Joint Position Paper:

Improving access to Pharmaceutical Benefits Schedule medicines for Aboriginal and Torres Strait Islander people through the Section 100 Remote Aboriginal Health Services Program

April 2012

The s100 Remote Aboriginal Health Services Program (s100 RAHSP)

- Section 100 (s100) of the National Health Act 1953 allows the Australian Health Minister to make special arrangements for the supply of Pharmaceutical Benefits Schedule (PBS) medicines where they cannot be effectively supplied through normal channels.

- The s100 RAHSP for remote area Aboriginal Health Services (RAAHS) was developed jointly by the Pharmacy Guild of Australia (the Guild) and the National Aboriginal Community Controlled Health Organisation (NACCHO) in 1999, in conjunction with the Department of Health and Ageing through the Australian Pharmaceutical Advisory Council (APAC).

- The s100 RAHSP has greatly improved access to medicines listed on the PBS and represents one of the most substantial positive developments in remote area Aboriginal health service delivery.

- The s100 RAHSP utilises the infrastructure of the network of remote area community pharmacies and their expertise in administering the PBS, and RAAHS's in their delivery of care to Aboriginal and Torres Strait Islander peoples.

- The s100 RAHSP addresses geographical, financial and other access barriers to all listed *PBS* medicines for all clients (Aboriginal and non-Aboriginal) of RAAHS's.

- PBS medicines listed under s100 RAHSP are provided at no cost to the patient, and without the need of a PBS prescription, to clients of RAAHS's.

- These arrangements eliminate:
  - the need for a client to pay any 'co-payment' for medicines and
  - bulk orders by RAAHS's mean that stocks of medicines are kept on site, eliminating the need for a client to take a prescription to another site for supply..

- The pharmacist is reimbursed for bulk orders by Medicare (excluding brand premiums).

- From its inception in 1999, the program has grown from:
  - servicing 35 RAAHS to 173 in 2011;
  - 250,000 PBS items supplied in 1999-2000 to more than 1.4 million in 2010-11; and
  - approximately 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[1]

Position

Throughout its 12 year history, numerous reviews have been conducted into the s100 RAHSP. These reviews have been consistent in their recommendations and unanimous in recognising the value of the program in addressing its **primary objective of increasing access to PBS medicines by Aboriginal and Torres Strait Islander People in remote areas**. The recent Senate report, for example, asserts that "*In summary, the committee has formed the view that the program has been successful in increasing access to PBS medicines through participating AHSs*"[2].

NACCHO and the Guild, as partners in the introduction and ongoing support and delivery of the program, hope that the Government's response to the Inquiry by the Senate Community Affairs References Committee will provide the opportunity to review the scheme in light not only of the Senate report, but also of the numerous reviews and evaluations which have preceded it.

Retention of Essential Features of Program

At the outset, NACCHO and the Guild believe that the essential features of the s100 RAHSP which have ensured its success to date must be retained. These include:

- Supply of PBS-medicines to RAAHS's through the existing network of community pharmacies, and at no cost to the patient,
- Utilisation of the existing infrastructure provided at the local RAAHS, without requiring the patient to travel to other venues,
- Provision of a one stop-shop at the RAAHS (patient gets medications and advice about using them at the time of visiting the RAAHS),
- Maintenance of culturally appropriate settings in which the patient is able to access medicines, and
- The simplicity of eligibility requirements for patients or staff (all clients are eligible without needing to produce Medicare or concession cards, or keep track of safety net totals).

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[1] Op. cit. p6

[2] Senate Community Affairs References Committee: The effectiveness of special arrangements for the supply of Pharmaceutical Benefits Scheme (PBS) medicines to remote Aboriginal Health Services. Senate Report October 2011. http://www.aph.gov.au/Senate/committee/clac_cttee/index.htm. Ch.2.9, p.15

Practical Ways to Enhance the Program

Uniform agreement from previous reviews establishes that in order to reach its full potential, a number of enhancements can and should be made to the program. Despite this there has to date been a failure to act on the many recommendations for improvements, noted by the recent senate report: *"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*."[3]

NACCHO and the Guild believe that the following enhancements would assist the program to reach its full potential, consistent with the Government's commitment to Closing the Gap.

1. **PBS medication utilisation data should be the accepted indication of the program's success in improving access to PBS medicines.**

   The primary objective of the program is to improve access to PBS medicines by enhancing supply. This is supported by the Cooperative Research Centre for Aboriginal and Tropical Health[4] review (2004) of the s100 RAHSP, which stated that the program is a supply program and the evaluation of its effectiveness pertains to indicators of supply, not on clinical impact. Further, this review notes that while it may be appealing to make claims regarding clinical outcomes, this confuses the issues relating to *access* to medicine with issues relating to the Quality Use of Medicines (QUM) and the effectiveness of medicines.

   Chapter 2.4 of the Senate report (while referring to chart 1) displays "*steady growth in the number of PBS items supplied to participating remote area AHSs".* It also refers to "*Studies completed by the AIHW…..confirm(ing) that the supply program has had an impact on the amount of PBS items being supplied to remote AHSs"*[5].

   To assist in QUM activities, RAAHS should receive an individual annual report from PBS utilisation data regarding items dispensed under the s100 RAHSP, including a breakdown of the class of medicine. Community pharmacies should also have access to this information.

2. **The current funding arrangements for supplying PBS medicines to RAAHS's through the existing network of community pharmacies should be enhanced.**

   All previous reviews agree that the program is working well, but should be enhanced.

3. **Freight costs should be funded based on a model which reflects the variables that drive these costs.**

   Where the cost of freight to and from the service is borne by RAAHSs and/or community pharmacies, this should be reimbursed. The reimbursement needs to take into account the *actual* cost of freight of the medicines, and the very nature of providing the medicines in bulk supply to *remote areas*. This cost can be impacted by the remoteness of the location, distance between the services, the freight services available in the area, and the ability to transport the medicines in a suitable environment, for example, maintaining cold-chain. Currently freight is a significant cost to both the RAAHS and to Community Pharmacy.

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[3] Op. cit p45

[4] M. Kelaher, D. Taylor-Thomson, N. Harrison, L. O'Donoghue, D. Dunt, T. Barnes and I. Anderson (2004) *Evaluation of PBS Medicine Supply Arrangements for Remote Area Aboriginal Health Services Under S100 of the National Health Act*, Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH), Menzies School of Health Research and the Program Evaluation Unit, University of Melbourne.

[5] op.cit. p.13

4. **RAAHS's should have increased access to a community pharmacist's services, supported by appropriate funding.**

As previous reports have highlighted, the true cost of providing QUM services need to be acknowledged. Community pharmacists provide more than just a supply service to RAAHS. For example, they assist the RAAHS in complying with state/territory legislation by advising and assisting in the establishment of protocols, including those related to the procurement of medicine, storage of medicines, medication compliance, administration of medicines and issue regarding supply, dispensing and record keeping.

The organisations believe a range of models could be devised to provide a higher level of QUM education and services. These need to be flexible and determined by the RAAHS and the community pharmacist jointly to result in an improved service to the patients.

For example:

- the underspend that is created by the difference between the s100 program handling fee and the PBS dispensing fee represents a service deficit, Where dispensing is occurring it is appropriate that a dispensing fee is paid. Or alternatively this money could be spent to improve QUM through other mechanisms such as a 'QUM budget' devised by the RAAH and in partnership with the community or academic pharmacist, similar to that developed as part of the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples (QUMAX) Program.[6]

- The Practice Nurse Incentive Program (PNIP) administered by Medicare Australia, where current support for AHSs can be provided to employ an 'allied health professional' instead of, or in addition to a practice nurse and/or Aboriginal Health Worker[7] should be expanded. The list of eligible 'allied health professionals' should be expanded to include the employment of 'community pharmacists' to offset the cost of the provision of QUM services to the RAAH.

- The activity of RAAHSs and community pharmacists in the supply and quality use of s100 medicines can be enhanced by introducing online systems for QUM workplan development under the s100 support allowance program (s100 PSAP)[8].

- The s100 PSAP should be 'uncapped' and relate to the volume of service and patient need, reflecting differences in care provided in acute care situations and chronic conditions management. Further, a full time position within NACCHO and the Guild could be established to promote and apply the s100 PSAP and its quality assurance to RAAHSs.[9]

[6] QUMAX was developed jointly by the Guild and the NACCHO under the 4th Community Pharmacy Agreement in 2006-07. It provided intensive QUM support, 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 under the 5th Community Pharmacy Agreement.

[7] Practice Nurse Incentive Program Guidelines (June 2011) Department of Health and Ageing.

[8] the s100 PSAP assists in enabling a community pharmacists to visit RAAHS's to provide them with a range of services to support QUM. The s100 PSAP is funded through the Community Pharmacy Agreements often with the pharmacy contributing to the cost of travel through income generated by the 'supply fee'.

[9] Nova Public Policy Pty Ltd. Evaluation of Indigenous Pharmacy Programs. Final Report. 28 June 2010

5. **A three-tiered handling fee should be adopted, which includes a subsidy for the provision of Dose Administration Aids (DAA) when requested by the RAAHS**

The Senate report at recommendation 3 (2.46)[10] recommends the provision of specific funding for DAA's, as have previous reports. In the absence of a DAA funding scheme under the s100 RAHSP, these costs have usually been borne by the RAAHS or community pharmacy themselves. The organisations believe that additional funding should be made, similar to the funding provided under the QUMAX Program which provides support to AHSs for DAAs in *non-remote* locations.

The three-tiered fee should include:

- a basic fee for 'bulk supply' to the pharmacist or dispensing pharmacy;
- a dispensing fee to RAAHSs (when generated by staff within the service) or the pharmacy; and
- a fee for the community pharmacy for the provision of DAAs when requested, similar to that provided under the Department of Veteran's Affairs DAA Service[11].

6. **The mobility of people living in remote areas should be recognised, along with their need to travel for specialist treatment and hospitalisation.**

Initiatives to improve Aboriginal peoples and Torres Strait Islander's access to PBS benefits in urban areas (QUMAX and Close the Gap - CTG PBS co-payment relief) have been successful, however, mechanisms are needed to enable the various schemes to work together to maintain access to PBS medicines while allowing patient travel between remote and urban areas, and between hospital and home. This is supported by Recommendation 9 (5.11) of the senate report where *"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."*[12]

The organisations believe that if an Aboriginal person or Torres Strait Islander is able to receive medicines under the s100 RAHSP, such patients should be registered for the CTG PBS Co-payment measure, if they meet eligibility criteria. RAAHSs should be permitted to provide CTG scripts to eligible patients if the service and the patient prefer this arrangement.

7. **The dispensing services in RAAHSs should be recognised.**

The supply activity of RAAHSs using medicines supplied in bulk from community pharmacy is currently not recognised as a cost to services which has led to a range of concerns regarding services capacity to undertake this activity. A scheme that provides funding for an adequate and full dispensing service for medicines supplied to clients through RAAHs would enable these clients to access appropriate pharmaceutical care.

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[10] Op.cit. p.24

[11] In 2008 the Department of Veterans' Affairs introduced a subsidised DAA service for eligible veterans in which the community pharmacist receives weekly payment for the DAA service, and payment to review the service every 6 months to ensure it remains appropriate.

[12] Op. cit. p50

8. **The inter-government Memorandums of Understanding established at the inception of the s100 RAHSP should be reviewed and reinstated.**

   Some states have elected to use tender processes to select which pharmacies will carry out the supply function under the program. This has resulted in the s100 RAHSP supply model differing significantly both between States and Territories and also between government and community controlled RAAHS's within the same State/Territory. There is a need for greater uniformity both to provide an even playing field and to achieve optimum outcomes, where the community pharmacy is providing more than just a supply service.

9. **The Department of Health and Ageing should establish a dedicated role to manage all PBS access programs for the Aboriginal population and be the key point of contact for pharmacists and RAAHS's and all ACCHSs.**

   A common source of frustration for RAAHS's and community pharmacies is the lack of clarity about who to contact where problems arise or when improvements are suggested. Integration of programs is recommended by the Senate report at Rec. 5.11.

10. **A national committee, including strong memberships from NACCHO, the Guild, and relevant state/territory authorities should be established for oversight of all PBS access programs for Aboriginal and Torres Strait Islanders.**

    This is consistent with recommendation 5 (2.71)[13] of the Senate report.

11. **Medicare Australia should collect medicine utilisation data through a streamlined electronic claiming system.**

    The review carried out by Australian Healthcare Associates (AHA) in 2010[14] noted that the current s100 RAHSP claiming process, which uses a paper-based multiple copy claims book, has not changed in the last ten years. Further, the review noted that the current claiming process is regarded by all participating pharmacists consulted to be cumbersome, frustrating and time consuming and results in unnecessary and costly delays in payment. Claims are generally submitted monthly but community pharmacists reported that it can take up to six weeks or longer to receive a cheque from Medicare Australia, which increases the financial burden borne by community pharmacies.

    To enable this Medicare Australia should develop an electronic claiming method for s100 RASHP claims that utilises already available technology such as PBS Online and Electronic Funds Transfer.

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[13] Op. cit. p30

[14] Australian Healthcare Associates (AHA). Review of the Existing Supply and Remuneration Arrangements for Drugs Listed under Section 100 of the National Health Act 1953. February 2010