

Central Australian Aboriginal Congress Aboriginal Corporation

Review of Pharmacy Remuneration and Regulation
Draft submission
September 2016

Executive Summary

The Central Australian Aboriginal Congress (Congress) functions as a comprehensive primary health care service that addresses health inequities and aims to close the gap between Aboriginal and non-Aboriginal people. The Review of Pharmacy Remuneration and Regulation is a great opportunity to make significant changes to the health outcomes of Aboriginal people by improving access to affordable medications in a culturally appropriate and effective way.

Comprehensive primary health care services include the provision of accessible and effective pharmacy services and medications. Pharmacists play a critical role in prevention, early intervention and treatment and management of disease, and Congress sees pharmacists as an important part of the multi-disciplinary primary health care team.

Since the introduction of Section 100 (S100) pharmacies in Remote Area Aboriginal Health Services (RAAHS), access to Pharmaceutical Benefits Scheme (PBS) medications has significantly improved for Aboriginal people in remote areas. While availability of medicines has improved, there is still a need for further action to address the escalating demand for medications, alongside a real need for effective pharmacy services and quality use of medication for Aboriginal people, to further close the gap in health outcomes. This includes addressing a number of barriers within the existing policy and legislative framework for the S100 scheme and community pharmacies. In the following submission, Congress proposes the following actions:

Recommendation 1: *Remunerate the value-add of staff pharmacists in Aboriginal health services: This recognises pharmacists as a part of the multidisciplinary team, and their critical role in medication and disease management, and allows for the generation of income that can be reinvested back into primary care and pharmacy services.*

Recommendation 2: *Extend the S100 PBS medications to include medications frequently used for common conditions in remote Aboriginal communities.*

Recommendation 3: *Support the ability of Aboriginal Community Controlled Health Services to establish and run a pharmacy business.*

Recommendation 4: *Improve patient access to S100 medicines by:*

- a) Taking a holistic approach to address issues around subsidies schemes and QUM programs for Aboriginal people*
- b) Establishing a scheme to allow for S100 pharmacies to supply four weeks of PBS medications to discharged hospital patients.*

1. Background

The Central Australian Aboriginal Congress (Congress) is pleased to provide input into the Review of Pharmacy Remuneration and Regulation. The Review is a great opportunity to make significant changes to the health outcomes of Aboriginal people by improving access to affordable medications in a culturally appropriate and effective way.

Congress is the largest Aboriginal community-controlled health service (ACCHS) in the Northern Territory, providing comprehensive, culturally-appropriate primary health care services to Aboriginal people living in and nearby Alice Springs as well as to six remote communities in Central Australia.

Congress functions as a comprehensive primary health care service that addresses health inequities and aims to close the gap between Aboriginal and non-Aboriginal people. The effectiveness of this model is due to the wide and innovative range of strategies that provide equity of access to services that are affordable and acceptable to the community,¹ and range of culturally appropriate services and programs that holistically care for health and wellbeing of Aboriginal people.

Comprehensive primary health care services therefore include the provision of accessible and effective pharmacy services and medications. Pharmacists play a critical role in prevention, early intervention and treatment and management of disease, and Congress sees pharmacists as an important part of the multi-disciplinary team.

2. S100 pharmacies in Remote Area Aboriginal Health Services

Since the introduction of Section 100 (S100) pharmacies in Remote Areas Aboriginal Health Services (RAAHS), access to Pharmaceutical Benefits Scheme (PBS) medications has significantly improved for Aboriginal people in remote areas.² Under S100, RAAHS clinics source medicines from community or hospital pharmacies in bulk which are then supplied to patients with instructions provided by a doctor, or alternatively by a nurse or Aboriginal Health Worker under the supervision of a doctor. Medications are provided at the point of consultation, and patients receive their medications immediately, rather than having to travel some distance to a pharmacy.³

In the larger ACCHS, however, there has been an increasing tendency to better utilise the Section 100 scheme to enable the employment of pharmacists who then dispense medicines directly to patients. This has greatly improved the quality of the process and ensured appropriate checks and balances are in place for all medication prescribing and dispensing as occurs in the mainstream where a doctor's prescription is always checked by a pharmacist before a patient receives their medications. This reduces the risk of medication errors and these are the most common errors that occur in the Australian health system.

The S100 RAAHS program has made a huge impact in improving the availability of medicines in difficult to serve areas. In its original purpose however, is limited to the supply of medications in bulk to the clinic, rather than dispensing by a pharmacist to the consumer. This means that the program does not provide for pharmacy activities such as dispensing and providing Quality Use of Medicines by Aboriginal and Torres Strait Islander people (QUMAX) activities including education and medication management support e.g. dose administration aids (DAAs).⁴ This is reflected in the pricing differences between the PBS

supply fee of \$2.92 and the dispensing fee of \$7.02 that applies in S90 pharmacies where there is a pharmacist and QUMAX activities.

3. *There is still a gap in access to medicines and pharmacy services.*

Despite the achievements of the S100 program in increasing medication availability, Aboriginal people still have significantly less access to medicines than other Australians. For example, in 2010-11 the total annual national expenditure on pharmaceuticals per Indigenous person was only \$369, 44 per cent of the figure for non-Indigenous people (\$832)⁵. The gap in PBS usage is also lower in the Northern Territory than elsewhere in Australia by a factor of three (3); and is lower in Central Australia than in the Top End.⁶ This reflects the success of the Section 100 initiative in overcoming many of the barriers to access to essential medicines for Aboriginal people in remote areas who are the sickest people in the country and most in need of medicines to prolong life.

Non-the-less the Northern Territory has the lowest number of PBS approved pharmacies per capita in Australia as well as the lowest per capita volume and cost for section 85 medicines (see Figure 1):

Figure 1: Average population by pharmacy and access to PBS medicines, by jurisdiction, June 2013⁷

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
Pharmacies approved at Jun 2013	1,802	1,261	1,076	4	5	1	3	7
Population 2013 (ABS Publication 3101.0)	7,465,500	5,791,000	4,690,900	1,677,300	2,550,900	514,000	242,600	384,100
Average Population per Pharmacy	4,142.90	4,592.39	4,359.57	3,847.02	4,522.87	3,472.97	7,351.52	5,261.64
Government Cost per Capita	334.60	313	297	356.90	263.20	389.90	113.20	240.10
Volume (Section 85) per Capita	9.50	9	9	10.60	7	11.40	3	9

Congress has the additional concern about a pharmacy monopoly in Alice Springs which creates a significant barrier to access of pharmaceuticals. The current ownership of the four pharmacies in Alice Springs, in accordance with both the ABN & ASIC register, indicate that a single group of pharmacists are co-owners of all the pharmacies in town. It is argued that the monopoly situation is contributing to increased pricing for the general population of Alice Springs and having a public pharmacy not owned by one group will improve competition and pricing and therefore improve access by breaking the monopoly.

In making this point, Congress is not in support of the complete deregulation of the pharmacy industry as this would make access significantly worse in remote areas. The system for allocating pharmacy licenses on a population basis according to need is a good one and Congress has used this system as a model to advocate for a similar system to ensure a more equitable distribution of GPs in Australia though geographic provider numbers. Congress supports only the approval of ACCHS to be able to obtain pharmacy licenses throughout Australia and this would help to address the monopoly situations which largely occur in rural and remote towns where there already is an ACCHS.

4. *The burden of disease is still significantly higher for Aboriginal people than non-Aboriginal people*

While the gap in health outcomes has decreased in recent years, Aboriginal people still experience a disease burden that is 2.3 times higher than non-Aboriginal people.⁸ In the Northern Territory the conditions that contribute most to the higher burden of disease for Aboriginal people are: cardiovascular diseases, mental and substance use disorders, injuries, kidney & urinary diseases, infectious diseases and endocrine disorders (which includes

diabetes). Chronic diseases are responsible for more 70% of the gap in disease burden. This is worse in remote and very remote areas.⁹

Chronic diseases, including heart disease, diabetes, renal disease, arthritis and back problems, are the main causes for the burden of disease as people get older. From ages five to 49, mental and substance use disorders are the main cause. The three main causes for loss of healthy years in children aged under five are infectious diseases, blood and metabolic disorders, and respiratory conditions such as asthma.¹⁰

Aboriginal people face the double-burden of disease of both chronic and infectious diseases. For instance, Aboriginal people in Australia have the highest prevalence of impetigo in the world.¹¹ Left untreated, the skin infection, often due to scabies from living in overcrowded homes, can lead to both rheumatic heart disease (RHD) and renal disease, which have life-long health implications.

5. The demand for health care, medicines and pharmacy services is growing

Nationally, the demand for health services is growing. This is linked to an ageing population and increasing prevalence of chronic disease as well as Aboriginal people taking greater agency for their own health care and self-management.¹² Additionally, the national demand for primary care services in Aboriginal -specific organisations has almost tripled over fifteen years, from 1.2 million in 1999-2000 to 3.5 million in 2014-15.¹³

The ageing population and increasing demand for health services is reflected at a local level in Central Australia. The number of Aboriginal people over the age of 55 who use Congress clinical services in Alice Springs has increased significantly by nearly a third in eight years (see Figure 1). The Central Australia Aboriginal population is projected to grow over the next ten years, from an estimate 17,000 in 2016 to almost 20,000 in 2026.

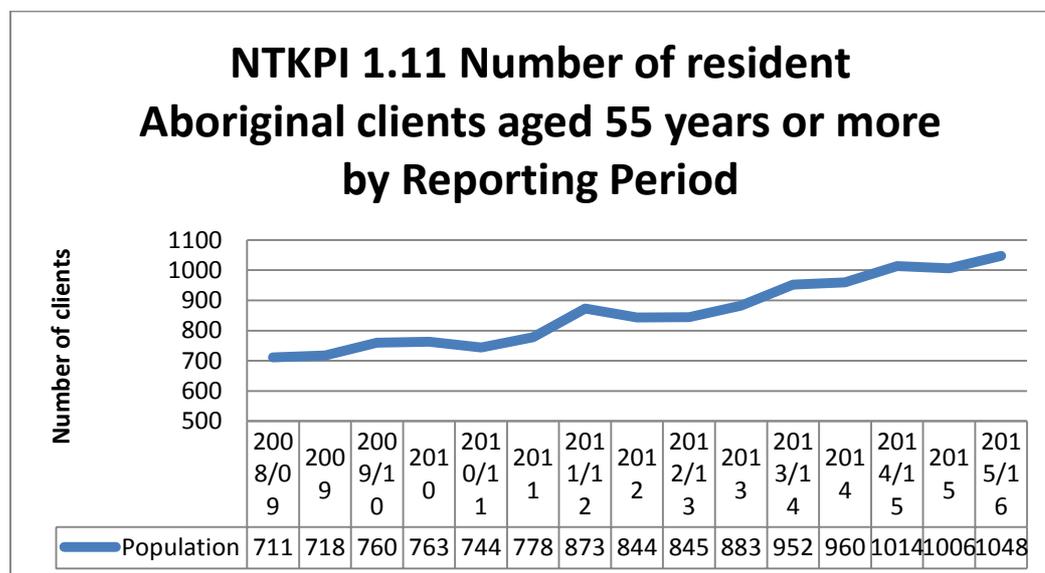


Figure 1

A similar trend is evident in the data for the remote health services that Congress provides in partnership with local health boards. This local data reflects the more than 30% improvement in overall Life Expectancy in the Northern Territory since 2000 based on the Council of Australian Government (COAG) Indigenous Reform Council reports. In fact, the

fastest growing segment of the population in Central Australia over the next twenty-five years is Aboriginal people over the age of 65 as thankfully, Aboriginal people are living longer. As the Aboriginal population ages, in the context of heightened risk of chronic disease, more people will require safe, effective and appropriate access to medicines.

Episodes of care at the existing Congress dispensary on Gap Road have been increasing at an average rate of 18% per year since 2008 and further increases in demand are expected (Figure 2). As noted above, an increasing demand for pharmacy services and medicines is expected to correspond with the increasing number of Aboriginal people over the age of 55 who use Congress clinical services, an expected rise in the Central Australian Aboriginal population.

The Congress Alice Springs dispensary is a vital access point for essential medicines from all over Central Australia as Aboriginal people travel to town without their medications at times or simply stay for a while and need their medications while in town. The ability to meet this need has been greatly assisted by the Shared Electronic Health Record in addition to expanded pharmacy services through Section 100. Over the years Congress has gone from one to three full time pharmacists and many additional technicians to meet this increased demand. The KPIs data from primary health care services in the Centre shows a trend for increasing BP control and glucose control which could be partly due to improved medication compliance due to better access and systems for continuing care.

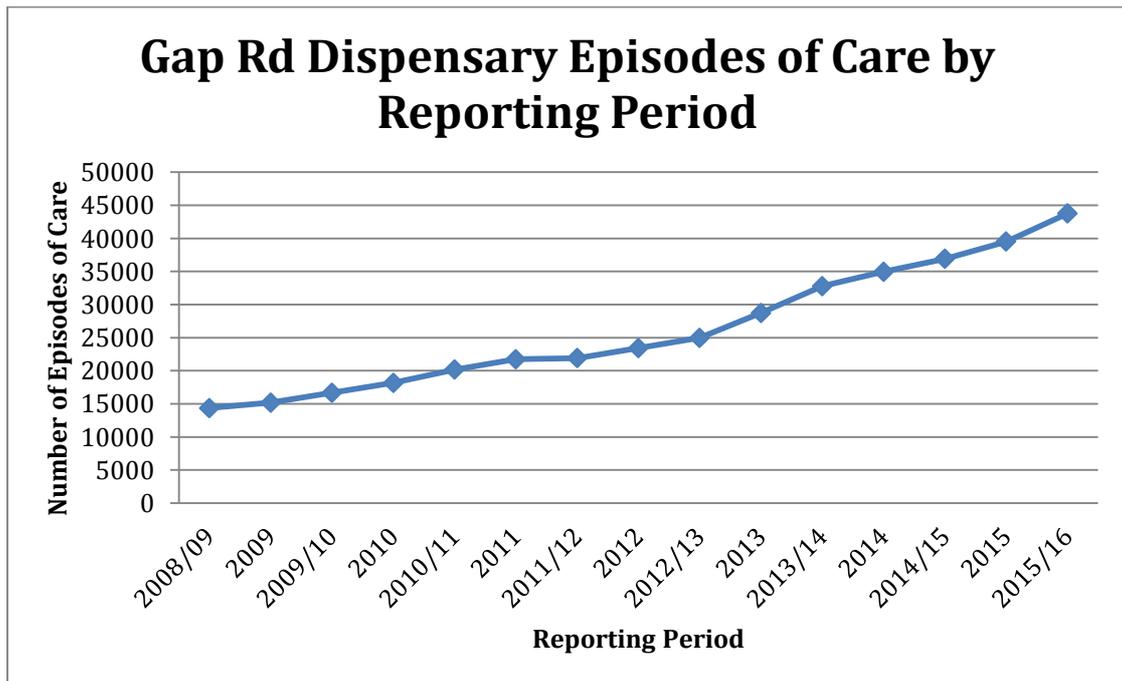


Figure 2

While the S100 RAAHS has significantly improved the availability of vital medicines for Aboriginal people, there is still a need for further action to address the escalating demand for medications and pharmacy services to Aboriginal people, to further close the gap in health outcomes. Congress therefore proposes the following actions:

Recommendation 1: *Remunerate the value-add of staff pharmacists in Aboriginal Health services.*

The S100 program has improved the supply of medicines to remote areas. The program, however, does not provide for pharmacy services. Poor health literacy and understanding of complex medicine regimes by patients often leads to adverse outcomes, at a high cost to both the patient and the health system.¹⁴ Even more important is the additional quality assurance that is provided when a pharmacist is always able to check that a doctor's prescription is accurate and there are no potential drug interactions in often complex, multiple medication regimes. Clinical pharmacists are now considered an essential part of the multidisciplinary team in the management of complex disease, and provide clinical care in areas such as control of blood sugar in diabetes, managing hypertension, as well as wound care. This may include self-management support for patients on complex medicines regimes, and managing changes through deprescribing on discharge from hospital.

The S100 Support Allowance does fund pharmacists from the supplying pharmacy to travel to remote areas and provide advice on S100 and education on Quality Use of Medicines (QUM) activities e.g. educating clinical staff on medications and alternatives, and manage supply and storage.¹⁵ However, at two visits per year this does not sufficiently meet the need, and does not address the need for an interface between patients and pharmacists.

Recognising there is a need for these value-added services and to ensure effective use of medicines in remote communities ACCHSs including Congress are employing pharmacists at their own cost, at least in larger, non-remote clinics which support remote clinics. These are funds that would be otherwise reinvested back into comprehensive primary care services.

Reimbursement for the value-add of pharmacists in S100 clinics will significantly improve the level of services with RAAHSs. The value-add of a pharmacy service and QUMAX activities within a primary health care service could be reimbursed through a data-driven Medicare Benefits Schedule-like rebate or as a practice incentive payment for the pharmacist as part of the multidisciplinary team. This may ultimately be more cost effective than medical practitioners providing education and support for medication use, and will also free up GP time. The money saved from reduced medication errors should also be considered in this analysis. The reimbursement will eventually pay for the pharmacist allowing for ACCHSs to employ their own pharmacist, making a significant additional contribution to closing the gap.

Recommendation 2: Extend the S100 PBS medications to include medications frequently used for common conditions.

While S100 arrangements have increased access to essential PBS medications in remote Aboriginal communities, this does not include all medications used to treat common medical conditions in remote areas. Many of these conditions are related to the wider social determinants of health that are manifestly entrenched in remote Aboriginal communities, such as overcrowding, alcohol misuse and poor nutrition, and leads to the gap in health outcomes.

Congress has identified the following medications, all of which have a significant evidence base and are frequently used in its clinics though not available as S100-supplied medications (Table 1). The cost of providing these medications is borne by Congress, diverting funds that could be reinvested back into primary health care services.

Table 1

Medication	Purpose
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Ferrograd C 325mg/500mg Cr-Tab (Iron)	For treatment of iron deficiency anaemia
Iodine and folic acid supplement	In pregnancy as per Minymaku Kutju Tjukurpa Women's Business Manual (Remote Primary Health Care Manual) and National Health and Medical Research Council recommendations , especially Aboriginal and Torres Strait Islanders.
Nystatin Oral Drop	Treatment of oral thrush which is common in infants. There is no other alternative.
Chloramphenicol Eye drops/ ointment	Treatment of bacterial conjunctivitis – common in children.
Thyroid – Eltroxin	The unrefrigerated alternative. This is TGA approved but not on the PBS. Current PBS listed thyroxine can only be stored out of a fridge for 21 days which means a client with dosage administration aid can only have two weeks dispensed at any time. In addition to this, a significant number of Aboriginal people live in houses without ready access to a fridge.
Liquid Antacid	Treatment of reflux disease
Cholecalciferol – vitamin D 1000IU	Treatment of vitamin D deficiency which is common.
Levonorgestrel 1.5mg (MAP)	Emergency contraception
Crotamiton 10% Cream	For babies < 6 months for treatment of scabies. AMH and eTG. There is no alternative.
Thiamine 100mg/ml	Parenteral thiamine is important for treatment of thiamine deficiency related to alcohol misuse and prevention of Wernickes Encephalopathy. This is commonly required in Aboriginal communities.
Lactulose liquid	Treatment of hepatic encephalopathy
Dimeticone Spray /Gel	Treatment of lice
Midazolam Ampoules 5mg /ml Plastic ampoules and nasal aspirator	Management status epilepticus
Olanzapine	Treatment in rehabilitation for addictions where paranoia is present but a diagnosis of schizophrenia or BAD has not been made.

Recommendation 3: Support the ability of ACCHSs to establish and run a pharmacy business by:

a) Allowing for ACCHSs to apply to operate as a pharmacy business in all State and Territories. In the absence of State/Territory provisions for AHS operated pharmacies, the Commonwealth

Government should develop a licencing framework that allows for ACCHSs to operate as a pharmacy supplier to S100 remote clinics.

b) Allow pharmacy proposals that seek to address specific population needs to seek exemption from Rule 130 of the Pharmacy Location Rules.

To address access to medicines and effective pharmacy services in Alice Springs, Congress is applying to own and operate its own pharmacy business under S90 of the *National Health Act 1953* (CTH). This requires applying for an exemption from Schedule 7 of the *Health Practitioners Act 2004 (the HPA)* under NT legislation which states that a person may not own a pharmacy unless they are an authorised pharmacy business owner. Expected benefits from an ACCHS-owned and operated pharmacy include:

- Better access and more effective pharmacy services provided to Aboriginal people in Central Australia including the systematic provision of counselling on the use of medications.
- Increased access to the QUM activities including diabetes control, Medscheck, DAAs etc.
- A greater capacity to generate income through the PBS potentially self-funding the pharmacy's operation including the employment of the pharmacist. The business will also be an opportunity to increase employment and training of Aboriginal people.
- The provision to be able to supply medications to S100 contracted remote clinics.

If achieved, the pharmacy is forecast to significantly improve Congress's revenue and free up all of the more than \$500 000 of core primary health care funds currently invested in pharmacy services. This improvement is based primarily on a reduction in the cost of operating the current dispensary, the realisation of a PBS s100 revenue stream and a conservative operating profit. This will be reinvested into the organisation to improve the quality and effectiveness of the supply of medicines and employ additional pharmacy staff (including Aboriginal staff). It will also enable other positions to be funded, such as additional chronic disease care coordinators.

The 'for profit' pharmacy business will also reduce Congress' dependence on government funding, and provide Congress with a sustainable, long-term service that could not otherwise currently be provided.

Northern Territory legislation already allows for ACCHSs to apply to operate as a pharmacy. An alternate solution to changing other State/Territory legislation would be to allow for S100 to have a class of pharmacy PBS licence under Commonwealth legislation, to supply PBS medications to S100 remote clinics. This would require employment of a pharmacist in charge.

Tailoring Location Rules for Special Purposes.

Rule 130 of the Pharmacy Location Rules, agreed to under the Sixth Community Pharmacy Agreement between the Pharmacy Guild and the Department of Health states that a pharmacy business must be "...at least 1.5 km, by straight line, from the nearest approved pharmacy."¹⁶ This is a barrier to establishing a pharmacy business that seeks to 'close the gap.'

ACCHSs applying to own a pharmacy business, for the purpose of removing barriers to accessing medications and pharmacy services specific population groups, should be able to apply for an exemption to Rule 130 of the Pharmacy Location Rules.

Recommendation 4: Improve patient access to S100 medicines by:

- a) Taking a holistic approach to address issues around subsidies schemes and QUM programs for Aboriginal people***
- b) Establishing a scheme to allow for S100 pharmacies to supply four weeks of PBS medications to discharged hospital patients.***

The Closing the Gap Indigenous Chronic Disease Co-Payment (CTG) allows Aboriginal people to have their PBS co-payment reduced from the general co-payment rate to the concessional rate. Patients must be registered prior to receiving a script under this measure. Prescribers must either be from an accredited General Practice, or from a non-remote Aboriginal Health Services.

S100 contracts do not allow Aboriginal people from remote areas to access the same service. Aboriginal health services in remote communities cannot write CTG prescriptions, and hospitals cannot write CTG prescriptions for out-patients.

This puts major limitations on remote clients who may travel into urban areas and require ongoing medications. For example, Congress clients who have a prescription from a remote Congress clinic from a Congress employed GP cannot access their medications unless they are prescribed on the town based Communicare system by another Congress GP even if they seek to fill it at the Congress pharmacy. This also applies under the Section 100 rules even if the patient is present with a CTG endorsed script from their remote GP. The Congress pharmacy cannot dispense against such a CTG script either. Such a patient would need to take the CTG script from their remote GP to a mainstream pharmacy and this is not what they want to do and often do not do. Additionally, the hospital cannot write CTG prescriptions for outpatients

This is an unnecessary barrier to access and does not recognise the mobility of people in remote areas. It is confusing for patients who are able to receive subsidised medications in one area, but not another. It also requires additional visits to providers for prescriptions at an unnecessary cost to the health system.

Additionally, remote ACCHSs cannot access QUMAX funding, as they can only access the S100 Support Allowance. In providing intensive expanded QUM services, S100 pharmacies should be able to access funding for QUMAX support services, such as the provision of DAA's. This will recognise the true cost of providing a QUMAX service and improve health outcomes. Likewise the supply fee in S100 pharmacies does not reflect the true value of S100 pharmacies that also dispense, and could be raised to reflect this value.

In its [submission](#)¹⁷ to the Review Board, the national peak Aboriginal health body, the National Aboriginal Community Controlled Health Organisation (NACCHO) suggests taking a comprehensive approach and systematically addressing all issues such as aligning S100 and CTG subsidy schemes. Additionally, NACCHO suggests creating a single QUM program that

aligns with QUMAX for all geographical locations, rather than incrementally adjusting programs which may lead to greater fragmentation. Congress supports the suggestion to align subsidy schemes and programs that are reinforcing barriers to access to medications and effective medication use.

Supplying four weeks of PBS medications to discharged hospital patients.

Royal Darwin Hospital has recently increased its discharge medications from one week supply to four weeks.¹⁸ This recognises the difficulty many patients face after discharge in getting to their GP to get a new prescription and more medication. Congress suggests that this should be the case for all hospitals, particularly those in remote areas where traveling to a GP and a pharmacy in a short period of time can be extremely difficult. In remote areas, four week medication supply should come through the S100 scheme.

¹ Freeman, T., Baum, F. Lawless, A., Javanparast, S. Jolley, G., Labonte, R. Bentley., M., Boffa, J., and Sanders, D. Reinstating the ability of Australian primary healthcare services to respond to health inequity, *Australian Journal of Primary Care*, 22, 2016, pp332-338.

² Stoneman, J. and Taylor, SJ., Improving access to medicines in urban, regional and rural Aboriginal communities – is expansion of Section 100 the answer? *Rural and Remote Health* 7: 738, 2007.

³ Stoneman, J. and Taylor, SJ. (above)

⁴ Stoneman, J. and Taylor, SJ.,(above)

⁵ Australian Institute of Health and Welfare (2015) Aboriginal and Torres Strait Islander Health Performance Framework 2014 report: Northern Territory. Cat. no. IHW 159. Canberra: AIHW, page 240

⁶ Malyon R, Zhao Y, Guthridge S (2010) Medicare Benefits Schedule and Pharmaceutical Benefits Scheme utilisation in the Northern Territory 1993-94 to 2008-09. Department of Health and Families, Darwin. Pages v, v1 and 34.

⁷ PBS Information Management Section, Pharmaceutical Policy Branch, Expenditure and Prescriptions twelve months to 30 June 2014, accessed from: <http://www.pbs.gov.au/statistics/2013-2014-files/expenditure-and-prescriptions-12-months-to-30-june-2014.pdf>

⁸ AIHW 2016. Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Australian Burden of Disease Study series no. 6. Cat. no. BOD 7. Canberra: AIHW.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Parksa,T. Smeesters, P., and Steer, A. Streptococcal skin infection and rheumatic heart disease, *Current Opinion in Infectious Diseases*. 25(2):145-53, 2012 Apr.

¹² <http://www.aihw.gov.au/australias-health/2016/preventing-ill-health/#t6>

¹³ <http://www.aihw.gov.au/australias-health/2016/in-brief/services/>

¹⁴ Davidson, P., Abbott, P., Davison, J., and DiGiacomo, M. Improving Medication Uptake in Aboriginal and Torres Strait Islander Peoples, *Heart, Lung and Circulation*, 19, 2010, 372-377.

¹⁵ Stoneman, J. and Taylor, SJ. (above)

¹⁶ Pharmacy Location Rules Applicant's Handbook v1.2 November 2015, Commonwealth of Australia 2015.

¹⁷ National Aboriginal Community Controlled Health Organisation (NACCHO) Submission to the Review of Pharmacy Remuneration and Regulation Discussion Paper, September 2016.

¹⁸ http://www.health.nt.gov.au/Pharmaceutical_Benefits_Scheme_Reform/index.aspx