicine misadventures out of the headlines or law courts.

Situation analysis

This will be looked at from the viewpoint of

- **The patient**
- **The AHS Board of management**
- **The prescribing doctor**
- **The RN or AHW**
- **The supplying pharmacy**
- **The peak organisations**

The patient – where everyone in Australia has access to a pharmacist when they have a prescription dispensed in the mainstream way of doing things – the remote Aboriginal person does not. The dispensing fee paid to an Approved Pharmacy to dispense a PBS medicine at $6.42 allows for the time that may be spent in counselling the patient. In remote Aboriginal health this simply does not happen and there is little pharmaceutical training of the AHWs or RNs who work at the coalface and supply the medicines.
The patient is missing out on advice re the medicine prescribed and also the knowledge that an accurate record is being kept of their medication history.
In some instances supply will be without a label placing other community people at risk should the package fall into the wrong hands.
The AHS Board of management – it is hoped that at most there will be one member of a board that understands quality use of medicine. If not then acceptance of an invitation from a pharmacist to attend a board meeting and appraise the board of the risks associated with a low quality pharmacy service and how this can be overcome could be expected. In many instance this is not the case and the Board's should be made aware of the nearest available pharmacy consultant to run over their procedures and give an appraisal of the urgency of a need to improve. Funds need to be available to allow this to happen. See Recommendations. In travelling around AHSs the author has been disappointed at the low level of attendance of a pharmacist at the services. The chosen pharmacy (if there is one) is usually content to supply without knowing where it is going to or dispense and not follow up on evaluation.
The prescribing doctor – there is no doubt that doctors working in remote Aboriginal health are genuinely concerned about the standard of pharmaceutical care. However given the immense difficulties confronted in improving Aboriginal health through the entire ambit of the social determinants it is understandable that doctors simply do not have the time to become involved in a practice function that should be the province of a pharmacist. All doctors spoken to by this author support improved pharmaceutical care and are excited at the prospect of (maybe) something happening. Their concern is for their patients and an improvement in the way pharmacy is practiced will lead to improved patient outcomes.
The RN or AHW – *"we don't know what we don't know"*[1] and this is true of AHWs or RNs working in remote Aboriginal health. Most have had no formal training in pharmacy practices and apart from

[1] Isobel Ellis. Address to CRANA Conference, Darwin, September 2005. "Implementing any new clinical practice requires us to recognize that what we are currently doing is not giving us, or our patients the best outcome possible. However we don't know what we don't know."

personal experiences have not been exposed to the intricacies, precision and control mechanisms utilised in "community" pharmacy. Hospital practice maybe for some RNs good background but essentially this is different to the unique nature of remote health practice.
At the start of the author's exposure to this sector it was made clear that the filling of dosette boxes was a demanding function of the "pharmacy" at a remote health clinic.
In addition to the ordering this was seen as one of the most disliked functions in the health clinic[2]. Training is lacking, mentoring is non–existent, and the funds made available for Quality Use of Medicine under the s100 support allowance no where near that needed to have more pharmacist involvement in remote health practice.
The supplying pharmacy – the selection of an Approved Pharmacy to supply the PBS under the s100 arrangement will have been determined by the owner of the AHS. This may be by tendering, self selection or a hospital pharmacy. The pharmacy is paid $2.69 for each item supplied in bulk with no labelling or control over the supply on to the patient. For the same PBS item the same pharmacy is paid $6.42 to dispense to a mainstream client. The PBS is thus saving $3.73 each time a supply is made to a remote living Aboriginal client. A support allowance is paid to the s100 supplying pharmacies to visit AHSs to assist with quality use of medicine however an amount that only provides for two visits a year is totally inadequate.
The $3.73 should be made available to the health service to "buy in" pharmacists support as it sees best. Community control is well recognised as the "way to go" but AHSs have no control over the standard of their pharmacy service or the funds to make improvements. See recommendations.
The peak organisations – this discussion is about a market with a population of some 150,000. The fact that their health status is three times worse than the mainstream population is not taken into account when a retailer or drug manufacturer is gauging the benefit that could accrue to them from an intensive effort when it comes to return on investment. The organisations involved are:

- **The Pharmacy Guild of Australia** represents the interests of 5,000 pharmacists who own businesses in Australia. Only 50 of these have taken up the opportunity to supply PBS under the s100 arrangements.
- **The Pharmaceutical Society of Australia** represents 14,000 pharmacists some of whom are keen on further professional development as practitioners in primary health care but have yet to find a way to be properly remunerated for their activities.
- **The Society of Hospital Pharmacists** is the organisation keenest to help in the situation described in this submission. It at least sees the need for a pharmacist to be located within a health service to add value to the medicines being supplied. This is akin to pharmacists in hospitals to integrate with the other primary health practitioners.
- **The National Aboriginal Community Controlled Health Organisations**, the peak body for Aboriginal health services recognised by Government is so tied up with the complexity of issues confronting *"Close the Gap"* that it has no time to look at "pharmacy" in any detail. While it is partnered with the Pharmacy Guild in discussions with the Government it seems to think its job is being done for it. It (NACCHO) tends to go along with what the Pharmacy Guild is recommending and that is inevitably something which will secure the sustainability of retail pharmacies – that is after all what it (the Guild) is in existence to do.

The outcome of all this is a sector of the Australian population largely ignored and allowed to squander in sub standard conditions in every respect – housing, employment, education, social justice, poverty and pharmacy services.

See Table 1 for a summary of the situation as seen by this author as lining up against the Committee's observed criteria.

[2] Dr Philippa Hudson. Prescribing and Dispensing Issues in remote NT communities. NPS. 2002

A solution

1. The sooner the better for **Australia to acknowledge that this is a Third World country for remote Aboriginals** and treat programs for alleviating disadvantage in a similar way as we do for developing countries.

- Stop developing programs for individuals and treating them as a small part of a universal system – **IT DOES NOT WORK** and if anything plays against the benefit of the client.
- Establish an agency alongside AusAid to develop programs
- Establish regional bodies to determine the best way to overcome disadvantage
- Stop paying money to individuals as welfare handouts and pay the same quantum of money to communities for development work and targeted individual assistance
- Inspire confidence in people to show they can get out of poverty
- Create opportunities through community development activities

2. **Create positions for pharmacists in the remote Aboriginal health systems** at both Government and Community Controlled Aboriginal health sectors. This can be achieved in a number of ways:

2.1 **Government health services**, namely NT Department of Health and Families, Remote Health Division; Queensland Health; and, WA Country Health Service – each need to create positions on a district or regional level for pharmacists to develop programs within the remote sector and utilise their knowledge in a professional manner. This would not interfere with the supply arrangements through retail pharmacies. The positions would allow pharmacists to interact with the entire primary health care effort and also provide input to public health programs where invited.

2.2 **Contracted pharmacy consultants** to work in AHSs alongside other health practitioners in devising programs that will improve quality use of medicine. The situation is so bad that a pharmacist will quickly establish priorities for action and recommend changes to ensure better quality in the use of medicines – that is what they are trained to do so there is no need for an extensive Job Description. The detail should be done WITH the Aboriginal health service – not for it.

2.3 **In house pharmacy businesses** within the Aboriginal health service or within the "growth town" to operate in a "hub" and "spoke" model providing superior services to smaller communities in the vicinity. This will have to be done in collaboration with the State/Territory legislature to adjust laws to meet the need. Laws are there to protect the public, not to hinder them from obtaining a safer service infrastructure. In this instance it is not just a superior service but also an opportunity for community control, employment and training opportunities and an improved and safer way of doing things towards a better future and longer life for the individuals. Table 2 shows maps of NT, Queensland and WA Kimberley regions where such "hub" businesses should be considered.

2.4 **Encourage local persons to follow the career path of pharmacy** in the hope that this will lead to a sustainable workforce with local skills and better futures. The opportunity exists for pharmacists, pharmacy technicians, Adherence Support Workers and clerical staff.

Funding for these options would come from the money now being saved by the PBS when a supply is made to a remote living Aboriginal person. In total for the 2007/08 financial year a total of 1,325,504 items were supplied to the 166 AHSs from 34 pharmacies[3]. It would be reasonable to suggest this was now at a rate of (say) 1,500,000 items in a 12 month period. At $3.73 an item this amounts to $5.6 million that could be an initial fund.

[3] DoHA PBS Indigenous Personal Communication

To this amount would be added the $100,000 Start Up Allowance paid to new pharmacy businesses opening in remote places in excess of 10 Kms from another pharmacy business and all of the proposed in Table 2 would qualify for this with the exception of Katherine (NT) and Cairns (Qld)

Summary

The explanation from health services when asked to describe the manner whereby their medicine supply systems meet the law is to say that a doctor supervises the activity. It is known this does not happen all the time and there is a need for some sort of amnesty so admissions of guilt will not be penalised while systems are "cleaned up".

The elements described above as happening in the majority of services visited by the author indicate a large problem when taken across the spectrum of Aboriginal health.

The *Close the Gap* campaign will succeed if given the co-operation and commitment from the AHSs and the professions. The pharmacy profession must "lift its game" in agitating for an expanded role in primary health care if it is to be a real contributor in improving quality and therefore health outcomes. So long as medicines continue to be supplied with little or no explanation of why and what to look out for, the longer it will take for patients to understand and respect their prescribed treatments as being in their best interests.

In order for change to occur there is a need for the peak organisations responsible for setting policy and recommending programs to acknowledge the need for upgrading to mainstream standard the mechanism for medicine supply to Aboriginal Health Services and their clients.

There is too much of a tendency for peak organisations when talking to Government to create the impression that the situation is not too bad – to state the obvious would be to admit mediocrity in an area of primary health care which in mainstream is beyond reproach when it comes to meeting regulatory requirements and having available to the public advice when it is needed.

Recommendations

1. That a peak organisation consultation be held to decide ways that quality use of medicine can be improved to remote living Aboriginal people. The National Medicines Policy Executive and Committee would be an appropriate agency to conduct this consultation.
2. That Medicare Australia pay to all AHSs an amount of money equivalent to $3.73 for every PBS item it has received in the previous 12 month period to be used to buy in advice and support in the quality use of medicine for its clients.
3. That funds be made available through the OATSIH PIRS program to fund the installation into all AHSs of an electronic system for ordering, recording, supplying and labelling all PBS items to clients on a par with that provided in mainstream practice.
4. That funds be made available through the OATSIH PIRS program to fund the installation into all AHSs with outpost clinical operations a storage cabinet that will securely and safely supply medicines by authorised persons
5. That a training program be developed that is a requirement for authorisation gained by AHWs and RNs working in remote Aboriginal health before being able to supply medicines.
6. That support is given to the concept of pharmacy businesses being considered as a useful addition to the economic activity being planned for remote towns in the NT and the major population centres across the North of Queensland and Western Australia.

Rollo Manning
Principal
30th May 2010

TABLE 1

Pharmaceutical care for remote living Aboriginal people

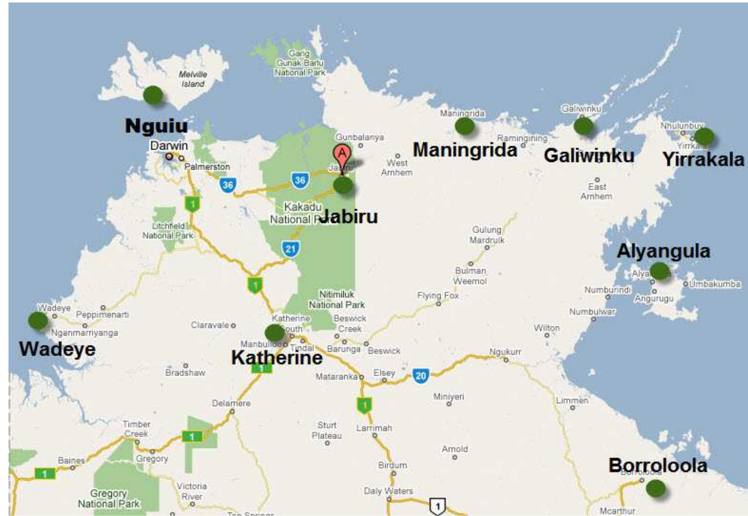
Table of comments against Committee's observed criteria

Criterion	Comment
1. A perceived need for a greater investment in people, resources and infrastructure to meet the needs and aspirations of regional and remote communities;	There is a definite need for investment in pharmacy services to remote Aboriginal communities. No investment in pharmaceutical care has been made. There is no reason why regional areas could not be serviced by a "mobile" setup based in a "Hub" centre and utilising technology to monitor access mechanisms from "Spoke" centres. People will gain employment and skills training; Resources are available through Commonwealth PBS programs; Infrastructure could be funded from trading profits over time. While there is no investment in "community pharmacy" in remote Aboriginal communities the Pharmacy Guild boasts on its website that the 5,000 pharmacies in Australia employ over 12,000 university-qualified pharmacists and approximately 30,000 highly trained pharmacy assistants, and contribute an annual turnover of $8 billion and tax revenues of $200 million to the Australian economy.
2. A commitment from state , territory and Commonwealth governments to long term relationships and partnerships with Indigenous people and communities as way of solving entrenched problems;	The entrenched problems associated with medicine taking are amplified by the absence of any statistical analysis of the PBS supplies that have been going to Aboriginal health services for ten years in most cases and the claim being made that such statistics are not available because of a manual claim system. There are only some 50 pharmacies involved and each is being paid by Medicare Australia with a summary of all items supplied that make up that payment. Statistical analysis is on offer from a skilled unit at the Centre for Chronic Diseases at the University of Queensland. Bureaucratic process has delayed a decision on when these stats can be made available for the past 12 months. Meanwhile State/Territory Governments are responsible for the quality of care and adherence to regulatory requirements in the supply of medicine. In many cases these are not being adhered to with State/Territory authorities taking no action to remedy the situation. If a similar scenario was evident in mainstream pharmacy practice immediate punitive action would be undertaken. In remote Aboriginal pharmacy practice there is no quality control measures in place through State/Territory Poisons Branch offices.
3. Ability of government programs to be tailored to the needs and strengths of communities, not the other way around;	A whole of Government approach is needed with the agencies responsible for health, business development, support services, training and employment all involved. "Pharmacy" is more than a retail shop or a health profession well trained to know all there is to know about the effect of chemicals on the human body. It embraces many of the elements sought after in improving Aboriginal disadvantage.
4. Increased accountability of bureaucracies to Indigenous people and communities; and	The "blame game" is apparent when working in this area.. The Commonwealth initiated the Section 100 supply but forgot to tell the States/Territories that all aspects of quality were still in their province. The States/Territories were so pleased to have someone else "pay the bill" that they chose to overlook their residual responsibilities. The demise of the Australian Pharmaceutical Advisory Council meant there was no watchdog to keep the various departments accountable.
5. A perceived lack of awareness of the serious nature of the issues confronting people living in regional and remote Indigenous communities.	The people themselves in remote areas are not aware that the pharmaceutical care they are receiving is below standard when compared to mainstream. It is all they know. In many instances the clinician (Drs, RNs and AHWs) working in remote health clinics has not been exposed to a high level of quality pharmaceutical care previously in their careers. The onus is fairly and squarely on the pharmacy profession through its peak representative bodies namely The Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and The Society of Hospital Pharmacists of Australia to join together in launching a Nationwide awareness campaign of the need to "Take medicines seriously" and not as an adjunct to a primary health care system that is overstretched and understaffed to handle any more improvements. The resources are there in the PBS and must be utilised with the help of a socially responsible pharmaceutical industry across manufacturing, distributing and retail sectors.

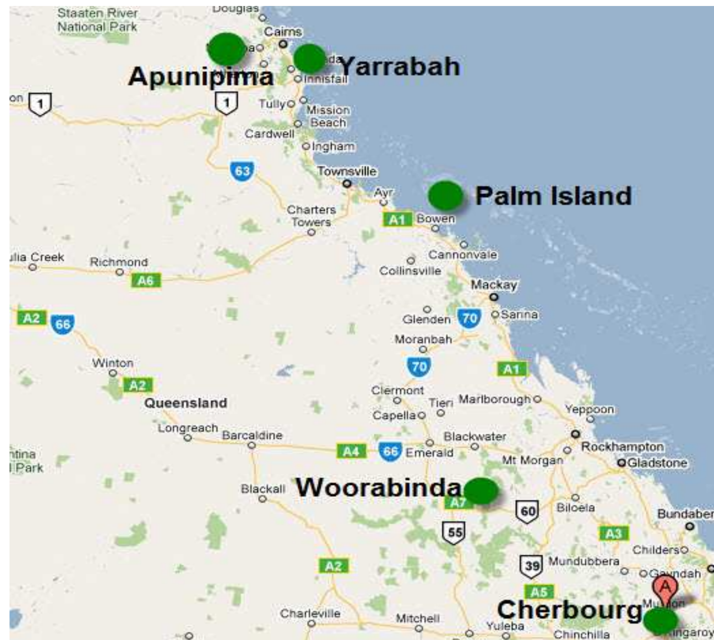
Table 2

Towns that could be targets for a local pharmacy business

NT



Queensland



WA - Kimberley